2022 Care-Based Incentive
Technical Specifications

PROVIDER INCENTIVES

Updated: September 2022

HEALTHY PEOPLE. **HEALTHY** COMMUNITIES.

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Table of Contents

CBI PROGRAM OVERVIEW

The Care-Based Incentive (CBI) Program is designed in collaboration with Alliance network providers, and offers financial incentives and technical assistance to primary care providers (PCPs) to assist them in making improvements in the following areas:

- Care Coordination.
- Quality of Care.
- Performance Targets.
- Exploratory Measures.

The financial incentive payments offered through the CBI Program are an important mechanism in influencing discretionary activities among the Alliance's provider network. This program aims to increase health plan operational efficiencies by prioritizing areas that drive high quality of care and reduce healthcare costs. Such discretionary activities include:

- Improving quality outcomes, as reflected in part by the Managed Care Accountability Set, including National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) scores;
- Improving member experience;
- Encouraging delivery of high value care;
- Improving patient access and utilization of primary care;
- Encouraging use of disease registries to address population health;
- Encouraging adoption of best-practice care guidelines as recommended by U.S. Preventive Services Task Force (USPSTF); and
- Reducing disparities in quality or service delivery between groups of members and/or geographic regions.

A payment adjustment has been added to the 2022 CBI program to align with State performance expectations for the Quality of Care Measures. Medi-Cal Plans must meet or exceed the 50th percentile for State reported metrics. If the health plan doesn't meet the 50th percentile in one or more measures, they may be required to complete Plan, Do, Study, Acts, (PDSAs); assigned a Corrective Action Plans (CAPs); or sanctioned (including financial penalty). See Alliance Provider Manual for additional information on the 2022 CBI payment adjustments.

Although the CBI Program evaluates performance on the Alliance's Medi-Cal line of business only, the Alliance encourages the provision of quality, cost-efficient care for all of your health center's patients.

As noted above, the CBI Program and its measurement set are developed collaboratively with internal and external stakeholders. The Alliance receives feedback and approval from the following parties:

PROVIDER NETWORK:

The Alliance distributes information regarding QI programs, activities, and reports and actively elicits provider feedback via the following channels:

- Provider Bulletins, memorandums and email communication;
- Linked Member List, Quality Reports, and Care-Based Incentives Reports in the Provider Portal;
- Board Reports;
- CBI workshops and performance reviews including;
    - Plan–Do-Study-Act (PDSA) activities and on Performance Improvement Plan teams;
    - Medical Director and Provider Relations' onsite and network communication;

- External committee meetings; and
- Alliance physician committees.

The Alliance is committed to cultivating a strong network of providers. Your support and feedback will help us continue to ensure excellent health outcomes for our members and a robust CBI program for our providers.

CBI WORKGROUP: The CBI Program internal workgroup consists of representatives from Finance, Provider Relations, Contracts, Compliance, Data Analytics Services & Health Informatics, Application Services & Technology, Care Management, Quality Improvement and Population Health, Pharmacy and Medical Affairs who reviews program policies and proposed measure ideas.

CONTINUOUS QUALITY IMPROVEMENT COMMITTEE (CQIC): This committee consists of external physicians and administrators within Santa Cruz, Monterey and Merced counties, from a variety of practice types, and Alliance Directors and Medical Directors. The CQIC provides recommendations and feedback on measures, as well as advises on CBI operations.

PHYSICIAN ADVISORY GROUP (PAG): This committee consists of external physicians and administrators within Santa Cruz, Monterey and Merced counties, from a variety of practice types, and Alliance Directors, an Alliance Board member, and Alliance Medical Directors. This is a Brown Act committee who provides recommendations and feedback on measures.

ALLIANCE BOARD OF COMMISSIONERS (ALLIANCE BOARD): The Alliance Board approves the CBI measures and financial budget.

CBI PROGRAM SUPPORT

The following resources are available to providers to assist in your success in the CBI program:

PROVIDER PORTAL: The Alliance's Provider Portal offers reports utilizing claims, laboratory, immunization registries, pharmacy and provider portal entered data received on relevant CBI measures to assist providers in monitoring their patients and streamlining their administrative processes. Note: Data on the Provider Portal is subject to claims lag.

The following reports are available on the Provider Portal:

Linked Member List Reports: These reports offer your practice up to date information on members who may be indicated for preventative health services and assists in monitoring linked members with recent ED and hospital admission or discharge information. These reports are based on eCensus data and claims data, which may be subject to claims lag.

- Linked Member Roster.
- Newly Linked Members and 120-Day Initial Health Assessment (IHA).
- Linked Members Inpatient Admissions.
- Linked Members Emergency Department (ED) Visits.
- Linked Member High ED Utilizer.
- Open Referrals.
- Member Missed Appointments Report.

Note: If you click on the hyperlinked member ID's on the Linked Member Roster report, a member report is generated showing all CBI measures that a member is due for.

Quality Reports: Monthly Quality reports are clinical measures to assist providers in monitoring their patient's preventative health screenings and recommended care. The Quality reports include a mix of CBI and NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) derived reports and are designed as a tool for providers to create patient recall lists only. Some of the quality reports vary from the CBI methodology to provide prospective information. The information section at the beginning of the report will note how each report is designed. All reports are now refreshed monthly.

QUALITY REPORTS	
▪ Adult Immunizations	▪ Chlamydia and Gonorrhea Screenings
▪ Asthma Medication Ratio	▪ COVID-19 Immunizations
▪ Body Mass Index Assessment: Children & Adolescents	▪ Diabetes Care
▪ Breast Cancer Screenings	▪ Immunizations for Adolescents
▪ Cervical Cancer Screenings	▪ Lead Screening in Children
▪ Child & Adolescent Well-Care Visits (3-21 years)	▪ Prenatal Immunizations
▪ Childhood Immunizations (Combo 10)	▪ Well Child Visits (0-15 Months)

Data Submission Tool: The Data Submission Tool (DST) allows Alliance providers to upload data files via the Provider Portal. The DST was created to support providers in submitting data from their electronic health record and medical records to achieve compliance in the Care

Based Incentive (CBI) Program, Health Effectiveness Data Information Set (HEDIS) audit, and quality improvement projects with our providers. This data should supplement what cannot be received through claims, and instructions are found in the Data Submission Tool Guide on the Provider Portal. Data can be uploaded for the following measures:

- Application of Dental Fluoride Varnish.
- Breast Cancer Screening (includes bilateral mastectomy codes, mammography).
- Body Mass Index Assessment (BMI): Child & Adolescents.
- Cervical Cancer Screening (includes cervical cytology, high-risk papillomavirus [hrPHV], and total abdominal hysterectomy codes).
- Child and Adolescent Well-Care Visits
- Chlamydia Screening in Women.
- Controlling High Blood Pressure (diastolic and systolic values).
- Diabetic HbA1c Poor Control >9.0% (HbA1c lab values).
- Immunizations: Adolescents.
- Immunizations: Adults.
- Immunizations: Children.
- Initial Health Assessment (IHA).
- Screening for Depression and Follow-Up Plan.
- Unhealthy Alcohol Use in Adolescents and Adults.
- Well-Child Visits in the First 15 Months.

CBI Reports: The CBI reports are a resource for monitoring overall performance in the CBI program, as well as identifying opportunities for preventive care in your clinics. The CBI reports are available for review throughout the year.

CBI SUMMARY & PERFORMANCE REPORT
Summary views show your site level performance in comparison to your peers. Hyperlinks on the measure names show performance trending over the past couple years.

CBI FORENSIC REPORT
CBI forensics shows opportunities for measure improvement including the number of members needed to reach minimum and maximum CBI points and applicable benchmarks.

CBI MEASURE DETAIL & DASHBOARD REPORTS

Measure details provide member level reports for opportunities of patient outreach and integration of services into your practice. The CBI Dashboard provides a comparison graph of each CBI quarter for selected measures to your rate, peer rate, and minimum and high-performance levels.

MEASURE CATEGORY	MEASURE NAME
CARE COORDINATION – ACCESS MEASURES	Application of Dental Fluoride Varnish
	Developmental Screening in the First 3 Years
	Initial Health Assessment (IHA)
	Unhealthy Alcohol Use in Adolescents and Adults
MEASURE CATEGORY	**MEASURE NAME**
CARE COORDINATION – HOSPITAL & OUTPATIENT	Ambulatory Care Sensitive Admissions
	Preventable Emergency Visits

MEASURES	Plan All-Cause Readmission
MEASURE CATEGORY	**MEASURE NAME**
QUALITY OF CARE	Asthma Medication Ratio
	Body Mass Index (BMI) Assessment: Children & Adolescents
	Breast Cancer Screening
	Cervical Cancer Screening
	Child and Adolescent Well-Care Visits (3-21)
	Diabetic HbA1c Poor Control >9.0%
	Immunizations: Adolescents
	Immunizations: Children (Combo 10)
	Screening for Depression and Follow-up Plan
	Well-Child Visit In The First 15 Months
PERFORMANCE TARGET MEASURES	Member Reassignment
	Performance Improvement
EXPLORATORY MEASURES	90-Day Referral Completion
	Adverse Childhood Experiences (ACEs) in Children and Adolescents
	Chlamydia Screening in Women
	Controlling High Blood Pressure
	Health Plan Health Disparity
	Immunizations: Adults
	Lead Screening in Children
	Tuberculosis (TB) Risk Assessment

Additional Provider Portal resources include:

- Claims Search.
- RA Search.
- Overpayment Letters Search.
- Member Eligibility Verification.
- Provider Directory.
- Member Prescription History.
- Procedure Code Lookup
- Authorization and Referrals Search and Entry.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

CBI PROVIDER WORKSHOPS AND COLLABORATIVES: The Alliance holds CBI Provider Workshops and collaboratives in Santa Cruz, Monterey and Merced Counties. Please contact your Provider Relations Representative at (800) 700-3874 ext. 5504 or at CBI@ccah-alliance.org, for additional information on the CBI Workshop and collaborative schedules.

CBI FORENSICS: At the close of each CBI Program year, the Alliance reviews CBI performance for each provider site in our network. The Alliance conducts outreach efforts to sites that may benefit from additional program support, but Alliance staff is also available to meet with sites upon request to review their CBI data and offer support in improving performance in the CBI program. This is a valuable opportunity to receive additional support and training. Please contact us at CBI@ccah-alliance.org to schedule a CBI forensics visit with our CBI Quality Improvement & Population Health staff.

CBI UPDATES: Throughout the CBI year any announcements or updates to the CBI measures will be announced through one or more of the following sources:

- Provider Flash Announcements.
- Provider Digest Announcements.
- Provider Relations Representative Outreach.
- Provider Bulletin Articles.
- CBI Webinars.

If you are not already receiving our email publications, you can sign up for our digital news updates.

CBI PROGRAM CONTACT INFORMATION:
Care-Based Incentive Team Email: CBI@ccah-alliance.org
CBI Website: Care-Based Incentive (CBI) Resources
Provider Relations: (800) 700-3874 ext. 5504

PROGRAMMATIC MEASURES OVERVIEW %

Payment based on the PCP Site's performance in programmatic measures occurs once yearly following the end of quarter 4. During the first three quarters of the year, PCP sites are given a quarterly rate for their programmatic measures to provide them with an estimate of their performance. No payment is made for programmatic measures until quarter 4.

The rates for each quarter are calculated using a rolling 12-month measurement period. Therefore, each quarter contains 12-months of data for eligible members (ex: quarter 1 contains data from quarter 2 of prior year through quarter 1 of current year), however some measure requirements will look back further for numerator or denominator information (See the CBI Timeline on the CBI Incentive Summary for more details). In quarter 4, when programmatic payments are made, the report will contain eligible data for the calendar year only, January-December.

Point allocations for Programmatic Points are listed in the chart below. There is a total of 100 CBI programmatic points available each year. For a condensed listing of all CBI measures, refer to the CBI Incentive Summary. For yearly performance targets and a detailed explanation of point allocations by measure refer to the 2022 CBI Programmatic Measure Benchmarks & Performance Improvement.

PROGRAMMATIC MEASURES %	POINTS
Care Coordination (CC) - Access Measures	**22.5**
Application of Dental Fluoride Varnish	2
Developmental Screening in First 3 Years of Life	2
Initial Health Assessment	5
Post-Discharge Care	10.5
Unhealthy Alcohol Use In Adolescents & Adults	3
Care Coordination (CC) – Hospital & Outpatient Measures	**27.5**
Ambulatory Care Sensitive Admissions	8
Preventable Emergency Visits	9
Plan All-Cause Readmission	10.5
Quality of Care (QoC) Measures	**40**
Asthma Medication Ratio	Points distributed based on measure eligibility
Body Mass Index (BMI) Assessment: Children & Adolescents	
Breast Cancer Screening	
Cervical Cancer Screening	
Child and Adolescent Well-Care Visits (3-21)	
Diabetic HbA1c Poor Control >9.0 %	
Immunizations: Adolescents	
Immunizations: Children	
Screening for Depression and Follow-up Plan	
Well-Child Visit In The First 15 Months	
Performance Target (PT) Measures	**10**
Performance Improvement	10
Total Points	**100**

CARE COORDINATION – ACCESS MEASURES

APPLICATION OF DENTAL FLUORIDE VARNISH

Fluoride varnish is an important component of primary care to help prevent dental carries and in some cases reverse early dental caries in young children. Not only can dental decay affect the level of pain experienced by the child, but also their speech, ability to eat, ability to learn, and the way the child feels about themselves. Low income children are often at a higher risk for dental decay, which makes fluoride applications at well-child visits, follow-up visits, or standalone appointments an important part of routine care. Measure intention is to improve oral health management for at risk members.

