2024 Care-Based Incentive
Technical Specifications

PROVIDER INCENTIVES

Updated: October 2024

HEALTHY PEOPLE. **HEALTHY** COMMUNITIES.

www.thealliance.health

Table of Contents

CBI PROGRAM OVERVIEW **4**
CBI PROGRAM SUPPORT **6**
PROGRAMMATIC MEASURES OVERVIEW **10**
CARE COORDINATION – ACCESS MEASURES **11**
ADVERSE CHILDHOOD EXPERIENCES (ACES) SCREENING IN CHILDREN AND ADOLESCENTS 11
APPLICATION OF DENTAL FLUORIDE VARNISH 13
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS 15
INITIAL HEALTH APPOINTMENT (IHA) 18
POST-DISCHARGE CARE 21
CARE COORDINATION – HOSPITAL & OUTPATIENT MEASURES **23**
AMBULATORY CARE SENSITIVE ADMISSIONS 23
PLAN ALL-CAUSE READMISSIONS 26
PREVENTABLE EMERGENCY VISITS 28
QUALITY OF CARE MEASURES **30**
BREAST CANCER SCREENING 30
CERVICAL CANCER SCREENING 33
CHILD AND ADOLESCENT WELL-CARE VISITS (3-21 YEARS) 36
DEPRESSION SCREENING FOR ADOLESCENTS AND ADULTS 38
DIABETIC HBA1C POOR CONTROL >9.0% 41
IMMUNIZATIONS: ADOLESCENTS 44
IMMUNIZATIONS: CHILDREN (COMBO 10) 47
LEAD SCREENING IN CHILDREN 50
WELL-CHILD VISITS IN THE FIRST 15 MONTHS 52
HEALTH EQUITY **55**
HEALTH EQUITY: CHILD AND ADOLESCENT WELL-CARE VISIT 55
PERFORMANCE TARGET MEASURE **58**
PERFORMANCE IMPROVEMENT MEASURE 58
MEMBER REASSIGNMENT **61**
MEMBER REASSIGNMENT THRESHOLD 61
EXPLORATORY MEASURES **62**
CHLAMYDIA SCREENING IN WOMEN 62
COLORECTAL CANCER SCREENING 64
CONTROLLING HIGH BLOOD PRESSURE 66
WELL-CHILD VISITS FOR AGE 15-30 MONTHS OF LIFE 69

FEE-FOR-SERVICE MEASURES 72
ADVERSE CHILDHOOD EXPERIENCES (ACES) TRAINING AND ATTESTATION 73
BEHAVIORAL HEALTH INTEGRATION 75
COGNITIVE HEALTH ASSESSMENT TRAINING AND ATTESTATION 76
DIAGNOSTIC ACCURACY AND COMPLETENESS TRAINING 78
PATIENT CENTERED MEDICAL HOME (PCMH) RECOGNITION 79
QUALITY PERFORMANCE IMPROVEMENT PROJECTS 80
SOCIAL DETERMINANTS OF HEALTH (SDOH) ICD-10 Z-CODE SUBMISSION 81
KEY TERMS AND DEFINITIONS 82

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.
- Health Equity.
- 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 (MCAS), 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 the use of disease registries to address population health.
- Encouraging adoption of best-practice care guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF).
- Reduce disparities in quality or service delivery between groups of members and/or geographic regions

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, Data Submission Tool, and Care-Based Incentive 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.
    - 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 and Provider Contracts, Data Analytics and Application Services, Pharmacy, Program Development, Quality Improvement and Population Health, Medical Directors and the CMO who reviews program policies and proposed measure ideas.

QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (QIHEC): This committee consists of contracted external physicians and administrators within Santa Cruz, Monterey, San Benito, Mariposa, 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 contracted external physicians and administrators within Santa Cruz, Monterey, San Benito, Mariposa, 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 Member HIF/MET
- Linked Members Inpatient Admissions.
- Linked Members Emergency Department (ED) Visits.
- Linked Member High ED Utilizer.
- Open Referrals.
- Member Missed Appointments Report.