MEASURE DESCRIPTION: The percentage of members ages 6 months to 5 years (up to before their 6th birthday) who received at least one topical fluoride application by staff at the PCP office during the measurement year.

MEMBER REQUIREMENT: PCP must have five members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: 6 months to 5 years (up to before their 6th birthday) at the end of the measurement period.

Continuous Enrollment: Continuously enrolled 4 months.

Eligible Member Event/Diagnosis: Paid claim for dental fluoride application or DST submission.

Exclusions:
- Administrative members at end of the measurement period.
- Dual coverage members.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: Number of members who received 1 dental fluoride applications by staff at the PCP office during the measurement year.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site that performed the service.

DATA SOURCE: Claims, Data Submission Tool.
CALCULATION FORMULA: Number of members who received one application of fluoride varnish in

the measurement year/total linked eligible members.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit fluoride varnish applications from their electronic health records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement
Application of Fluoride Varnish Tip Sheet
Fluoride Varnish Helping Smiles Stay Strong brochure for parents and caregivers.
Child Health and Disability Prevention (CHDP) Dental Training: Fluoride Varnish
CHDP Fluoride Varnish Protocol and Standing Order
CHDP Steps to Implement Fluoride Varnish in Your Medical Practice
CHDP County Offices
AAP Oral Health Prevention Primer
Smiles for Life: A National Oral Health Curriculum
Key Elements to Incorporate Oral Health in the Pediatric Electronic Health Record AAP Section on Oral Health

CODE SET:
CPT Code: 99188
CDT Code: D1206

DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS

The first years of a child's life are important in terms of cognitive, social and physical development. As a healthcare provider you play a pivotal role in identifying if a child has a developmental delay early and referring the child to receive the appropriate intervention services and support. Refer to the American Academy of Pediatrics (AAP) Bright Futures for guidelines on early childhood developmental screenings.

MEASURE DESCRIPTION: Percentage of members ages 1 – 3 years screened for risk of developmental, behavioral and social delay using a standardized tool in the 12 months preceding, or on their first, second or third birthday.

MEMBER REQUIREMENT: PCP must have five members that meet the eligible population criteria as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: 1 – 3 years of age.

Continuous Enrollment: Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday, with no more than one gap in enrollment of up to 45-days. Must be enrolled on the child's first, second, or third birthday.

Eligible Member Event/Diagnosis: None.

Exclusions:

- Administrative members as of end of CBI measurement period.
- Dual coverage members.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: Linked members 1 – 3 years with a developmental screening 12 months preceding or on their first, second, or third birthday.

DOCUMENTATION REQUIREMENTS: Documentation must include a standardized developmental screening tool, and note in the member's medical record:

- Indication of the standardized tool that was used.
- The date of the screening, and evidence that the tool was completed and scored.

Refer to the chart below for examples of standardized screening tools:

Developmental Screening Tool Name	Category	Topics Covered	Age	Time for Parent to Complete
Ages and Stages Questionnaire (ASQ-3)*	Development	Behavior, language development, motor, problem solving	1 month to 5 ½ years	10-15 minutes
Parents' Evaluation of Developmental Status (PEDS)	Development	Behavior, language development, motor, problem solving, social-emotional development	Birth to 8 years	2 minutes
Parents' Evaluation of Developmental Status- Developmental Milestones (PEDS-DM)	Development, social-emotional development	Behavior, language development, motor, problem solving, social-emotional development	Birth to 8 years	5 minutes
Survey of Well-being of Young Children (SWYC)	Development, autism, social-emotional development, maternal depression, social determinants of health	Autism, family stress, language development, maternal depression, motor, social-emotional development	Children under 5 years of age	5-10 minutes

Note: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional with established reliability, validity and sensitivity/specificity ratings of 0.70 and above.

Standardized tools that specifically focus on one domain of development (e.g. child's social emotional development [ASQ-SE] or autism [M-CHAT] do not qualify as screening tools that identify risk of developmental, behavioral, and social delays.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site who was linked during the child's 1st, 2nd, or 3rd birthday. The linked PCP site does not have to be the provider site that performed the service.

DATA SOURCE: Claims, Data Submission Tool, DHCS Fee-for-Service (FFS) encounter claims.

CALCULATION FORMULA: Members 1 – 3 years of age who received developmental screenings in the 12 months preceding or on their first, second or third birthday/total eligible members.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit developmental screenings from their electronic health records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement
Developmental Screening Tip Sheet
Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening.
Identification, Evaluation, and Management of Children With Autism Spectrum Disorder.
Developmental Surveillance: What, Why and How.
A Sample of A Screening Workflow.
Referring infants to Early Intervention Services.
CDC's Developmental Surveillance Resources for Healthcare Providers.
Developmental Screening Tool: Well-Validated Tools for Developmental Screening.
Birth to 5: Watch Me Thrive!

CODE SET
CPT Code: 96110

INITIAL HEALTH ASSESSMENT (IHA)

The Initial Health Assessment (IHA) measure encourages PCPs to perform a comprehensive visit within the first 120 calendar days of enrollment with the Alliance. IHAs support PCP practices in establishing strong physician-patient relationships and are an important tool for bringing new members up to date on preventative health screenings and providing health interventions to reduce future healthcare expenditures.

MEASURE DESCRIPTION: New members that receive a comprehensive IHA within 120 days of enrollment with the Alliance. The IHA must include an age appropriate Staying Healthy Assessment (SHA) form.

MEMBER REQUIREMENT: PCP must have five members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: All new members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members. If there is a lapse in enrollment with the Alliance of twelve (12) months, the member is re-eligible for the IHA incentive.

Age: N/A.

Continuous Enrollment: 120 days following enrollment (4 calendar months), no gap allowance.

Eligible Member Event/Diagnosis: New enrollment with the Alliance, or a renewed enrollment with a gap of greater than 12 months.

Exceptions/Exclusions:

- Administrative members at the end of the CBI measurement period.
- Dual coverage members within 120 days after enrollment.

DENOMINATOR: All new members linked to provider at the end the 120 days post enrollment. **Members must be enrolled in the Medi-Cal Program on or between October 1, 2021 and September 1, 2022 to qualify for the measure denominator.**

NUMERATOR: Claim showing IHA visit within 120 day of enrollment. IHA visit must be completed between October 2021 and December 2022. Note this is a rolling 15-month measurement period to accommodate 120 days post enrollment date as indicated in the denominator above.

DOCUMENTATION REQUIREMENTS:
All IHA visits require a:

- Comprehensive health history.
- Physical exam.
- Mental status exam.
- Health education/anticipatory guidance.
- Behavioral assessment.
- Diagnoses and a plan of care.

- SHA Form.

The California Department of Health Care Services (DHCS) **requires** the PCP to administer a SHA form within 120 days of enrollment, and again at defined intervals. For more background information, refer to the DHCS Staying Healthy Assessment webpage.

The Alliance has implemented the IHA dummy code combination to allow providers to report certain exemptions to performing the IHA. These exemptions include IHA completed 12 months prior to enrollment, members refusing an IHA, missed appointment or when they've attempted to schedule a member **at least** three times for their IHA appointment.

IHA 12 months prior to Medi-Cal enrollment
All elements of the IHA must be completed (including SHA) and if the members plan PCP did not perform the IHA within the last 12 months the PCP must record that the findings have been reviewed and updated in the members medical record. For members who have become newly eligible or had a commercial insurance prior but remain at an established PCP office an IHA is needed if a SHA was not completed in the visit 12 months prior.

Refusal
A member or members parent(s) may refuse the IHA appointment, in this case documentation of refusal should be in members medical record along with any attempts to schedule the IHA.

Missed Appointment
Should a member miss a scheduled appointment, two additional attempts must be made to reschedule the appointment and documentation must live in members medical record.

3 Attempts to Schedule
Providers can make three documented unsuccessful scheduling attempts (2 telephone attempts and 1 written attempt) to qualify for the measure.

The following coding combination is required for all above listed examples:
Procedure code: 99499
Modifier: KX
ICD-10 Code: Z00.00
Members will be compliant for an IHA if the provider has submitted a claim or uploaded to the Data Submission Tool on the Alliance Provider Portal:

Note: SHA forms are a required component of the IHA visit. Providers **do not** need to fax the SHA form to the Alliance. SHA forms should be maintained in the patient's chart and will be audited as part of the routine Facility Site Review (FSR) requirements. The Alliance performs random audits to ensure that IHA dummy codes were submitted appropriately.

SERVICING PROVIDER REQUIREMENT: Members must be linked to the PCP Site at the end of the measurement period for the member to qualify for the site's IHA rate. Administrative members are eligible for the IHA incentive if they are linked to a PCP site at the end of the measurement period.

DATA SOURCE: Claims, Data Submission Tool.

CALCULATION FORMULA: Number of members with an IHA or outreach attempts within 120 days/eligible members as detailed above.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Linked Members List- Newly Linked Members and 120 IHA** monthly report provides a list of your linked members due for an IHA.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit initial health assessment visit or outreach data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement
Initial Health Assessment Tip Sheet
DHCS SHA Instruction Sheet for the Provider Office (includes the SHA Periodicity Table)
DHCS Staying Healthy Questionnaires (including English, Spanish and Hmong versions)
DHCS MMCD Policy Letter No. 08-003
DHCS MMCD Policy Letter 99-07

CODE SET LINKS:
IHA Codes: See Initial Health Assessment Tip Sheet

POST-DISCHARGE CARE

Members who have been discharged from an acute hospital stay benefit from a follow-up visit with their PCP to review their post-discharge instructions, perform medication reconciliation, and ensure the member has adequate post hospital support. This is a critical transition and can prevent adverse events and reduce the probability of hospital readmissions.

The Alliance offers the Post-Discharge Care incentive to compliment the Plan All-Cause Readmission incentive and support providers in reducing hospital readmissions.

MEASURE DESCRIPTION: 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.

MEMBER REQUIREMENT: PCP must have five linked members that meet the eligible population criteria as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: N/A.

Eligible Member Event/Diagnosis: Any linked member that has an inpatient discharge.

Continuous Enrollment: Member must be continuously enrolled for any 4 months during the CBI Measurement Period, no gap allowance. Member must be enrolled for the 14 days following the qualifying inpatient discharge.

Exclusions:

- Postpartum and healthy newborn care visits are excluded. NICU newborns are *included*.
- Administrative members at the end of the CBI measurement period.
- Dual coverage members.

DENOMINATOR: All instances of Members discharged from hospital during the rolling 12-month measurement period and 14 days prior to the end of the measurement period.

If provider has 0 inpatient admissions during the measurement period, they receive full points for the measure. >1 inpatient admission is measured based on a rate of post discharge visits/inpatient admissions and compared to the established benchmarks to determine point allocations. See 2022 CBI Programmatic Measure Benchmarks & Performance Improvement for more details.

NUMERATOR: Instances of members who received a post discharge visit with their linked PCP within 14 days of discharge from hospital inpatient stay. Outpatient visits include telehealth (telephone, online assessment, or video visit matching Medi-Cal guidelines for billing telehealth visits and the post-discharge code set).

SERVICING PCP SITE REQUIREMENT: Member must be seen for post discharge visit by the linked

PCP provider site. Visits completed by specialists or a PCP at a site where the member is not linked will *not* be counted.

DATA SOURCE: Claims.

CALCULATION FORMULA: Number of post discharge visits with 14 days of discharge/total number of inpatient discharges.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal **Linked Member List- 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 Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.

CODE SET LINKS:
2022 Post-Discharge Care Codes

UNHEALTHY ALCOHOL USE IN ADOLESCENTS & ADULTS

Unhealthy alcohol use screening in adolescents & adults is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol. The United States Preventive Services Task Force (USPSTF) recommends that providers screen adolescent and adult members for alcohol use disorder and work towards providing those currently suffering from or at risk of developing these disorders with a comprehensive, integrated delivery of early intervention and treatment services.

MEASURE DESCRIPTION: Members 11 years and older who are screened for unhealthy alcohol use in primary care settings and providing persons 18 years and older engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use in the measurement year.

MEMBER REQUIREMENT: PCP must have five members that meet the eligible population criteria as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: 11 years of age or older.

Continuous Enrollment: Member must be continuously enrolled for any 4 months during the CBI Measurement Period, no gap allowance.

Eligible Member Event/Diagnosis: N/A.

Exclusions:

- Administrative members as of end of CBI measurement period.
- Dual coverage members.
- Claims submitted to Beacon.

DENOMINATOR: All linked members 11 years and older as of the end of the measurement period.

NUMERATOR: Linked members 11 years and older with a finalized paid claim or DST submission in the measurement year for either:

- Annual unhealthy alcohol use screening, 15 minutes.
- Brief face-to-face behavioral counseling for unhealthy alcohol use, 15 minutes.

Note: Members with either a screening or a brief intervention in the measurement year will qualify as CBI compliant. However, if a member has a screening and an intervention or multiple interventions, they will be counted multiple times in the numerator. This means it is possible that your site will see a rate of >100% in this measure. The maximum number of points awarded does not increase with an >100% score. The Alliance asks that providers use clinical judgment in assessing the needs of their patients.

Alcohol screening and treatment services are reimbursed outside of regular capitated rates. For both capitated and non-capitated Alliance providers, the Alliance will reimburse 150% of Medi-Cal rates to our contracted providers. FQHCs may want to review how these payments effect State reconciliation cost reporting. **FQHC / Rural Health Center tip:** Do not bill the Alliance for more than what Medi-Cal allows

to avoid repayment.

DOCUMENTATION REQUIREMENTS:
Initial Screening: Screening is only reimbursable with a validated screening tool. Example tools include:

- **Alcohol Use Disorders Identification Test (AUDIT)**: Tool was originally designed for adults 18 years and older, but research supports the use in adolescents 14 years and older.
- **Alcohol Use Disorders Identification Test - Concise (AUDIT-C)**.
- **CRAFT (Car, Relax, Alone, Friends, Forget, Trouble)**: for adolescents only.
- **CAGE (Cut-Annoyed-Guilty-Eye)**: Tool originally designed for individuals over the age of 16 years old.
- **Michigan Alcoholism Screening Test Geriatric (MAST-G)** alcohol screening for geriatric population.
- **Parents, Partner, Past and Present (4Ps)** for pregnant women and adolescents.
- **Single-question screening**, such as asking, "How many times in the past year have you had 4 (for women and all adults older than 65 years) or 5 (for men) or more drinks in a day?" as aligned in the Staying Healthy Assessment.
- **Tobacco, Alcohol, Prescription medication and other Substances (TAPS)**.

Brief Intervention: When an initial screening is positive, providers should use an appropriate validated assessment tool like the Alcohol Use Disorders Identification Test (AUDIT). The brief intervention may include an initial intervention, a follow-up intervention and/or a referral; and can take place on the same date of service as the full screen or on subsequent days.

SERVICING PCP SITE REQUIREMENT: Members need to be linked to a PCP at end of measurement period, and the service must be performed by a provider billing under the PCP site group. If performed by Behavioral Health therapists, the service should be billed under the same clinic NPI as the linked PCP to be awarded CBI payment.

DATA SOURCE: Claims, Data Submission Tool.

CALCULATION FORMULA: Members with completed AMSC in the measurement year/total eligible members.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit codes for screenings and or brief interventions from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation. The member must be 11 years or older at the time of the screening.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.

Unhealthy Alcohol Use in Adolescents and Adults Tip Sheet.
CDC Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use a Step-by-Step Guide for Primary Care Practices.

CODE SET:

CODE TYPE	CODE	CODE DESCRIPTION
LOINC	88037-7	(Men 18 years and older): How often have you had five or more drinks in one day during the past year
LOINC	75889-6	(Women 18 years and older & Older Adults): How often have you had four or more drinks in one day during the past year
LOINC	75624-7	Screening tool: AUDIT
LOINC	75626-2	Screening tool: AUDIT-C
HCPCS	G0442	Annual alcohol misuse screening, 15 minutes
HCPCS	G0443	End date June 30, 2021: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
HCPCS	H0049	Start date June 9. 2020: Screening for 11yrs+: Alcohol and/or drug screening
HCPCS	H0050	Start date July 1, 2021: Treatment for 18yrs+: Alcohol and/or drug services, brief intervention, per 15 minutes

CARE COORDINATION – HOSPITAL & OUTPATIENT MEASURES

AMBULATORY CARE SENSITIVE ADMISSIONS

Reductions in hospitalizations for ambulatory care sensitive conditions are considered a measure of good access to primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care (defined as medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services) can reduce ambulatory care sensitive admission by preventing the onset of particular conditions, controlling an acute episodic illness or condition, or managing a chronic disease or condition.

MEASURE DESCRIPTION: The rate of ambulatory care sensitive admissions per 1,000 members per year. The list of ambulatory care sensitive conditions is derived from the Prevention Quality Indicators (PQI) and the Pediatric Quality Indicators (PDI) criteria released by the Agency for Health Care Research and Quality (AHRQ).

Note: This is an inverse measure; a lower rate of readmission qualifies for more CBI points.

MEMBER REQUIREMENT: PCP must have an average of 100 members that meet the eligible population criteria during the measurement period **or** a minimum of 100 members that meet the eligible population criteria on the last day of the measurement period.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: Condition specific as outlined by AHRQ.

Continuous Enrollment: Member must be continuously enrolled for any 4 months during the CBI Measurement Period, no gap allowance.

Denominator Event/Diagnosis: None.

Exclusions:

- Condition specific as outlined by the AHRQ.
- Administrative members.
- Dual coverage members.
- California Children's Services (CCS) members.

DENOMINATOR: Total linked member months.

NUMERATOR: Inpatient admission with a qualifying diagnosis from the Alliance adapted AHRQ ambulatory care sensitive condition list.

Diagnosis list includes:

- Angina without procedure.
- Asthma in younger adults.
- Bacterial pneumonia.
- COPD/Asthma in older adults (> 40 years old).
- Diabetes long-term complications.

- Diabetes short-term complications.
- Heart failure.
- Hypertension.
- Lower extremity amputation w diabetes.
- Pediatric asthma.
- Pediatric gastroenteritis.
- Pediatric short-term diabetes.
- Pediatric urinary tract infection.
- Uncontrolled diabetes.
- Urinary tract infection.

SERVICING PCP SITE REQUIREMENT: The member's linked PCP at time of admission.

DATA SOURCE: Claims.

CALCULATION FORMULA: (Number of Ambulatory Care Sensitive Admissions/Total member months) *12,000.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal **Linked Member List- Linked Member Inpatient Admissions** report provides a real time report of your linked members with inpatient admissions or recent discharges at regional hospitals using eCensus data (Note: not all hospitals participate in eCensus).

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Ambulatory Care Sensitive Admissions Tip Sheet.

CODE SET LINKS:
The list of ambulatory care sensitive conditions is derived from the Prevention Quality Indicators (PQI) and the Pediatric Quality Indicators (PDI) criteria released by the Agency for Health Care Research and Quality (AHRQ). Note that the links below contain both the AHRQ code sets as well as the actual Alliance code sets used to calculate the measure.
2022 Ambulatory Care Sensitive Admissions Inclusion Codes.
2022 Ambulatory Care Sensitive Admissions Exclusion Codes.

Measure Derived From:
AHRQ PQI Individual Measure Technical Specifications (v2021 coding).
AHRQ PDI Individual Measure Technical Specifications (v2021 coding).

PLAN ALL-CAUSE READMISSIONS

Discharge from a hospital is a critical transition point in a patient's care. Poor care coordination at discharge can lead to adverse events for patients and avoidable readmissions. Unplanned readmissions are associated with increased mortality and increased healthcare costs. The CBI Program seeks to improve the communication and coordination of care during an admission stay and to improve communication with caregivers at the time of discharge. The Alliance offers the Post Discharge incentive to compliment the Plan All-Cause Readmission incentive and support providers in reducing hospital readmissions.

MEASURE DESCRIPTION: 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.

Note: This is an inverse measure; a lower rate of readmission qualifies for more CBI points.

MEMBER REQUIREMENT: PCP must have an average of 100 members that meet the eligible population criteria during the measurement period **or** a minimum of 100 members that meet the eligible population criteria on the last day of the measurement period.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: 18-64 years of age.

Continuous Enrollment: 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date with a 45-day gap during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.

Eligible Member Event/Diagnosis: Readmission within the past 30 days.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.
- Deceased members in the measurement year.
- Member died during the stay.
- Female members with a principal diagnosis of pregnancy or perinatal condition on the discharge claim.
- Planned admissions associated with:
  - A principal diagnosis of maintenance chemotherapy.
  - A principal diagnosis of rehabilitation.
  - Organ transplants (kidney, bone marrow, organ, and introduction to autologous pancreatic cells).
- Potentially planned procedures without a principal acute diagnosis (Example: Coronary Artery Bypass, drainage of upper extremity, and fusion of lumbosacral joint).

DENOMINATOR: An acute inpatient or observation stay with a discharge date on or between January 1 and December 1 of the measurement year (known as Index Discharge Date).

NUMERATOR: Count of acute readmissions that occur within 30 days of an acute inpatient discharge. PCP at time of the Index Discharge Date.

SERVICING PCP SITE REQUIREMENT: Member must be linked to PCP at time of initial hospital stay discharge date.

DATA SOURCE: Claims.

CALCULATION FORMULA: (#Readmissions/Index Discharge Date).

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal **Linked Member List- Linked Member Inpatient Admissions** report provides a real time report of your linked members with inpatient admissions or recent discharges at regional hospitals using eCensus data (Note: not all hospitals participate in eCensus).

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Plan All-Cause Readmission Tip Sheet.

CODE SET LINK:
2022 Plan All-Cause Readmission Exclusion Codes.

PREVENTABLE EMERGENCY VISITS

Research has found that a substantial proportion of visits to the emergency department (ED) and urgent care centers could have been avoided through timely primary care. Health centers play a vital role in reducing preventable ED and urgent visits by providing accessible, continuous and comprehensive primary care.

The CBI Program encourages PCP providers to focus on member access, education and after-hours options to reduce preventable ED and urgent visits.

MEASURE DESCRIPTION: Rate of preventable ED and urgent visits per 1,000 members per year. This measure is derived from the *Statewide Collaborative Quality Improvement Project: Reducing Avoidable Emergency Room Visits.*

Note: This is an inverse measure; a lower rate of readmission qualifies for more CBI points.

MEMBER REQUIREMENT: PCP must have an average of 100 members that meet the eligible population criteria during the measurement period **or** a minimum of 100 members that meet the eligible population criteria on the last day of the measurement period.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: Greater than one year old at date of service.

Continuous Enrollment: Member must be continuously enrolled for any 4 months during the CBI Measurement Period, no gap allowance.

Eligible Member Event/Diagnosis: None.

Exclusions:

- ED visits that result in inpatient admissions.
- Members less than one year of age at date of service.
- Administrative members.
- Dual coverage members.
- California Children's Services (CCS) members.

DENOMINATOR: Total linked member months.

NUMERATOR: ED and urgent visits with a principal diagnosis of a preventable condition.

SERVICING PCP SITE REQUIREMENT: Linked PCP at date of preventable emergency visit.

DATA SOURCE: Claims.

CALCULATION FORMULA: (# of Preventable ED and Urgent Visits/Total member months) *12,000
Note: Urgent visits count as one half of a visit.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal **Linked Member List- Linked Member ED Visits** provides a real time report of your linked members recently seen at the emergency department at regional hospitals using eCensus data (Note: not all hospitals participate in eCensus). Under the same Linked Member List reports is a **Linked Member List- Linked Members High ED Utilizers** report that shares members who have received services in the ED 3 or more times in a 90-day period.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement
Preventable Emergency Visit Diagnosis
Preventable Emergency Visits Tip Sheet
Impacting Use of the Emergency Department Physician Toolkit and PCP Assessment Tool

Measure derived from: Statewide Collaborative Quality Improvement Project: Reducing Avoidable Emergency Room Visits.

CODE SET LINKS:
2022 Preventable Emergency Visits Codes.

QUALITY OF CARE MEASURES

ASTHMA MEDICATION RATIO

Asthma is a lifelong disease that can limit a person's quality of life. Medications for asthma are categorized into long-term controller medications used to achieve and maintain control of persistent asthma and quick-relief controllers used to treat acute symptoms and exacerbations.

The CBI Program encourages PCPs to monitor the appropriate ratios of asthma medications to reduce hospitalizations, emergency room visits and healthcare expenditures. The Alliance offers the Healthy Breathing for Life (HBL) program to assist members in self-managing their asthma.

MEASURE DESCRIPTION: The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

MEMBER REQUIREMENT: PCP Site must have at least 30 members that meet the eligible population criteria, as defined below.

DEFINITIONS:

Oral medication dispensing event: One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days' supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.

Inhaler dispensing event: When identifying the eligible population, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the Drug ID field in the National Drug Code (NDC) list to determine if the medications are the same or different.

Injection dispensing event: Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Units of medications: When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, or a 30-day or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event.

Use the package size and units' columns in the NDC list to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicate the dispensed amount is 30 g, this designates 3 inhaler canisters were dispensed.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: 5 – 64 as of the last day of the measurement period.

Continuous Enrollment: Rolling 24 months with a 45-day allowable gap during each year of continuous enrollment. Member must be enrolled on the last day of the measurement period.

Exclusions:

- Members who had a diagnosis of any of the following any time during the member's history through December 31 of the measurement year:
  - Emphysema.
  - COPD.
  - Obstructive Chronic Bronchitis.
  - Chronic Respiratory Conditions Due to Fumes/Vapors.
  - Cystic Fibrosis.
  - Acute Respiratory Failure.
- Members who had no asthma medications (controller or reliever) dispensed (Asthma Controller and Reliever Medications List) during the measurement year.
- Members enrolled in hospice.
- Administrative members at the end of the CBI measurement period.
- Dual coverage members.

ELIGIBLE MEMBER EVENT/DIAGNOSIS: Follow the steps below to identify the eligible population.

Step 1 - Identify members as having persistent asthma who met at least one of the following criteria during **both the measurement year and the year prior** to the measurement year. Criteria need not be the same across both years.