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 (ex. childhood immunizations, well-child visits 0-15 months) 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 refreshed monthly with **weekly refreshes to the reports shown with an asterisk below.**

QUALITY REPORTS	
Adult Immunizations	Chlamydia and Gonorrhea Screenings
Adverse Childhood Experiences (ACEs) Screenings*	COVID-19 Immunizations*
Asthma Medication Ratio	Diabetes Care
Body Mass Index Assessment: Children & Adolescents*	Immunizations for Adolescents*
Breast Cancer Screenings	Lead Screening in Children
Cervical Cancer Screenings	Prenatal Immunizations*
Child & Adolescent Well-Care Visits (3-21 years)	Well Child Visits (0-15 Months)*
Childhood Immunizations (Combo 10)*	Well Child Visits (15-30 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, annual MCAS 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).
- Cervical Cancer Screening (includes cervical cytology, high-risk papillomavirus [hrPHV], total abdominal hysterectomy codes, and agenesis and aplasia of cervix).
- Child and Adolescent Well-Care Visits
- Chlamydia Screening in Women.
- Colorectal Cancer Screening
- Controlling High Blood Pressure (diastolic and systolic values).
- Developmental Screening in the First 3 Years of Life.
- Diabetic HbA1c Poor Control >9.0% (HbA1c lab values).
- Immunizations: Adolescents.
- Immunizations: Adults.
- Immunizations: Children.
- Initial Health Appointment (IHA).
- Screening for Depression and Follow-Up Plan.
- 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. Hyperlinks on the measure names show performance trending over the past couple years.

CBI MEASURE DETAIL REPORT	
Measure details provide member level reports for opportunities of patient outreach and reconciliation 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
	Initial Health Appointment (IHA)

MEASURE CATEGORY	MEASURE NAME
CARE COORDINATION HOSPITAL & OUTPATIENT MEASURES	Ambulatory Care Sensitive Admissions
	Plan All-Cause Readmission
	Preventable Emergency Visits
MEASURE CATEGORY	**MEASURE NAME**
QUALITY OF CARE	Breast Cancer Screening
	Cervical Cancer Screening
	Child and Adolescent Well-Care Visits
	Depression Screening for Adolescents and Adults
	Diabetic HbA1c Poor Control >9.0%
	Immunizations: Adolescents
	Immunizations: Children (Combo 10)
	Lead Screening in Children
	Well-Child Visit in the First 15 Months
MEASURE CATEGORY	**MEASURE NAME**
HEALTH EQUITY	Health Equity: Child and Adolescent Well-Care Visits
MEASURE CATEGORY	**MEASURE NAME**
EXPLORATORY MEASURES	Chlamydia Screening in Women
	Colorectal Cancer Screening
	Controlling High Blood Pressure
	Well-Child Visits for Age 15-30 Months of Life
MEASURE CATEGORY	**MEASURE NAME**
FEE FOR SERVICE MEASURES	Adverse Childhood Experiences (ACEs) Training and Attestation
	Cognitive Health Assessment Training and Attestation
	Diagnostic Accuracy and Completeness Training

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

CBI DASHBOARD REPORT

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.

Additional Provider Portal resources include:

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

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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

CBI PROVIDER WORKSHOPS: The Alliance holds annual CBI Provider Workshops to share upcoming changes for the new program year. 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.

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.
- Email Communication.
- 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 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.

PROGRAMMATIC MEASURES %	POINTS
Care Coordination (CC) Access Measures	**21.5**
Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents	3
Application of Dental Fluoride Varnish	2
Developmental Screening in the First 3 Years	2
Initial Health Assessment	4
Post-Discharge Care	10.5
Care Coordination (CC) Hospital & Outpatient Measures	**25.5**
Ambulatory Care Sensitive Admissions	7
Plan All-Cause Readmission	10.5
Preventable Emergency Visits	8
Quality of Care (QoC) Measures	**38**
Breast Cancer Screening	Points distributed based on measure eligibility
Cervical Cancer Screening	
Child and Adolescent Well-Care Visits (3-21)	
Depression Screening for Adolescents and Adults	
Diabetic HbA1c Poor Control >9.0 %	
Immunizations: Adolescents	
Immunizations: Children	
Lead Screening in Children	
Well-Child Visit in the First 15 Months	
Heath Equity	**5**
Health Equity: Child and Adolescent Well-Care Visits	5
Performance Target (PT) Measures	**10**
Performance Improvement	10
Total Points	**100**

CARE COORDINATION – ACCESS MEASURES

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 that 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, San Benito, Mariposa, or Merced counties, excluding dual coverage members.