- At least one ED visit with a principal diagnosis of asthma.
- At least one acute inpatient encounter with a principal diagnosis of asthma without telehealth.
- At least one acute inpatient discharge with a principal diagnosis of asthma (Inpatient Stay and Nonacute Inpatient Stat).
- At least four outpatient visits, observation visits, or telehealth (Telephone or Online Assessment) visits on different dates of service, with any diagnosis of asthma ***and*** at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events for any controller medication or reliever medication.

Note: Follow Medi-Cal guidelines when submitting telehealth services, referenced in the resources section below.

Step 2 – A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year).

DENOMINATOR: Eligible population (as defined above).

NUMERATOR: The number of members who have a medication ratio of 0.50 or greater during the measurement year.

Follow the steps below to calculate the ratio.

Step 1 – For each member, count the units of controller medications (Asthma Controller Medications List) dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 2 – For each member, count the units of reliever medications (Asthma Reliever Medications List) dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 3 – For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4 – For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

$$\frac{\text{Units of Controller Medications (step 1)}}{\text{Units of Total Asthma Medications (step 3)}}$$

Step 5 – Sum the total number of members who have a ratio of 0.50 or greater in step 4.

ASTHMA CONTROLLER AND RELIEVER MEDICATIONS

Asthma Controller Medications		
Description	**Prescriptions**	**Route**
Antiasthmatic combinations	Dyphylline-guaifenesin	Oral
Antibody inhibitors	Omalizumab	Injection
Anti-interleukin-4	Dupilumab	Injection
Anti-interleukin-5	Benralizumab	Injection
Anti-interleukin-5	Mepolizumab	Injection
Anti-interleukin-5	Reslizumab	Injection
Inhaled steroid combinations	Budesonide-formoterol	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Inhalation
Inhaled corticosteroids	Beclomethasone	Inhalation
Inhaled corticosteroids	Budesonide	Inhalation
Inhaled corticosteroids	Ciclesonide	Inhalation
Inhaled corticosteroids	Flunisolide	Inhalation
Inhaled corticosteroids	Fluticasone	Inhalation
Inhaled corticosteroids	Mometasone	Inhalation
Leukotriene modifiers	Montelukast	Oral
Leukotriene modifiers	Zafirlukast	Oral
Leukotriene modifiers	Zileuton	Oral
Methylxanthines	Theophylline	Oral

Asthma Reliever Medications		
Description	**Prescriptions**	**Route**
Short-acting, inhaled beta-2 agonists	• Albuterol	• Inhalation
Short-acting, inhaled beta-2 agonists	• Levalbuterol	• Inhalation

Note: Beginning Jan. 1, 2022, Medi-Cal pharmacy benefits will be provided through Medi-Cal Rx. You can access their Contact Drugs List, Medi-Cal Rx portal, subscribe to Medi-Cal Rx news updates or locate a Medi-Cal Rx pharmacy on the DHCS Medi-Cal Rx homepage.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site who prescribed the medications.

DATA SOURCE: Claims, Pharmacy, DHCS FFS encounter claims,

CALCULATION FORMULA: Number of members with a controller medication ratio of 0.50 or greater (calculated from units of controller medications/units of total asthma medication)/total eligible population.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report - Asthma Medication Ratio** provides a list of linked members and their asthma care, including counts of controller and reliever medications, and the current asthma medication ratio.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Asthma Medication Ratio Tip Sheet.
Alliance Provider Network: Guidance on Telehealth Services.

CODE SET LINKS:
2022 Asthma Exclusions Codes.
2022 Asthma Inclusion Codes.
2022 Asthma Controller and Reliever Medication NDC Codes.
2022 Hospice Exclusion Codes.

BODY MASS INDEX (BMI) ASSESSMENT: CHILDREN & ADOLESCENT

Over the last three decades, childhood obesity has more than doubled in children and tripled in adolescents[1]. Childhood Obesity is the primary health concern among parents in the United States and has long-term effects on the health and well-being of the child.

The CBI Program assists PCPs to monitor BMI screenings and establish routine preventive care to help members in reaching their healthy weight goals and reduce healthcare costs.

MEASURE DESCRIPTION: The percentage of members 3 - 17 years of age who had an outpatient visit with a PCP or OB/GYN and had a BMI percentile documented during the measurement year.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: 3 – 17 years as of December 31 of the measurement year.

Continuous Enrollment: The measurement year with a 45-day allowable gap. Member must be enrolled on the last day of the measurement period.

Eligible Member Event/Diagnosis: Members who had an outpatient visit with a PCP or an OB/GYN during the measurement year.

Exclusions:

- Members enrolled in hospice.
- Administrative members.
- Dual coverage members.
- Female members who had a diagnosis of pregnancy during the measurement year.

DENOMINATOR: Eligible population, as defined above.

NUMERATOR: BMI percentile during the measurement year.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site that performed the service.

DATA SOURCE: Claims, Data Submission Tool, DHCS FFS encounter claims.

CALCULATION FORMULA: Number of members who had an outpatient visit using criteria above with evidence of a BMI documented/total eligible linked members.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report - Body Mass Index Assessment: Children and Adolescents** provides a list linked members 3-17 years of age a list of who, according to our records may or may not have not received their annual BMI screening.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit BMI percentile data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Body Mass Index (BMI) Assessment: Children and Adolescents Tip Sheet.
Promoting Health Weight Implementation Tip Sheet from Bright Futures.

REFERENCES:
Centers for Disease Control and Prevention (CDC). 2013. "Adolescent and School Health: Childhood Obesity Facts." http://www.cdc.gov/healthyyouth/obesity/facts.htm American Heart Association. 2013.

CODE SET LINKS:
2022 Children & Adolescent BMI Assessment Inclusion Codes.
2022 Children & Adolescent BMI Assessment Exclusion Codes.
2022 Hospice Exclusion Codes.

BREAST CANCER SCREENING

Breast cancer is the second most common cancer among women after certain skin cancers regardless of your race or ethnicity, and it can occur at any age, but the risk of getting it increases with age[1]. Early breast cancer is typically without symptoms, and survival rates are highest when breast cancer is found early. Mammograms will detect 80 – 90% of breast cancers in women without any symptoms[2].

MEASURE DESCRIPTION: 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.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: 52–74 years of age by the end of the measurement period.

Continuous Enrollment: October 1 two years prior to the measurement year through December 31 of the measurement year. No more than one gap of enrollment of up to 45 days for each full calendar year of continuous enrollment. Member must be enrolled on the last day of the measurement period.

Eligible Member Event/Diagnosis: None.

Exclusions:

- Administrative members at end of the measurement period.
- Dual coverage members.
- Members enrolled in hospice.
- Members receiving palliative care during the measurement year.
- A bilateral mastectomy or two separate unilateral mastectomy procedures on right and left side any time during the member's history through the end of the measurement period. Example:

LEFT MASTECTOMY (ANY OF THE FOLLOWING)	RIGHT MASTECTOMY (ANY OF THE FOLLOWING)
Unilateral mastectomy with a left-side modifier (same procedure)	Unilateral mastectomy with a right-side modifier (same procedure)
Unilateral mastectomy found in clinical data with a left-side modifier (same procedure)	Unilateral mastectomy found in clinical data with a right-side modifier (same procedure)
Absence of the left breast	Absence of the right breast
Left unilateral mastectomy	Right unilateral mastectomy

- Members 66 years of age and older as of the end of the measurement year with frailty and advanced illness. To identify members with frailty, at least one claim for frailty (frailty device, diagnosis, encounter, or symptom) during the measurement year. To identify members with advanced illness, any of the following criteria during the measurement year or the year prior to the measurement year are eligible:
    - At least two outpatient visits, observation visits, online assessments, ED visits, e-visit or virtual check-in, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits.
    - At least one acute inpatient encounter or inpatient discharge with an advanced illness diagnosis.
    - A dispensed dementia medication.

TABLE: DEMENTIA MEDICATIONS

DESCRIPTION	PRESCRIPTION		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	Memantine		
Dementia combinations	Donepezil-memantine		

Note: Beginning Jan. 1, 2022, Medi-Cal pharmacy benefits will be provided through Medi-Cal Rx. You can access their Contact Drugs List, Medi-Cal Rx portal, subscribe to Medi-Cal Rx news updates or locate a Medi-Cal Rx pharmacy on the DHCS Medi-Cal Rx homepage.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: One or more mammograms any time on or between October 1 two years prior to the Measurement Period and the end of the Measurement Period.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site that performed the service.

DATA SOURCE: Claims, DST, DHCS FFS encounter claims.

CALCULATION FORMULA: Number of paid claims for mammograms on or between October 1 two years prior to the measurement period to the end of the measurement period/total linked eligible members.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Breast Cancer Screenings** provides a list of linked members who, according to our records may or may not have received breast cancer screenings and their screening date.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit mammography and bilateral mastectomy data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal

account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Breast Cancer Screening Tip Sheet

CODE SET:
2022 Breast Cancer Screening Inclusion Codes
2022 Breast Cancer Screening Exclusion Codes
2022 Breast Cancer Medications
2022 Hospice Exclusion Codes
2022 Dementia Medication NDC Exclusion Codes
2022 Palliative Care Exclusion Codes

REFERENCE:
1. Division of Cancer Prevention and Control, Centers for Disease Control and Prevention. Breast Cancer Statistics. Nov. 4, 2019 https://www.cdc.gov/cancer/breast/statistics/index.htm.
2. Siu AL, on behalf of the U.S. Preventive Services Task Force. Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2016;164:279-296. doi: 10.7326/M15-2886.

CERVICAL CANCER SCREENING

Cervical cancer can be detected in its early stages by regular screening with cytology (Pap smear) test. The American College of Obstetricians and Gynecologists, the American Medical Association and the American Cancer Society recommend Pap testing every three years for all women who have been sexually active and who are over 21. For women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing or cervical high-risk human papillomavirus (hrHPV) is recommended every 5 years.

The CBI Program assists PCPs to monitor cervical cancer screenings and establish routine preventive care to decrease morbidity and mortality from cervical cancer, with reduced proximal healthcare expenditures.

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

- Women age 21–64 who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women age 30–64 who had cervical cytology and human papillomavirus (HPV) co-testing performed within the last 5 years.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: Women 24 – 64 as of the last day of the measurement period.

Continuous Enrollment: The measurement year and the two years prior to the measurement year. No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. Member must be enrolled on the last day of the measurement period.

Eligible Member Event/Diagnosis: None.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.
- Members receiving palliative care during the measurement year.
- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through the end of the measurement period.

DENOMINATOR: Eligible population, as defined above.

NUMERATOR: The number of women who were screened for cervical cancer as identified in steps 1 and 2 below.

Step 1 – Identify women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year.
Step 2 – From the women who did not meet step 1 criteria, identify women 30–64 years of age as of

December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) test during the measurement year or the four years prior to the measurement year ***and*** who were 30 years or older on the date of the test.

Note: If a member had a recent hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix after a lab screening within the measurement timeframe, the member will remain in the denominator for the compliant lab screening.

DOCUMENTATION REQUIREMENTS: Please document the following in the medical records:

- A note indicating the date when the cervical cytology or hrHPV test was performed was performed as well as the result or finding.
- For evidence of hysterectomy with no residual cervix
    - Documentation of "complete," "total" or "radical" hysterectomy (abdominal, vaginal or unspecified).
    - Documentation of "vaginal hysterectomy."
    - Documentation of "vaginal pap smear" in conjunction with documentation of "hysterectomy."
    - Documentation of "hysterectomy" in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

  Documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site that performed the service.

DATA SOURCE: Claims, laboratory data, Data Submission Tool, DHCS FFS encounter claims.

CALCULATION FORMULA: Number of women who screened for cervical cancer using criteria above/total eligible linked members.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Cervical Cancer Screenings** provides a list of linked members who, according to our records may or may not have received cervical cancer screenings and their screening date.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit cervical cancer screening and hysterectomy data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Cervical Cancer Screening Tip Sheet.

CODE SET LINKS:
2022 Cervical Cytology & HPV Test Codes.
2022 Cervical Cancer Screening Exclusion Codes.
2022 Hospice Exclusion Codes.
2022 Palliative Care Exclusion Codes.

CHILD AND ADOLESCENT WELL-CARE VISITS (3-21 YEARS)

Annual preventive care allows for assessment of physical, emotional and social development, which is particularly important for children and adolescents. Behaviors established during childhood or adolescence such as eating habits and physical activity, often extend into adulthood, and can be influenced by the provider to establish healthy lifestyle routines and development.

The CBI Program encourages PCPs to monitor well child visits and establish routine preventive care for adolescents to reduce healthcare expenditures.

MEASURE DESCRIPTION: 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.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: 3 – 21 years as of the last day of the measurement period.

Continuous Enrollment: Rolling 12 months with a 45-day allowable gap. Member must be enrolled on the last day of the measurement period.

Eligible Member Event/Diagnosis: None.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.

DENOMINATOR: Eligible population age 3-21 years, as defined above.

NUMERATOR: At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period. The performing practice site does not have to be the practice site assigned to the member.

Telehealth visits are considered to be compliant if billed with a telehealth modifier and/or telehealth POS code. Follow Medi-Cal guidelines when submitting telehealth services that align with the well-visit codes, referenced in the resources section below.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site that performed the service.

DATA SOURCE: Claims, Data Submission Tool, DHCS FFS encounter claims.

CALCULATION FORMULA: Number of members with a qualifying child and adolescent well-care visits/total eligible linked members.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Well Child Visits (3-6 years)** and **Well Adolescent Visits (12-21 years)** provides a list of linked members who, according to our records may or may not have received a well-care visit in the last 12 months.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit well-child visit data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

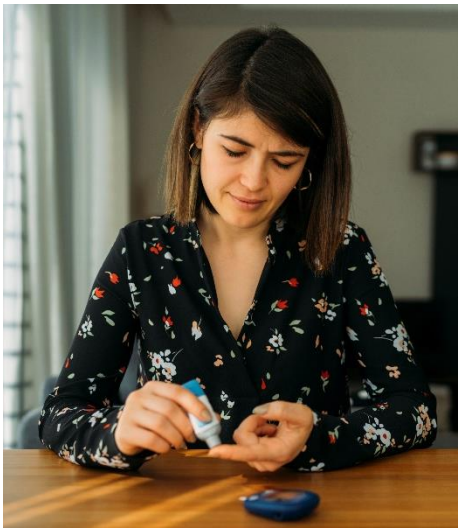
If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Support Specialist at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Child and Adolescent Well-Care Visits Tip Sheet.
APL 20-04 Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19.
Well-Child Visits During COVID-19
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 A Pediatrician's Guide to an LGBTQ+ Friendly Practice

CODE SET LINKS:
2022 Child and Adolescent Well-Care Visits Codes.
2022 Hospice Exclusion Codes.

DIABETIC HBA1C POOR CONTROL >9.0%

Diabetes is one of the most costly and prevalent chronic diseases in the United States. Diabetes is a complex group of diseases marked by high blood glucose due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, amputation, blindness, kidney disease, diseases of the nervous system, and premature death. These complications can be prevented if detected and addressed in the early stages. Proper diabetes management is essential to control blood glucose, reduce risks for complications, prolong life, and reduce healthcare expenditures.



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

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: 18 – 75 years as of the last day of the measurement period.

Continuous Enrollment: Rolling 12 months with a 45-day allowable gap. Member must be enrolled on the last day of the measurement period.

Eligible Member Event/Diagnosis: There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The Alliance uses both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter with a diagnosis of diabetes **without** telehealth.
- At least one acute inpatient discharge (Inpatient Stay or Nonacute Inpatient Stay) with a diagnosis of diabetes on the discharge claim.
- At least two outpatient visits, observation visits, or telehealth (Telephone or Online Assessment) visits, ED visits, or non-acute inpatient encounters or discharge on different dates of service, with a diagnosis of diabetes on the discharge claim. Visit type need not be the same for the two visits. Only include nonacute inpatient encounters **without** telehealth.

Note: Follow Medi-Cal guidelines when submitting telehealth services, referenced in the resources section below.

***Pharmacy data*:** Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medication List).

DIABETES MEDICATION

DESCRIPTION	PRESCRIPTION		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empaglifozin-linagliptin	• Empagliflozin-metformin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®)	• Albiglutide • Semaglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Note: Beginning Jan. 1, 2022, Medi-Cal pharmacy benefits will be provided through Medi-Cal Rx. You can access their Contact Drugs List, Medi-Cal Rx portal, subscribe to Medi-Cal Rx news updates or locate a Medi-Cal Rx pharmacy on the DHCS Medi-Cal Rx homepage.

Exclusions:

- Members who do not have a diagnosis of diabetes in any setting during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.
- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.
- Members receiving palliative care during the measurement year.
- Members 66 years of age and older as of the end of the measurement year with frailty and advanced illness. To identify members with frailty, at least one claim for frailty (frailty device, diagnosis, encounter, or symptom) during the measurement year. To identify members with advanced illness, any of the following criteria during the measurement year or the year prior to the measurement year are eligible:
  - At least two outpatient visits, observation visits, online assessments, ED visits, e-visit or virtual check-in, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter or inpatient discharge with an advanced illness diagnosis.
  - A dispensed dementia medication.

TABLE: DEMENTIA MEDICATIONS

DESCRIPTION	PRESCRIPTION		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	Memantine		
Dementia combinations	Donepezil-memantine		

Note: Beginning Jan. 1, 2022, Medi-Cal pharmacy benefits will be provided through Medi-Cal Rx. You can access their Contact Drugs List, Medi-Cal Rx portal, subscribe to Medi-Cal Rx news updates or locate a Medi-Cal Rx pharmacy on the DHCS Medi-Cal Rx homepage.

DENOMINATOR: Eligible population with a diagnosis of type (1 or 2) diabetes, as defined above.

NUMERATOR: The member is numerator compliant for poor control if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Only the most recent test in the measurement period is used to determine compliance for this measure.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site that performed the service.

DATA SOURCE: Claims, laboratory data, Data Submission Tool, DHCS FFS encounter claims, Santa Cruz Health Information Exchange (SCHIE).

CALCULATION FORMULA: Number of members in poor control with a most recent HbA1c score >9.0%/total linked diabetic members. Note member is considered to be in poor control if no HbA1c test was completed during the measurement period, a test was performed with no value, or if the HbA1c value was >9%.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Diabetes Care** provides a list of linked members who, according to our records may or may not have received a HbA1c screenings or diabetic retinal eye exams in the past year, or a negative diabetic retinopathy screening in the year prior.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit HbA1c data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement
Diabetic HbA1c Poor Control >9% Tip Sheet

CODE SET LINKS:
2022 Diabetes Eligible Population Codes.
2022 Diabetes Medication NDC Codes.
2022 HbA1c Inclusion Codes.
2022 Diabetes Exclusion Codes.
2022 Hospice Exclusion Codes.
2022 Dementia Medication NDC Exclusion Codes.
2022 Palliative Care Exclusion Codes.

IMMUNIZATIONS: ADOLESCENTS

Adolescence is a dynamic period of development where effective preventive care measures can promote safe behaviors and growth of lifelong health habits. One of the foundations of adolescent care is timely vaccination, and every visit can be used as an opportunity to update and complete necessary immunizations. The HPV vaccine is also the best way to protect against most of the cancers caused by the Human Papillomavirus (HPV) infection that can affect male and female patients.

The CBI Program encourages PCPs to monitor adolescent vaccines, update member records in county immunization registries, and establish routine preventive care to reduce health care costs.

MEASURE DESCRIPTION: The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: Adolescents who turned 13 years of age during the measurement period.

Continuous Enrollment: 12 months prior to the member's 13th birthday with no more than one gap in enrollment up to 45 days. Member must be enrolled on their 13th birthday.

Eligible Member Event/Diagnosis: None.

Exclusions:

- Administrative Members on date of 13th birthday.
- Members enrolled in hospice.
- Dual coverage members.
- Encephalopathy / adverse reaction anytime on or before the member's 13th birthday for Tdap.
- Anaphylactic reaction to the vaccine or its components any time on or before the member's 13th birthday.

DENOMINATOR: The eligible population as defined above.

NUMERATOR: Members who received one dose of Meningococcal, one dose of Tdap, and completed HPV series on or before their 13th birthday.

- Meningococcal serogroups A,C,W,Y: At least one meningococcal vaccine with a date of service on or between the member's 11th and 13th birthday.
- Tdap: At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine with a date of service on or between the member's 10th and 13th birthday.
- HPV: At least two HPV vaccine with dates of service at least 146 days apart on or between the member's 9th and 13th birthdays. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.

OR

- At least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.

Note: To avoid double counting events, all immunizations must be at least 14 days apart.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at the date when the member turns 13 years old. The linked PCP site does not have to be the provider site who administered the vaccinations. We encourage providers to enter all vaccination history, from those vaccines administered at your site, or another provider office, into the immunization registry.

DATA SOURCE: Claims, immunization registries (CAIR & RIDE), Data Submission Tool, DHCS FFS encounter claims, SCHIE.

To ensure the Alliance receives all qualifying data for this measure, providers are encouraged to enter any immunizations the member receives into their county's immunization registry (CAIR or RIDE), this includes immunizations received outside the linked PCP Site's office (historical records). Member information is matched in the registries by First Name, Last Name, and DOB.

CALCULATION FORMULA: Number of members who receive one dose of Meningococcal conjugate, one dose of Tdap, and completed HPV series/total qualifying 13-year olds.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Immunizations for Adolescents** provides a list of linked members who, according to our records may or may not have received one or more of the vaccinations listed above. This report looks prospectively before the member turns 13 years.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit immunization data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request

Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Immunization: Adolescents Tip Sheet.
CAIR Immunization Registry http://cairweb.org/.
RIDE (Healthy Futures) Immunization Registry http://www.myhealthyfutures.org/.
California Immunization Coalition.
The Alliance's Immunization Resources web page.
CDC Top 10 Tips for HPV Vaccination Success: Attain and Maintain High HPV Vaccination Rates.

CODE SET LINKS:
2022 Immunizations - Adolescents Codes.
2022 Immunizations - Adolescents Exclusion Codes.
2022 Hospice Exclusion Codes.

IMMUNIZATIONS: CHILDREN (COMBO 10)

Childhood is a period of life when people are most vulnerable to disease. Immunizations not only protect individual children from disease but also help to protect the health of our community, particularly for those who cannot be immunized, and the small proportion of people who don't respond to a vaccine. Immunization coverage must also be maintained in order to prevent a resurgence of vaccine-preventable diseases.

The CBI Program encourages PCPs to monitor immunization status, update immunizations in county immunization registries, and establish routine preventive care to reduce health care costs.

MEASURE DESCRIPTION: The percentage of children who have received **all** of the following vaccines (Combo 10) by their second birthday:

- 4 diphtheria, tetanus, and acellular pertussis (DTaP) (first dose after 42 days after birth);
- 3 inactivated polio vaccine (IPV) (first dose after 42 days after birth);
- 1 measles, mumps and rubella (MMR)* (on or between child's 1st and 2nd birthday), or history of illness;
- 3 haemophilus Influenzae Type B (HiB) (first dose after 42 days after birth);
- 3 hepatitis B (HepB)*(first dose 0-4 weeks) or history of hepatitis B illness;
- 1 varicella (VZV)* (on or between child's 1st and 2nd birthday) or History of varicella zoster (e.g. chicken pox) illness;
- 4 pneumococcal conjugate vaccine (PCV) (first dose after 42 days after birth);
- 2 or 3 Rotavirus (RV)** (first dose after 42 days after birth);
- 1 hepatitus A (HepA)* (on or between child's 1st and 2nd birthday) or history of hepatitis A illness;
- 2 Influenza (flu)*** (vaccines given after 180 days after birth, up to or on the child's 2nd birthday).

*For MMR, HepB, HepA and VZV documentation of history of illness or a seropositive test result for the antigen would meet compliance.

**Members may need 2 or 3 doses, depending on the brand of vaccine that was administered. Any of the following will make the member compliant for this vaccine:

- 3 doses for RotaTeq.
- 2 doses Rotarix.
- 1 Rotarix AND two RotaTeq.

***LAIV (influenza) vaccination must occur on the child's second birthday.

NOTE: These vaccines are the minimum recommended CDC vaccines for children under 2 years. Please follow the recommended CDC vaccine schedule (see link below) for minimum ages and dosage spacing.

MEMBER REQUIREMENT: PCP Site must have at least 30 members that meet the eligible population criteria.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: Children who turn 2 years of age during the measurement year.

Continuous Enrollment: 12 months prior to child's 2nd birthday with no more than one gap of enrollment up to 45-days. Member must be enrolled on their 2nd birthday.

Eligible Member Event/Diagnosis: None.

Exclusions:

- Administrative members on day of child's 2nd birthday.
- Members enrolled in hospice.
- Dual coverage members.
- Anaphylactic reaction to the vaccine or its components
- Encephalopathy with a vaccine adverse-effect code for DTaP
- For MMR, VZV and influenza:
  - Immunodeficiency
  - HIV
  - Lymphoreticular cancer, multiple myeloma or leukemia
  - Anaphylactic reaction to neomycin
- Severe combined immunodeficiency or history of intussusception for rotavirus.
- Anaphylactic reaction to streptomycin, polymyxin B or neomycin for IPV.
- Anaphylactic reaction to common baker's yeast for HepB.

The complete exclusion code list is below under 2022 Immunizations: Children Exclusion Codes.

DENOMINATOR: Eligible population who turn 2 during the measurement period, as defined above.

NUMERATOR: Members who received all Combo 10 (noted above) immunizations by their second birthday

Note: To avoid double counting events, all immunizations must be at least 14 days apart.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP site on the day when the member turns 2 years old. The linked PCP site does not have to be the provider site that provided the vaccinations. We encourage providers to enter all vaccination history, from those vaccines administered at your site, or another provider office, into the immunization registry.

DATA SOURCE: Claims, immunization registries (CAIR or RIDE), Data Submission Tool, DHCS FFS encounter claims, SCHIE.

To ensure the Alliance receives all qualifying data for this measure, providers are encouraged to enter any immunizations the member receives into their county's immunization registry (CAIR or RIDE), this includes immunizations received outside the linked PCP Site's office (historical records). Member information is matched in the registries by First Name, Last Name, and DOB.