Ages: 1 – 20.99 years of age.

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.

DENOMINATOR: Eligible population as defined above.

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

FQHC / Rural Health Center tip: FQHCs will need to bill the HCPCS codes on a separate claim than the office visit. https://www.acesaware.org/learn-about-screening/billing-payment/

DOCUMENTATION REQUIREMENTS:
Documentation must include a standardized screening tool. Screening tools do not need to be sent to the Alliance. However, please make sure the medical record includes the standardized ACE screening tool used, the date of the screening, that the completed screen was reviewed, the results of the screen, the interpretation of results, what was discussed with the Member and/or family, and any appropriate actions taken. score.

- ACEs questionnaire for adults (ages 18 years and older).
- Pediatric ACEs and Related Life-events Screener (PEARLS) for children (ages 0 to 19 years).

For more information on the types of screening tools, please see the ACES AWARE Screening Tools resources.

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.

DATA SOURCE: Claims.

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

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.

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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents Tip Sheet
- Provider training (PCPs, physician assistants, nurse practitioner)**:** Becoming ACEs Aware in California Training.
- Clinic staff training (medical assistants, nurses, office managers, etc.)**:** Screening for Adverse Childhood Experiences (ACEs) and ACE Screenings Resource Guide.
- 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.
- Trauma-Informed Network of Care Roadmap

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)**

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

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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 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

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, San Benito, Mariposa, 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.

Developmental screenings are recommended at the **9, 18, and 30-month visits** following the Bright Futures periodicity schedule. Developmental concerns found through developmental surveillance should be followed by standardized developmental screening or direct referral to intervention and specialty care and be documented for medical necessity in the chart.

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 & Stages Questionnaires®, Third Edition (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.

Note: Following CMS Child Core measure guidelines, this measure counts all submitted claims (e.g., paid, suspended, pending, or denied).

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 monthly **Quality Report – Developmental Screening in the First Three Years** provides a list linked members who may be due for a developmental screening. .

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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 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.
- AAP's Identify Risks, Strengths, and Protective Factors for Children and Families: A Resource for Clinicians Conducting Developmental Surveillance.

Measure derived from CMS Core Child Set Developmental Screening in the First Three Years of Life: CMS Child Core Set Reporting Resources.

CODE SET:

- **CPT Code:** 96110

INITIAL HEALTH APPOINTMENT (IHA)

The Initial Health Appointment (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.

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, San Benito, Mariposa, 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: Member must be enrolled 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, 2023 and September 1, 2024 to qualify for the measure denominator.**

NUMERATOR: Claim showing IHA visit within 120 days of enrollment. IHA visit must be completed between October 2023 and December 2024. 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.
- Member Risk Assessment - These should include at least one of the following risk assessment domains:
  - Health Risk Assessment.
  - Social Determinants of Health (ex. housing instability, functioning, quality of life outcomes and risk, utility needs, interpersonal safety, etc.). Example tool includes the Social Needs Screening Tool.
  - Cognitive Health Assessment
  - Adverse Childhood Experiences Screening.
- Physical exam.
- Mental status exam.
- Dental assessment. A review of the organ systems that include documentation of "inspection of the mouth" or "seeing dentist" meets the criteria.
- Health education/anticipatory guidance.
- Behavioral assessment.
- Diagnoses and a plan of care.

Note: For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings is covered in accordance with the American Academy of Pediatrics (AAP) /Bright Futures periodicity schedule,

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
If the members plan PCP did not perform the IHA within the last 12 months because it was performed by another provider, the PCP must record that the findings have been reviewed and updated in the members medical record.

For members who are currently established patients and then become newly eligible (this includes having other health coverage prior), the provider must document that the member received an initial appointment that meets all IHA requirements in the members medical record.