CALCULATION FORMULA: Number of members who had all combo 10 vaccines by their 2nd birthday /total number of members who turned 2 during the measurement period.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Childhood Immunizations (Combo 10)** provides a list of linked members who, according to our records may or may not have received one or more of the vaccinations listed above. This report looks prospectively before the child turns 12 months.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit immunization data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Immunizations: Children (Combo 10) Tip Sheet.
CDC Vaccination Schedule.
California Immunization Registry (CAIR2)
Healthy Futures Public Health Information System (RIDE)
California Immunization Coalition.
The Alliance's Immunization Resources web page.

CODE SET LINKS:
2022 Immunizations: Children Codes.
2022 Immunizations: Children Exclusion Codes.
2022 Hospice Exclusion Codes.

SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN

Major depressive disorder is the second leading cause of disability worldwide, with lifelong prevalence estimated to range from 10-15%[1]. 15-21% of pregnant women are also estimated to experience moderate to severe symptoms of depression or anxiety, while approximately 21% of women experience major or minor depression following childbirth. This measure is intended to promote screening of beneficiaries never previously diagnosed with depression or bipolar disorder and ensure adequate follow-up care is provided for members experiencing depression.

MEASURE DESCRIPTION:
The percentage of members 18 to 64 years of age who are screened for depression on the date of the visit using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: All patients 18 years and older.

Continuous Enrollment: None.

Eligible Member Event/Diagnosis: Outpatient visit during the measurement year.

Exclusions:
- Administrative members
- Dual coverage members.
- Members enrolled in hospice.
- Members with an active diagnosis of depression or bipolar disorder that starts prior to the start of the encounter and is still active at the start of the encounter.

DENOMINATOR: Members in the Eligible Population who were screened positive for depression.

NUMERATOR: Members screened for depression on the date of the encounter or 14-days prior to the date of the encounter using an age appropriate standardized depression screening tool **and**, if positive, a follow-up plan is documented on the date of the eligible encounter.

DOCUMENTATION REQUIREMENTS:
Medical records must document:
- The name of the depression screening tool. If this is positive, documentation of the follow-up plan (must be on the same date as the positive screen). The date of the encounter and screening must occur on the same date of service and the name of the tools must be documented in the medical record.

Documented follow-up plans can include:
- Additional screening at the same encounter as the initial positive screen (additional screen alone does not count toward a valid follow-up intervention to an initial positive screen). Examples are: additional evaluation or assessment for depression such as psychiatric interview or evaluation, assessment for bipolar disorder.

- Suicide risk assessment (e.g. Beck Depression Inventory or Beck Hopelessness Scale).
- Referral to a practitioner who is qualified to diagnose and treat depression (e.g. psychiatrist, psychologist, social worker, mental health counselor).
- Referral to a program or other mental health service (e.g. family or group therapy, support group, depression management program, other service to treat depression).
- Pharmacological intervention.
- Other interventions or follow-up.

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 ADULTS	RESULTS CONSIDERED AS POSITIVE FINDING
Patient Health Questionnaire (PHQ-9)	Total Score ≥ 5
PRIME MD-PHQ2	Total Score ≥ 3
Beck Depression Inventory (BDI or BDI II)	Total Score ≥ 10 and ≥14 respectively
Center for Epidemiologic Studies Depression Scale (CES-D)	Total Score ≥ 16
Depression Scale (DEPS)	Total Score ≥ 9
Duke Anxiety-Depression Scale (DADS)	Total Score ≥ 5
Geriatric Depression Scale (GDS)	Total Score ≥ 10
Cornell Scale for Depression in Dementia (CSDD)	Total Score › 10
Hamilton Rating Scale for Depression (HAM-D)	Total Score ≥ 8
Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)	Total Score ≥ 6

PERINATAL SCREENING TOOLS	RESULTS CONSIDERED AS POSITIVE FINDING
Edinburgh Postnatal Depression Scale	Total Score › 13
Postpartum Depression Screening Scale	Total Score ≥ 60
Patient Health Questionnaire 9 (PHQ-9)	Total Score ≥ 5
Beck Depression Inventory (BDI or BDI II)	Total Score ≥ 10 and ≥14 respectively
Center for Epidemiologic Studies Depression Scale (CES-D)	Total Score ≥ 16
Zung Self-Rating Depression Scale	Total Score ≥ 50

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site that performed the screening or follow-up care.

DATA SOURCE: Claims, Data Submission Tool.

CALCULATION: Number members appropriately billed for a negative depression screening or a positive screening and follow-up plan documented/total members with an outpatient visit within the measurement year.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal quarterly CBI reports provides a roster of compliant and

non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit depression screenings from their electronic health records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Screening for Depression and Follow-Up Plan Tip Sheet.
Alliance Behavioral Health website.
Beacon Primary Care Provider (PCP) Referral Form.
Beacon Primary Care Provider (PCP) Referral Form with Spanish.
Beacon Care Management Referral Form.

CODE SET:

CODE TYPE	CODE	CODE DESCRIPTION
HCPCS	G8431	Screening for depression is documented as being positive and a follow-up plan is documented.
HCPCS	G8433	Screening For Depression Not Completed, Documented Patient Or Medical Reason
HCPCS	G8510	Screening for depression is documented as negative, a follow-up plan is not required.

2022 Screening for Depression Eligible Population Codes.
2022 Screening for Depression Inclusion Codes.
2022 Screening for Depression Exclusion Codes.

REFERENCE:
1. NCQA. Depression Screening and Follow-Up for Adolescents and Adults (DSF). Retrieved 12/09/21 from https://www.ncqa.org/hedis/measures/depression-screening-and-follow-up-for-adolescents-and-adults/.

WELL-CHILD VISITS IN THE FIRST 15 MONTHS

Assessing physical, emotional, and social development milestones is important at every stage of life. Well-child visits up to early school years are particularly important[1]. Behaviors established during early childhood such as eating habits and physical activity often extend into adulthood[2]. Well-care visits provide an opportunity for PCPs to influence health and development and are a critical opportunity for screening.

The CBI Program encourages PCPs to provide routine preventive care for children, ensuring improved care and reduced healthcare expenditures.

MEASURE DESCRIPTION: The percentage of members age 15 months old who had 6 or more well-child visits with a PCP during the first 15 months of life.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.

Continuous Enrollment: 31 days to 15 months with no more than one gap in enrollment of up to 45 days. The member must be enrolled on the date the child turns 15 months old.

Eligible Member Event/Diagnosis: None.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.

DENOMINATOR: Eligible population age 15 months old, as defined above.

NUMERATOR: At least 6 well-child visits on or before 15 months of age with a PCP during the measurement period.

Telehealth visits are considered to be compliant if billed with a telehealth modifier and/or telehealth POS code**.** Follow Medi-Cal guidelines when submitting telehealth services that align with the well-visit codes.

Note: All visits must be at least 14 days apart.

DOCUMENTATION REQUIREMENT: Please document following in the medical records:

- Health history.
- Physical developmental history.
- Mental developmental history.
- Physical exam.
- Health education/anticipatory guidance.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site on the day when the member turns 15 months old. The linked PCP site does not have to be the provider site that performed the service.

DATA SOURCE: Claims, DHCS FFS encounter claims, Data Submission Tool.

CALCULATION FORMULA: Number of members with a qualifying well-child exam/total linked eligible members.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Well Child Visits (0-15 Months)** provides a list of linked members who, according to our records may or may not have received the 6 well-child visits in the last 15 months. This report looks prospectively before the child turns 15 months.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit well-child visit data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Well-Child Visits in the First 15 Months Tip Sheet.

CODE SET LINKS:
2022 Well Child 0-15 Month Visit Codes.
2022 Hospice Exclusion Codes.

REFRENCES:

1. Child Trends. 2012. "Well-child visits." http://www.childtrends.org/?indicators=well-child-visits
2. Centers for Disease Control and Prevention (CDC). 2014. "Youth Risk Behavior Surveillance—United States, 2013." http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf

PERFORMANCE TARGET MEASURES

PERFORMANCE IMPROVEMENT MEASURE

Performance improvement is at the heart of the CBI program and the Alliance recognizes the investments PCP site's make toward improving their scores. The Performance Improvement measure awards CBI points to site's who improve their CBI scores year over year, or sites who meet and maintain top performance benchmarks.

MEASURE DESCRIPTION: PCPs shall be awarded Performance Improvement points for every measure they qualify for by either:

- Meeting the Plan Goal (see the 2022 CBI Programmatic Measure Benchmarks & Performance Improvement for this year's Plan Goals for each measure), **or**
- Achieve a 5% improvement in Care Coordination - Hospital & Outpatient Measures or five percentage point improvement in either Care Coordination- Access Measures or Quality of Care measures compared to the prior year.

REGARDING NEW MEASURES: New measures that were formerly scored as exploratory or are newly introduced, do not have quality scores from prior years. For this reason, it is only possible to receive Performance Improvement points for these measures by meeting the Plan Goal. If providers do not meet the Plan Goal for the measures indicated below, their points will be redistributed among the other measures their site qualifies for. Measure's which qualify for Performance Improvement points via Plan Goal only include:

- Breast Cancer Screening.
- Screening for Depression and Follow-up Plan.

Measures which qualify for Performance Improvement points via *Plan Goal and Performance Improvement over the prior year* include:

- Ambulatory Care Sensitive Admissions.
- Application of Dental Fluoride Varnish.
- Asthma Medication Ratio.
- Body Mass Index (BMI) Assessment: Children & Adolescent.
- Cervical Cancer Screening.
- Child and Adolescent Well-Care Visits.
- Developmental Screening in the First Three Years.
- Diabetic HbA1c Poor Control >9.0%.
- Immunizations: Adolescents.
- Immunizations: Children (Combo 10).
- Initial Health Assessment.
- Plan All-Cause Readmission.
- Post-Discharge Care.
- Preventable Emergency Visits.
- Well-Child Visits in the First 15 Months.
- Unhealthy Alcohol Use in Adolescents & Adults.

MEMBER REQUIREMENT: The Performance Improvement measure is worth a total of 10 potential CBI points, divided among all measures for which the PCP qualifies. PCPs qualify for measures by meeting the applicable member requirements set out by the measure:

- ≥30 eligible member for all Quality of Care measures and ≥5 for the Care Coordination-Access Measures.
- ≥100 eligible members for the Care Coordination- Hospital & Outpatient Measures

For measures without comparative prior year data, as listed above, the provider can qualify for Performance Improvement points by meeting the plan goal. If the Plan goal is not met, the points for that measure will be redistributed among the other measures the provider qualifies for. See grid below.

The total number of Performance Improvement points each measure is worth is determined by the total number of measures for which the PCP qualifies (see explanation of qualifications above). See grid below.

PERFORMANCE IMPROVEMENT POINTS	
Number of Qualifying Measures	Maximum Points per Measure
1	10.00
2	5.00
3	3.33
4	2.50
5	2.00
6	1.67
7	1.43
8	1.25
9	1.11
10	1
11	.91
12	.83
13	.77
14	.71
15	.67
16	.63

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: Measure specific.

Continuous Enrollment: Measure specific.

Eligible Member Event/Diagnosis: Measure specific.

Exclusions: Measure specific.

DENOMINATOR: Measures specific.

NUMERATOR: Measure specific.

SERVICING PCP SITE REQUIREMENTS: Measure specific.

PAYMENT FREQUENCY: Annually, following the end of quarter 4.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.

DATA SOURCE: Measure specific.

MEMBER REASSIGNMENT THRESHOLD

Member reassignments are challenging and disruptive to the provision of healthcare to our members. The Alliance encourages provider sites to limit the number of members they reassign from their practice. This measure penalizes providers who exceed the established threshold of member reassignments in a calendar year.

MEASURE DESCRIPTION: The rate of linked members a PCP Site reassigns from their practice during a calendar year. The member reassignment threshold is a maximum of 1 reassignment per 150 linked members. PCP Sites that exceed one reassignment per year per average 150 linked members are at risk of losing ½ of their CBI programmatic payments.

MEMBER REQUIREMENT: PCP must have an average of 100 eligible members during the measurement period or a minimum of 100 eligible members on the last day of the measurement period.

Exclusions:

- Dual coverage members on date of reassignment.
- Administrative members on date of reassignment.

Not all member reassignments count as part of the CBI member reassignment measure. Member reassignments for the following reasons are exempt and do not count against the PCP site.

- Medication Management (BA).
- Abusive/Disruptive Behavior (AB).
- Fraud (FR).
- Aged Out (AO).
- Member Requested (MI).
- Non Medi-Cal member reassignments.

SERVICING PCP SITE REQUIREMENTS: Members who are linked to provider at time of reassignment are counted toward the reassignment threshold.

EXPLORATORY MEASURES

90-DAY REFERRAL COMPLETION

A recent study by the Institute for Healthcare Improvement and the National Patient Safety Foundation noted that more than 100 million subspecialist referrals are requested each year in ambulatory settings nationally, but only half of those are completed. This measure was designed to increase awareness of outstanding referrals and encourage follow-up from the PCP office to ensure that the member is seen within 90 days of referral to a specialist.

MEASURE DESCRIPTION: The percentage of members who completed their initial referral from a PCP to a specialist in 90 days.

Note: Payment limited to first visit to referral specialist per unique referral.

MEMBER REQUIREMENT: PCP must have five members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: N/A.

Continuous Enrollment: Continuously enrolled 4 months of the measurement year.

Eligible Member Event/Diagnosis: One paid claim for a referral completion with a referral claim number list on the claim.

Exclusions:
- Administrative members at end of the measurement period.
- Dual coverage members.
- Denied and pending claims.

DENOMINATOR: Eligible population as defined above.
Members must have referrals written on or between October 1, 2021 and September 30, 2022 to qualify for the measure denominator.

NUMERATOR: Number of paid claims received from the specialist with a referral claim number listed on the claim within 90 days. Referral visit must be completed between October 2021-December 2022. Note this is a rolling 15-month measurement period to accommodate 90 days post referral start date as indicated in the denominator above.
Data Elements must include:
- Member ID.
- Member's full name.
- DOB.
- PCP's group NPI.
- Referral number on claim.
- PCP linked to member at time referral is written, and at time of specialist visit.

SERVICING PCP SITE REQUIREMENTS: Linked PCP at time of initial specialist visit will receive compliance for this measure.

DATA SOURCE: Claims.

CALCULATION FORMULA: Number of paid claims with referral claim number listed on the claim/total linked eligible members.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2022.

PROVIDER PORTAL: The Provider Portal **Linked Member List-Open Referrals** provides a real time report of your linked members with an open consultation or authorization referral to a specialist.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
90-Day Referral Completion - Exploratory Measure Tip Sheet.
PCP Referral Request: Brief Patient Education Guide
ACP High Value Coordination Toolkit

CODE SET: N/A.

ADVERSE CHILDHOOD EXPERIENCES (ACES) SCREENING IN CHILDREN AND ADOLESCENTS

ACEs are potentially traumatic events that occur during childhood (0-17 years of age). Around 61% of adults surveyed across 25 states reported that they've experienced at least one ACE, and nearly one in six reported they've experienced four or more types of ACEs.[1] ACEs can be long lasting and are linked to chronic health conditions such as mental illness, asthma, diabetes, and heart disease.

MEASURE DESCRIPTION: The percentage of members ages 1-20 years of age who are screened for Adverse Childhood Experiences (ACEs) annually using a standardized screening tool.

MEMBER REQUIREMENT: PCP must have five members that meet the eligible population criteria as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Ages: 1 – 20.99 years of age.

Continuous Enrollment: Continuously enrolled 4 months.

Eligible Member Event/Diagnosis: N/A.

Exclusions:

- Administrative members as of end of CBI measurement period.
- Dual coverage members.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: Linked members 1 – 20.99 years with a paid claim for ACE screening in the measurement year.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site that performed the service.

DATA SOURCE: Claims.

CALCULATION FORMULA: Members 1 – 20.99 years of age who received an ACE screening/total eligible member.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2022.

PROVIDER PORTAL: The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents – Exploratory Measure Tip Sheet.
California's ACEs AWARE Initiative
ACEs Aware Number Story Exam Room Poster
ACEs Aware Patient/Family Education Handouts
CDC's ACE resources
Video on administering a PEARLS Resilience De-identified, positive and negative screening.
ACE Screening Clinical Workflows.
ACE Screening Implementation How-To Guide
Trauma-Informed Network of Care Roadmap
Non-clinical staff training on ACEs

REFERENCE:
1. https://www.cdc.gov/violenceprevention/aces/fastfact.html.

CODE SET:

CODE TYPE	CODE	CODE DESCRIPTION	NOTES
HCPCS	G9919	Screening performed – results positive and provision of recommendations provided	ACE score **4 or greater (high risk)**
HCPCS	G9920	Screening performed – results negative	ACE score **between 0 – 3 (lower risk)**

CHLAMYDIA SCREENING IN WOMEN

Chlamydia is one of the most commonly reported sexually transmitted infections (STIs) in the United States. The United States Preventive Services Task Force (USPSTF) recommends screening for chlamydia and gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection. The USPSTF has recommendations on screening for other STIs including hepatitis B, genital herpes, HIV, and syphilis. Also recommended is behavioral counseling for all sexually active adolescents and for adults who are at increased risk for STIs. These recommendations are available on the USPSTF web site.

MEASURE DESCRIPTION: The percentage of women ages 16 to 24 years old who are identified as sexually active and who had at least one test for chlamydia during the measurement year.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: Women 16–24 years old as of December 31 of the measurement year.

Continuous Enrollment: Rolling 12 months with no more than one gap of enrollment up to 45-days. Member must be enrolled on the last day of the measurement period.

Eligible Member Event/Diagnosis: Sexually active members identified through pharmacy data and claim/encounter data.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.
- Exclude members who qualified for the measure based on a pregnancy test alone **and** who meet either of the following:
    - A pregnancy test during the measurement year and a prescription for isotretinoin (retinoid) on the date of the pregnancy test or the six days after the pregnancy test.
    - A pregnancy test during the measurement year and an X-ray on the date of the pregnancy test or the six days after the pregnancy test.

RETINOID MEDICATION

DESCRIPTION	PRESCRIPTION
Retinoid	• Isotretinoin

CONTRACEPTIVE MEDICATIONS

DESCRIPTION	PRESCRIPTION	
Contraceptives	• Desogestrel-ethinyl estradiol • Dienogest-estradiol (multiphasic) • Drospirenone-ethinyl estradiol • Drospirenone-ethinyl estradiol-levomefolate (biphasic) • Ethinyl estradiol-ethynodiol • Ethinyl estradiol-etonogestrel • Ethinyl estradiol-levonorgestrel	• Ethinyl estradiol-norelgestromin • Ethinyl estradiol-norethindrone • Ethinyl estradiol-norgestimate • Ethinyl estradiol-norgestrel • Etonogestrel • Levonorgestrel • Medroxyprogesterone • Mestranol-norethindrone • Norethindron
Diaphragm	• Diaphragm	
Spermicide	• Nonoxynol 9	

Note: Beginning Jan. 1, 2022, Medi-Cal pharmacy benefits will be provided through Medi-Cal Rx. You can access their Contact Drugs List, Medi-Cal Rx portal, subscribe to Medi-Cal Rx news updates or locate a Medi-Cal Rx pharmacy on the DHCS Medi-Cal Rx homepage.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: At least one chlamydia test during the measurement year.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP site at the end of the measurement period.

DATA SOURCE: Claims, laboratory data, pharmacy data, and the Data Submission Tool.

CALCULATION FORMULA: Number of members with completed chlamydia tests during the measurement year/total linked eligible members.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2022.

PROVIDER PORTAL: The Provider Portal **Quality Report- Chlamydia and Gonorrhea Screenings** provides a list of your linked members who, according to our records may or may not have received chlamydia screenings and their screening date.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit chlamydia screening data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Chlamydia Screening in Women – Exploratory Measure Tip Sheet.
Chlamydia Screening Starter Guide
A Guide to Taking a Sexual History
CDC Sexually Transmitted Infections Treatment Guidelines, 2021

CODE SET:
2022 Chlamydia Screening Inclusion Codes
2022 Chlamydia Eligible Population Codes
2022 Contraceptive Eligible Population NDC Codes
2022 Chlamydia Exclusion Codes
2022 Chlamydia Exclusion Retinoid Medications NDC Codes
2022 Hospice Exclusion Codes

CONTROLLING HIGH BLOOD PRESSURE

High blood pressure or hypertension is known as the "silent killer." Hypertension increases the risk of heart disease and stroke, which are the leading causes of death in the United States[1]. Maintaining adequate blood pressure (BP) control reduces the risk of heart attack, stroke, kidney disease, and dementia.

MEASURE DESCRIPTION: The percentage of 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.**

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: 18–85 years old as of December 31 of the measurement year.

Continuous Enrollment: Rolling 12 months with no more than one gap in continuous enrollment up to 45-days. Member must be enrolled on the last day of the measurement period.

Eligible Member Event/Diagnosis: Members who had at least 2 visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Visit type needs to be the same for the two visits. Includes outpatient visits (Outpatient without UBREV codes) and telehealth visits (Telephone, Online assessments).

Exclusions:

- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.
- Members receiving palliative care during the measurement year.
- Members 81 years of age and older as of the end of the measurement year with frailty during the measurement year.
- Members 66 years of age and older as of the end of the measurement year with frailty and advanced illness. To identify members with frailty, at least one claim for frailty (frailty device, diagnosis, encounter, or symptom) during the measurement year. To identify members with advanced illness, any of the following criteria during the measurement year or the year prior to the measurement year are eligible:
  - At least two outpatient visits, observation visits, online assessments, ED visits, e-visit or virtual check-in, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter or inpatient discharge with an advanced illness diagnosis.
  - A dispensed dementia medication.

TABLE: DEMENTIA MEDICATIONS

DESCRIPTION	PRESCRIPTION		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	Memantine		
Dementia combinations	Donepezil-memantine		

Note: Beginning Jan. 1, 2022, Medi-Cal pharmacy benefits will be provided through Medi-Cal Rx. You can access their Contact Drugs List, Medi-Cal Rx portal, subscribe to Medi-Cal Rx news updates or locate a Medi-Cal Rx pharmacy on the DHCS Medi-Cal Rx homepage.

- Members with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant on or prior to December 31 of the measurement year.
- Female members with a diagnosis of pregnancy during the measurement year.
- All members who had a nonacute inpatient admission during the measurement year.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: Most recent BP reading taken during an outpatient visit (Outpatient without UBREV codes), online assessment, nonacute inpatient visit, or remote blood pressure monitoring event.

The BP reading must occur on or after the date of their second diagnosis of hypertension.

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

Note: Follow Medi-Cal guidelines when submitting telehealth services.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP site at the end of the measurement period.

DATA SOURCE: Claims, Data Submission Tool, DHCS FFS encounter claims, SCHIE.

CALCULATION FORMULA: Number of members with recent BP readings adequately controlled (<140/90mm Hg)/total linked eligible members.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2022.

PROVIDER PORTAL: The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit blood pressure values from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:

2022 CBI Programmatic Measure Benchmarks & Performance Improvement.

Controlling High Blood Pressure – Exploratory Measure Tip Sheet.

CODE SET:

2022 Blood Pressure Inclusion Codes.
2022 Blood Pressure Exclusion Codes.
2022 Hospice Exclusion Codes.
2022 Dementia Medication Exclusion Codes.

REFERENCES:

1. Centers for Disease Control and Prevention (CDC). 2012. "About High Blood Pressure." http://www.cdc.gov/bloodpressure/about.htm
2. James, P.A., S. Oparil, B.L. Carter, W.C. Cushman, C. Dennison-Himmelfarb, J. Handler, D.T. Lackland, et al. 2014. 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults. Report from the Panel Members Appointment to the Eighth Joint National Committee (JNC 8). 311:507–20. https://www.ncbi.nlm.nih.gov/pubmed/24352797

HEALTH PLAN HEALTH DISPARITY

Health disparities may be associated to race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, gender, and geographic location, and all can contribute to an individual's ability to achieve good health. In 2020, the Alliance's Population Needs Assessment found well child visit disparities among different age and racial/ethnic groups in our member population. NCQA has adopted to stratify select HEDIS measures to advance health equity within health plan performance, including stratifying the Child and Adolescent Well-Care Visits measure.

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

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: 3 – 21 years as of the last day of the measurement period.

Continuous Enrollment: Rolling 12 months with a 45-day allowable gap. Member must be enrolled on the last day of the measurement period.

Eligible Member Event/Diagnosis: None.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.

DENOMINATOR: Eligible population age 3-21 years, as defined above.

NUMERATOR: At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period. The performing practice site does not have to be the practice site assigned to the member.

Telehealth visits are considered to be compliant if billed with a telehealth modifier and/or telehealth POS code. Follow Medi-Cal guidelines when submitting telehealth services that align with the well-visit codes, referenced in the resources section below.

SERVICING PCP SITE REQUIREMENT: If the Alliance membership does not have statistically significant differences for well-child rates comparing the largest race/ethnicity to other groups, all CBI groups meeting the member requirement will be given credit.

DATA SOURCE: Claims, DHCS FFS encounter claims, Data Submission Tool.

CALCULATION FORMULA: Using a Chi-square, two-tailed testing with Yates correction, determine if there are any statistically significant differences between race/ethnicity in review of the number of members with a qualifying child and adolescent well-care visits/total eligible linked members.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2022.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Well Child Visits (3-6 years)** and **Well Adolescent Visits (12-21 years)** provides a list of linked members who, according to our records may or may not have received a well-care visit in the last 12 months.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit well-child visit data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Child and Adolescent Well-Care Visits Tip Sheet.
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 A Pediatrician's Guide to an LGBTQ+ Friendly Practice

CODE SET:
2022 Child and Adolescent Well-Care Visits Codes.
2022 Hospice Exclusion Codes.

IMMUNIZATIONS: ADULTS

Childhood vaccines can wear off over time, and members may be at risk for vaccine-preventable diseases due to their age, job, lifestyle, travel or health conditions. Vaccines have greatly reduced the risk of infectious diseases such as tetanus, diphtheria, shingles, and whooping cough.

MEASURE DESCRIPTION: The percentage of members 19 to 65 years of age who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap) and zoster.

Members 19 years of age or older should receive all of the following vaccines:

- Influenza.
- Tetanus, diphtheria toxoids and acellular pertussis (Tdap).

Members 50 years of age or older:

- Zoster.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: 19 to 65 years of age. Must be 19 for the Flu or Tdap population at the start of the measurement period (01/01/2022) or 50 at the start of the measurement period for Zoster.