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 member's 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: IHA visit notes 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** 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

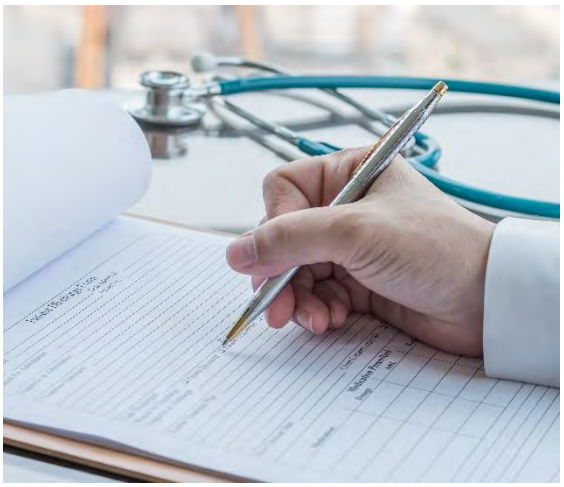
- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement
- Initial Health Appointment Tip Sheet
- APL 22-030 Initial Health Appointment
- APL 22-17 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review
  - Medical Record Review (MRR) Standards
- Population Management Policy Guide

CODE SET:
IHA Codes: See Initial Health Appointment 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 complement 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 Santa Cruz, Monterey, San Benito, Mariposa, 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 or during hospitalization.
- 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 2024 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).

One eligible post-discharge visit per hospital admission is counted, however if multiple admissions are both within the window of a 14-day outpatient visit, that outpatient visit is counted as a follow-up for both hospital admissions.

Multiple hospital discharges with either a single or multiple post-discharge visit(s) are counted.

SERVICING PCP SITE REQUIREMENT: Member must be seen for post discharge visit by the linked PCP provider site by a rendering provider with a CCAH PCP contract. Visits completed by specialists (claim adjudicated with a CCAH specialist contract) 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:
2024 CBI Programmatic Measure Benchmarks & Performance Improvement.

CODE SET:
Post-Discharge Care Codes

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 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, San Benito, Mariposa, 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: All inpatient admissions of Eligible Population (as defined above) during measurement period.

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

Diagnosis list includes:

- Asthma in younger adults.
- Community acquired 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Ambulatory Care Sensitive Admissions Tip Sheet.

Measure Derived From:
AHRQ PQI Individual Measure Technical Specifications (v2023 coding).
AHRQ PDI Individual Measure Technical Specifications (v2023 coding).

CODE SETS:
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.
Ambulatory Care Sensitive Admissions Inclusion Codes.
Ambulatory Care Sensitive Admissions Exclusion Codes.

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, San Benito, Mariposa, 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 in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.
- Members with a principal diagnosis of pregnancy or perinatal condition on the discharge claim.
- Planned hospital stay using any of the following:
  - 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Plan All-Cause Readmission Tip Sheet.

Measure derived from NCQA HEDIS Plan All-Cause Readmission.

CODE SET:
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, San Benito, Mariposa, 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: All emergency and urgent care visits for eligible members with date of service within the measurement period.

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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 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:
Preventable Emergency Visits Codes.

QUALITY OF CARE MEASURES

BREAST CANCER SCREENING

Breast cancer is the second most common cancer among women after certain skin cancers regardless of 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, San Benito, Mariposa, 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. Members 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 in hospice or using hospice services anytime during the measurement year.
- Members receiving palliative care during the measurement year.
- Members who died any time 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 December 31 of the measurement year with frailty and advanced illness:
    - At least two indications of frailty with different dates of service during the measurement year.
    - Any of the following during the measurement year or year prior to the measurement period (count services that occur over both years):
        - At least two outpatient, observation, emergency department (ED) visits or non-acute inpatient encounter on a different date of service (DOS), with an advanced illness diagnosis. Visit types must be the same for the two visits.
        - At least one acute inpatient encounter with an advanced illness diagnosis.
        - A dispensed dementia medication.

Note: Medi-Cal pharmacy benefits are 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 breast cancer screenings 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Breast Cancer Screening Tip Sheet
- NIH Breast Cancer Screening Evidence-Based Programs Listings
- CDC Breast Cancer Screening Change Package
- CDC's Power of Prevention: Health and Economic Benefits of Breast Cancer Interventions
- CPSTF Cancer Screening: Multicomponent Interventions Breast Cancer
- ASTHO Breast Cancer Disparities Online Toolkit
- CDC patient resource information:
    - What Is Breast Cancer Screening?
    - The Right to Know Campaign Breast Cancer Screening
    - If Your Mammography report says you have dense breasts, what does that mean?

CODE SETS:

Breast Cancer Screening Inclusion Codes
Breast Cancer Screening Exclusion Codes
Breast Cancer Medications
Hospice Exclusion Codes
Dementia Medication NDC Exclusion Codes
Palliative Care Exclusion Codes

REFERENCE:

1. Division of Cancer Prevention and Control, Centers for Disease Control and Prevention. Breast Cancer Statistics. June. 8, 2023 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 aged 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 21–64 years of age 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 30–64 years of age 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, San Benito, Mariposa, or Merced counties, excluding dual coverage members.

Ages: Women 2 – 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 in hospice or using hospice services anytime during the measurement year.
- Members receiving palliative care during the measurement year.
- Members who died during the measurement year.
  Members with a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.

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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Cervical Cancer Screening Tip Sheet.
- Patient resource information:
  - CDC's Do you know how to protect yourself from cervical cancer?
  - CDC's Cervical Cancer is Preventable infographic

CODE SETS:

Cervical Cytology & HPV Test Codes.
Cervical Cancer Screening Exclusion Codes.
Hospice Exclusion Codes.
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, San Benito, Mariposa, 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 who died during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.

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 – Child and Adolescent Well-Care Visit (3-21)** 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Child and Adolescent Well-Care Visits Tip Sheet.
- Get to Know Bright Futures Guidelines and Core Tools.
- Integrate Bright Futures Into Your Electronic Health Record System.
- Practical Tips for Implementing Bright Futures in Clinical Practice from Bright Futures.
- Promoting Health for Children and Youth with Special Health Care Needs from Bright Futures.
- Integrating Social Determinants of Health into Health Supervision Visits from Bright Futures.
- Equitable Health Toolkit from Washington Chapter of the American Academy of Pediatrics.
- American Academy of Pediatrics (AAP) A Pediatrician's Guide to an LGBTQ+ Friendly Practice.
- AAP Family-Centered and Equitable Care Approaches.
- "Medi-Cal for Kids and Teens" DHCS developed child and teen focused brochures.

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

DEPRESSION SCREENING FOR ADOLESCENTS AND ADULTS

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

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, San Benito, Mariposa, or Merced counties, excluding dual coverage members.

Ages: Members 12 years and older at the start of the measurement year.

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: Outpatient visit during the measurement year.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members who died any time during the measurement year.
- Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period.
- Members with depression that starts during the year prior to the measurement period.
- Members in hospice or using hospice services any time during the measurement period.

DENOMINATOR: The initial population, minus exclusions.

NUMERATOR: Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period.

DOCUMENTATION REQUIREMENTS:
Medical records must document:

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

If a screening is positive, documented follow-up care can include:

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

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

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

INSTRUMENTS FOR ADULTS	RESULTS CONSIDERED AS POSITIVE FINDING
Patient Health Questionnaire 9 (PHQ-9)	Total Score ≥ 10
Patient Health Questionnaire-2 PHQ2	Total Score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)	Total Score ≥ 8
Beck Depression Inventory (BDI or BDI II)	Total Score ≥ 20
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥ 17
Duke Anxiety-Depression Scale (DUKE-AD)	Total Score ≥ 30
Geriatric Depression Scale Short Form (GDS)	Total Score ≥ 5
Geriatric Depression Scale Long Form (GDS)	Total Score ≥ 10
Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥ 10
My Mood Monitor (M-3)	Total Score ≥ 5
PROMIS Depression	Total Score (T Score) ≥ 60
Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥ 31

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: 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Depression Screening for Adolescents and Adults Tip Sheet.
- Alliance Behavioral Health website.
- Carelon Behavioral Health Primary Care Provider (PCP) Referral Form.
- Carelon Care Management Referral Form.