Continuous Enrollment: Rolling 12 months with a 45-day allowable gap.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.
- Members with active chemotherapy any time during the measurement period.
- Members with a bone marrow transplant any time during the Measurement Period.
- Member with a history of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia and HB-S disease or cerebrospinal fluid leaks any time during the member's history through the end of the Measurement Period.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: Immunizations completed by 19 years of age or older:

- **Influenza** - Members 19 years and older who received an influenza vaccine on or between July 1 of the year prior to the measurement period-June 30 of measurement year or had a prior influenza virus vaccine adverse reaction any time before or during the measurement year.
- **Td/Tdap** - Members 19 and older who received at least one Td or Tdap vaccine in the prior nine years or during the measurement year or had a history of contraindications from anaphylaxis or encephalopathy due to Tdap or Td vaccine at any point before the end of the measurement year.
- **Zoster** - Members 50 years and older who received at least one dose of herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) or had a prior adverse reaction caused by zoster vaccine or its components any time before the end of the measurement year.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP site at the end of the measurement period. We encourage providers to enter all vaccination history, from those vaccines administered at your site, or another provider office, into the immunization registry.

DATA SOURCE: Claims, Data Submission Tool, immunization registries (CAIR/RIDE).

CALCULATION FORMULA: Number of completed vaccines/total linked eligible members.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2022.

PROVIDER PORTAL: The Provider Portal **Quality Report – Adult Immunizations** list of your linked members who, according to our records may or may not have received the vaccinations listed above.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

PCPs can submit immunization data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Immunizations: Adults – Exploratory Measure Tip Sheet.
CAIR Immunization Registry.
RIDE (Healthy Futures) Immunization Registry.
California Immunization Coalition.
The Alliance's Immunization Resources web page.

CODE SET:
2022 Adult immunization Inclusion Codes.
2022 Adult Immunization Exclusion Codes.

2022 Hospice Exclusion Codes.

LEAD SCREENING IN CHILDREN

The prevalence of lead poisoning in children has been greatly reduced since the removal of lead from paint and gasoline in the 1970s. However, healthcare professionals should perform screening for lead poisoning in alignment with the American Academy of Pediatrics Bright Futures Periodicity Schedule as California law. Children who were exposed to lead have no obvious symptoms, as a result lead poisoning may go unrecognized.

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.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: Children who turn 2 years old during the measurement year.

Continuous Enrollment: 12 months prior to the child's second birthday with no more than one gap of enrollment up to 45-days. Member must be enrolled on the child's second birthday.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members enrolled in hospice.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: At least one lead capillary or venous blood test on or before the child's second birthday.

DOCUMENTATION REQUIREMENTS:

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. Provides 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 – 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 applies:

- In the professional judgement 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.
- 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 that the reason for not obtaining a signed statement in the child's medical records (ex. when services are provided via telehealth or party declines to sign).

For more information, reference the California Department of Public Health's Standard of Care Guidelines on Childhood Lead Poisoning for California Health Care Providers and All-Plan Letter 20-16.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP site on the day when the member turns 2 years old.

DATA SOURCE: Claims, laboratory data, DHCS FFS encounter claims.

CALCULATION FORMULA: Number children with completed lead screenings completed by the child's 2nd birthday/total linked eligible members.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2022.

PROVIDER PORTAL: The Provider Portal **Quality Report – Lead Screening in Children** provides a list of your linked members who, according to our records may or may not have received lead testing within the past 12 months. This report looks prospectively before and after the child turns 12 and 24 months in accordance to APL 20-16.

The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:
2022 CBI Programmatic Measure Benchmarks & Performance Improvement.
Lead Screening in Children – Exploratory Measure Tip Sheet.
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

CODE SET:
2022 Lead Screening Codes.
2022 Hospice Exclusion Codes.

TUBERCULOSIS (TB) RISK ASSESSMENT

Approximately 30% of persons exposed to Mycobacterium tuberculosis (TB) will develop LTBI and, if untreated, approximately 5% to 10% of these persons will progress to active tuberculosis disease or reactivation of tuberculosis. Primary care clinicians can change the fate of those members infected with TB but never treated for it. There are 13 million persons estimated to be living with LTBI[1]. See the U.S. Preventive Services Task Force (USPSTF) recommendation on TB screening: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations

MEASURE DESCRIPTION: The percentage of members ages 12 months to 21 years (up to before their 21st birthday) who have been screened for latent tuberculosis infection (LTBI) risk factors by staff at the PCP office during the measurement year.

MEMBER REQUIREMENT: PCP must have 5 members that meet the eligible population criteria, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding dual coverage members.

Age: Members 12 months to 21 years of age (up to the 21st birthday.

Continuous Enrollment: 4 months of continuous enrollment.

Exclusions:

- Administrative members.
- Dual coverage members.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: TB Risk Assessment was completed in the measurement year.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP site at the end of the measurement period.

DATA SOURCE: Claims.

CALCULATION FORMULA: Number of who received risk assessments/total linked eligible members.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2022.

PROVIDER PORTAL: The Provider Portal quarterly CBI reports provides a roster of compliant and non-compliant members, trending graphs, and comparison to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal webpage. 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.

RESOURCES:

2022 CBI Programmatic Measure Benchmarks & Performance Improvement.

Tuberculosis (TB) Risk Assessment Tuberculosis - Exploratory Measure Tip Sheet.

REFERENCE:

[1]https://jamanetwork.com/journals/jama/fullarticle/2547762.

CODE SET: Z11.1 screening for pulmonary TB.

FEE-FOR-SERVICE MEASURES

Fee-for-Service (FFS) Measures provide a single payment incentive to PCP sites. All 2022 measures require providers to submit a form to the Alliance attesting the completion of the recognition or certification to receive CBI incentive payment. FFS incentives are paid on a quarterly basis, at the end of the quarter in which the attestation form was received, as long as the date of service was within the calendar year. There is no rate calculation for FFS measures; PCP Sites are paid each time a qualifying service is performed.

Unlike Programmatic measures, there are no minimum eligible member requirements for FFS measures. PCP Site's will receive incentive payments for each member with a qualifying service, regardless of how many members were eligible for the measure.

BEHAVIORAL HEALTH INTEGRATION

Behavioral health conditions are often under-diagnosed or diagnosed late, delaying treatment. This leads to poorer health outcomes and higher costs of care. Often these conditions can be identified and treated in a primary care setting and improve the treatment of behavioral health conditions. This distinction also helps practices deliver whole person care.

MEASURE DESCRIPTION: CBI Groups who have achieved the NCQA Distinction in Behavioral Health, after completion of the NCQA Patient Centered Medical Home (PCMH) recognition.

MEMBER REQUIREMENT: N/A.

ELIGIBLE POPULATION:

Membership: N/A.

Ages: N/A.

Continuous Enrollment: N/A.

Eligible Member Event/Diagnosis: N/A.

EXCLUSIONS: N/A.

SERVICING PCP SITE REQUIREMENTS: N/A.

FEE-FOR-SERVICE AMOUNT: $1,000 for initial achievement of NCQA distinction in behavioral health.

PAYMENT FREQUENCY: Quarterly. Payments are made a single time after the distinction is received. Payments do not reoccur yearly or quarterly.

DATA SOURCE: Receipt of earning the Distinction in Behavioral Health Integration from NCQA.

RESOURCES:
Contact your Provider Relations Representative for instructions on submitting your earned Distinction Behavioral Health Integration.
NCQA Distinction in Behavioral Health Integration.

CODE SET: N/A.

PATIENT CENTERED MEDICAL HOME (PCMH) RECOGNITION

This measure encourages PCP sites to adopt the Patient Centered Medical Home (PCMH) model of care to transform primary care practices into medical homes. The PCMH model can lead to higher quality of care and lower costs, while improving both care coordination and communication.

MEASURE DESCRIPTION: PCP Sites who receive NCQA or The Joint Commission (TJC) documentation validating achievement of Patient Centered Medical Home (PCMH) recognition or certificate will receive incentive payment. PCMH payment is made per NCQA/TJC application that results in PCMH status, regardless of the number of sites included on the application.

MEMBER REQUIREMENT: N/A.

ELIGIBLE POPULATION:

Membership: N/A.

Ages: N/A.

Continuous Enrollment: N/A.

Eligible Member Event/Diagnosis: N/A.

EXCLUSIONS: N/A.

SERVICING PCP SITE REQUIREMENTS: N/A.

FEE-FOR-SERVICE AMOUNT:

- $2,500 NCQA Recognition.
- $2,500 (The Joint Commission) TJC PCMH certification.

PAYMENT FREQUENCY: Quarterly. Payments are made a single time after certification. Payments do not reoccur yearly or quarterly.

DATA SOURCE: Receipt of NCQA or TJC documentation of achievement.

RESOURCES:
To sign up for PCMH recognition through NCQA use Alliance discount code **CCAAHA** to save 20% on your initial application fee.

Q&A on PCMH reporting.

PCMH Renewal Information.

Getting Started Toolkit: Get Started With NCQA PCMH Recognition

The Joint Commission PCMH Resources

AAP National Resource Center Pediatric Medical Home Resources.

National Center for Medical Home Implementation Salud Para Todos Project Lessons Learned.

Contact your Provider Relations Representative if you have additional questions.

CODE SET: N/A.

KEY TERMS AND DEFINITIONS

ADMINISTRATIVE MEMBERS: An "administrative member" is a member who is not assigned to a specific physician or clinic and, therefore, may see any willing Medi-Cal provider within the Alliance's Service Area.

CALIFORNIA CHIDREN'S SERVICES (CCS): Plan's Medi-Cal Members who are eligible to receive treatment for a CCS eligible health condition under the CCS Program.

CONTINUOUS ENROLLMENT: The minimum amount of time, including allowed gaps, that a member must be enrolled with the Alliance before becoming eligible for a measure. The purpose of continuous enrollment requirements is to ensure providers have enough time to render services.

DATA SUBMISSION TOOL: PCPs can submit data from their Electronic Health Records (EHR) and paper charts using the Data Submission Tool on the Provider Portal. Log on to your Provider Portal account -Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.

DENOMINATOR: The count of all members eligible for the measure as defined by the measure specification (e.g. the Eligible Population).

DUAL COVERAGE MEMBERS: Members who are eligible for Medi-Cal and for health insurance coverage from another source, such as Medicare or a commercial plan health plan. CCS Members that do not have other health insurance coverage are not dual coverage members for the purposes of CBI.

ELIGIBLE POPULATION: The eligible population for a given measure includes all members who satisfy specified criteria, including criteria related to membership, age, continuous enrollment, anchor date enrollment, and medical event or diagnosis requirements.

- Eligible Population criteria for Care Coordination measures and Fee-for-Service incentives are Alliance-defined.
- Eligible Population criteria for Quality of Care measure are based on the HEDIS 2022 Technical Specifications and the CMS Core Measure Set.

EXCLUSIONS: Some measures exclude members from the denominator who are identified as having a certain procedure, diagnosis or comorbidity. Members who meet exclusionary criteria for a measure, based on administrative claims /encounter data, will not be included in rate calculations. Some exclusions are optional while others are required dependent on measure source specification. Members with dual coverage are excluded from all CBI measures.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®): HEDIS is the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service, developed by the National Committee for Quality Assurance (NCQA). NCQA is a private, non-profit organization dedicated to improving health care quality. HEDIS measures are used in a compliance audit monitored by the Department of Health Care Services' External Quality Review Organization to ensure accurate, reliable measure performance that is publicly reported across health plans. Several of the CBI measures are also HEDIS measures. As a result, CBI performance can impact provider's HEDIS performance and vice versa.

INDEX HOSPITAL STAY (IHS): An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of measurement year, as identified in the denominator.

INDEX ADMISSION DATE: Is the index hospital stay admission date.

INDEX DISCHARGE DATE: The index hospital stay discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.

LINKED MEMBER: A member of the Alliance is an individual who has selected or been assigned to a PCP.

MEASUREMENT PERIOD: The period for which the Alliance will measure data in order to calculate the applicable CBI rates. For some measures this may include a look-back period (a defined time frame before the measured occurrence).

MEMBER MONTHS: Member Months represent a member's active enrollment in a practice's total yearly membership and are used for measures designed to capture the frequency of certain services or events. Measures that use Member Months in calculations include:

- Ambulatory Care Sensitive Admissions.
- Preventable Emergency Visits.
- Initial Health Assessment.
- Post-Discharge Care.

MEASUREMENT YEAR: Is the rolling 12-month timeframe back from the current Quarterly run.

MINIMUM MEMBER REQUIREMENT: The minimum number of qualifying members (defined in these tech specs as Eligible Population) per measure required for provider to be eligible for programmatic measures. Note: FFS measures have no minimum member requirement.

NUMERATOR: The count of all members who received the treatment or service being measured.

PRIMARY CARE PHYSICIAN (PCP) SITE: PCP Site is a Participating Provider site who is eligible for CBI payment in accordance with the Alliance contract and CBI Addendum. For the purpose of this document PCP site is the provider site to which CBI payment is made. PCP Sites must be practicing in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology or another specialty approved by the Alliance.

EXPLORATORY MEASURES: These measures are included in the CBI Program to monitor for possible payment in the upcoming CBI year. Payments are not made for these measures in the current CBI year.