CODE SETS:

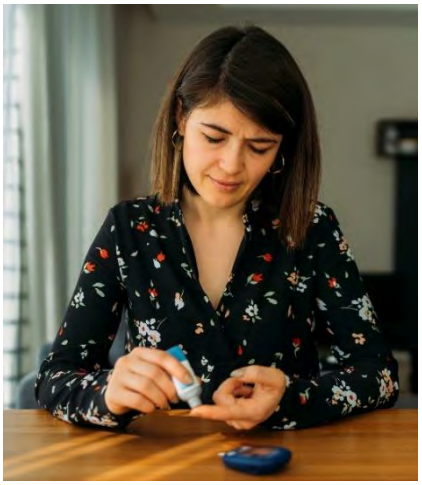
Screening for Depression Inclusion Codes.
Screening for Depression Exclusion Codes.

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/.

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 submitted, a claim without an HbA1c value, or an HbA1c value >9% will be considered compliant for this measure.

The goal for this measure is for members to be non-compliant and have an A1C of <9% and be in good control. (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, San Benito, Mariposa, 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 (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).

Note: Medi-Cal pharmacy benefits are 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:
- Administrative members.
- Dual coverage members.
- Members who do not have a diagnosis of diabetes in any setting during the measurement year or the year prior **and** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or year prior.
- Members in hospice or using hospice services anytime during the measurement year.
- Members receiving palliative care during the measurement year.
- Members who died any time during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness:
    - At least two indications of frailty with different dates of service during the measurement year.
    - Any of the following during the measurement year or year prior to the measurement period (count services that occur over both years):
        - At least two outpatient, observation, ED visits, e-visits or virtual check-ins, non-acute inpatient encounter, or nonacute inpatient discharge on a different date of service (DOS), with an advanced illness diagnosis. Visit types must be the same for the two visits.
        - At least one acute inpatient encounter or one acute inpatient discharge with an advanced illness diagnosis.
        - A dispensed dementia medication.

Note: Medi-Cal pharmacy benefits are 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement
- Diabetic HbA1c Poor Control >9% Tip Sheet

CODE SETS:
Diabetes Eligible Population Codes.
Diabetes Medication NDC Codes.
HbA1c Inclusion Codes.
Diabetes Exclusion Codes.
Hospice Exclusion Codes.
Dementia Medication NDC Exclusion Codes.
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, San Benito, Mariposa, 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.
- Dual coverage members.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

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 **or** anaphylaxis due to the meningococcal vaccine any time before the member's 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 **or** anaphylaxis **or** encephalitis due to the Tdap vaccine any time before the member's 13th birthday.

- HPV: Any of the following meet criteria
  - At least two HPV vaccine on or between the member's 9th and 13th birthdays with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.
  - At least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.
  - Anaphylaxis due to the HPV vaccine any time on or before the members 13th birthday.

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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Immunization: Adolescents Tip Sheet.
- CDC Top 10 Tips for HPV Vaccination Success: Attain and Maintain High HPV Vaccination Rates
- CAIR Immunization Registry http://cairweb.org/ for Santa Cruz and Monterey Counties.
- RIDE (Healthy Futures) Immunization Registry http://www.myhealthyfutures.org/ for Merced County.
- California Immunization Coalition.
- National HPV Vaccination Roundtable: Start at 9 Toolkit.
- Vaccines for Children (VFC) Program

CODE SETS:

Immunizations - Adolescents Codes.
Immunizations - Adolescents Exclusion Codes.
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) or anaphylaxis or encephalitis due to the diphtheria, tetanus or pertussis vaccine.
- **3 inactivated polio vaccine (IPV)** or anaphylaxis due to the IPV vaccine (first dose after 42 days after birth).
- **1 measles, mumps and rubella (MMR)** (on or between child's 1st and 2nd birthday), history of measles, mumps and rubella illness, or anaphylaxis due to the MMR vaccine.
- **3 haemophilus influenzae type b (Hib)** (first dose after 42 days after birth) or anaphylaxis due to the Hib vaccine.
- **3 hepatitis B (HepB)** (first dose 0-4 weeks), history of hepatitis B Vaccine, or anaphylaxis due to the Hepatitis B vaccine.
- **1 varicella (VZV)**(on or between child's 1st and 2nd birthday), history of varicella zoster (e.g. chicken pox) illness, or anaphylaxis due to the VZV vaccine.
- **4 pneumococcal conjugate vaccine (PCV)** (first dose after 42 days after birth) or anaphylaxis due to the pneumococcal conjugate vaccine.
- **2 or 3 rotavirus (RV)*** (first dose after 42 days after birth) or anaphylaxis due to the rotavirus vaccine.
- **1 hepatitis A (HepA)** (on or between child's 1st and 2nd birthday), history of hepatitis A illness, or anaphylaxis due to the hepatitis A vaccine
- **2 influenza (Flu)**** (vaccines given after 180 days after birth up to or on the child's 2nd birthday) or anaphylaxis due to the influenza vaccine

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

- 3 doses for RotaTeq.
- 2 doses Rotarix.
- 1 Rotarix AND 2 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, San Benito, Mariposa, 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.
- Dual coverage members.
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died during the measurement year.
- Members who had any of the following on or before their second birthday: Severe combined immunodeficiency, immunodeficiency, HIV, lymphoreticular cancer, multiple myeloma or leukemia, or intussusception.

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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Immunizations: Children (Combo 10) Tip Sheet.
- CDC Vaccination Schedule.
- Alliance Immunization Resources
- California Immunization Registry (CAIR2) for Santa Cruz and Monterey Counties
- Healthy Futures Public Health Information System (RIDE) for Merced County
- Vaccines for Children (VFC) Program
- California Immunization Coalition.
- A step-by-step guide to improving vaccine uptake in outpatient settings
- Fall 2022 Influenza Vaccination Talking Points
- 2022-23 Late Influenza Vaccine Talking Points
- Don't Wait-Vaccinate Campaign Talking Points

CODE SETS:

Immunizations: Children Inclusion Codes.
Immunizations: Children Exclusion Codes.
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, San Benito, Mariposa, 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 in hospice or using hospice services anytime during the measurement year.
- Members who died any time during the measurement year.

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

California law requires a blood lead test for Medi-Cal members at 12 and 24 months of age and requires health care providers performing blood lead analysis to report all results to the California Department of Public Health (CDPH) Childhood Lead Poisoning Prevention Branch. 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: Annually, following the end of quarter 4.

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 with 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Lead Screening in Children 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 SETS:
Lead Screening Codes.
Hospice Exclusion Codes.

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 aged 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, San Benito, Mariposa, 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 who died any time during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.

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 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Well-Child Visits in the First 15 Months Tip Sheet.
- The Child & Adolescent Health Measurement Initiative Well Visit Planner.
- Maternal Infant Health Initiative: Infant Well-Child Visit Learning Collaborative
- Center for Health Care Strategies (CHCS) Improving Preventive Care Services for Children Toolkit
- AAP's A Stepped Intervention Increases Well-Child Care and Immunization Rates in a Disadvantaged Population
- AAFP Remove Roadblocks and Improve Access to Preventive Care
- "Medi-Cal for Kids and Teens" DHCS developed child and teen focused brochures.

CODE SETS:
Well Child 0-15 Month Visit Codes.
Hospice Exclusion Codes.

REFERENCES:

1. Bright Futures. 2021. https://brightfutures.aap.org/
2. Lipkin, Paul H., Michelle M. Macias, Section on Developmental and Behavioral Pediatrics Council on Children with Disabilities, Kenneth W. Norwood Jr, Timothy J. Brei, Lynn F. Davidson, Beth Ellen Davis, et al. 2020. "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening." Pediatrics 145 (1): e20193449. https://doi.org/10.1542/peds.2019-3449

HEALTH EQUITY

HEALTH EQUITY: CHILD AND ADOLESCENT WELL-CARE VISIT

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.

Rates stratified by member race and ethnicity include: White, Black, Latinx, Asian, and Other. A point will be awarded for each ethnicity group that reaches its improvement goal.

MEMBER REQUIREMENT: PCP must have 30 members that meet the eligible population criteria for the Child and Adolescent Well-Care measure, as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey, San Benito, Mariposa, 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 who died during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.

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.

BASELINE RATE: CBI 2023 Q4 rates for White, Black, Latinx, Asian, and Other Medi-Cal populations measured against the 2023 reporting year (2022 HEDIS Measurement Year) benchmarks.

SERVICING PCP SITE REQUIREMENT: A point will be awarded for each ethnicity group that reaches its improvement goal. All CBI groups meeting the member requirement will be given credit.

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

CALCULATION FORMULA: The entire CBI pool of CBI Providers will be eligible to receive up to 5 points based on the table below:

Ethnicity Metric Starting Point for CBI 2023	Points earned for 5% improvement for each ethnicity	Points earned for 10% improvement for each ethnicity
< 50th percentile	0.5	1
>50th percentile	0.125	0.25

Baseline rates will be captured at the end of quarter 4 of the 2023 CBI Term.

Rate for each race/ethnicity = Total members who were received a well care visit by their PCP/OBGYN/ Total Eligible Members.

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

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Child and Adolescent Well-Care Visit (3-21)** 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Child and Adolescent Well-Care Visits Tip Sheet.
- Get to Know Bright Futures Guidelines and Core Tools.
- Integrate Bright Futures Into Your Electronic Health Record System.
- Practical Tips for Implementing Bright Futures in Clinical Practice from Bright Futures.
- Promoting Health for Children and Youth with Special Health Care Needs from Bright Futures.
- Integrating Social Determinants of Health into Health Supervision Visits from Bright Futures.
- Equitable Health Toolkit from Washington Chapter of the American Academy of Pediatrics.
- American Academy of Pediatrics (AAP) A Pediatrician's Guide to an LGBTQ+ Friendly Practice.
- AAP Family-Centered and Equitable Care Approaches.
- "Medi-Cal for Kids and Teens" DHCS developed child and teen focused brochures.

CODE SETS :

Child and Adolescent Well-Care Visits Codes.
Hospice Exclusion Codes.

PERFORMANCE TARGET MEASURE

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 sites 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 2024 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:

- Lead Screening in Children
- Depression Screening for Adolescents and Adults

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

- Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents
- Ambulatory Care Sensitive Admissions.
- Application of Dental Fluoride Varnish.
- Breast Cancer Screening.
- 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 Appointment.
- Plan All-Cause Readmission.
- Post-Discharge Care.
- Preventable Emergency Visits.
- Well-Child Visits in the First 15 Months.

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
17	.59

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey, San Benito, Mariposa, 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:
2024 CBI Programmatic Measure Benchmarks & Performance Improvement.

DATA SOURCE: Measure specific.

MEMBER REASSIGNMENT

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.

RESOURCES:

- Request for Member Reassignment Form

EXPLORATORY MEASURES

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, San Benito, Mariposa, 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. Members 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 who died any time during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.
- 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.
    -

Note: Medi-Cal pharmacy benefits are 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Chlamydia Screening in Women – Exploratory Measure Tip Sheet.
- Chlamydia Screening Starter Guide
- CDC's A Guide to Taking a Sexual History
- CDC Sexually Transmitted Infections Treatment Guidelines, 2021
- NCQA's Improving Chlamydia Screening Strategies from Top Performing Health Plans

CODE SETS:

Chlamydia Screening Inclusion Codes
Chlamydia Eligible Population Codes
Chlamydia Medication NDC Codes
Chlamydia Exclusion Codes
Hospice Exclusion Codes

COLORECTAL CANCER SCREENING

Of cancers that affect both men and women, in 2023, an estimated 106,970 cases of colon cases and 46,050 cases of rectal cancer will be diagnosed in the US. A total of 52,550 people will die from those cancers. Screening is the most effective measure in preventing colorectal cancer through the detection and removal of precancerous polyps, often detecting colorectal cancer in its early stages, when treatment is most effective.

MEASURE DESCRIPTION: The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer. For members 46-75 years use any of the following criteria:

- Fecal occult blood test within the last year.
- Flexible sigmoidoscopy within the last 5 years.
- Colonoscopy within the last 10 years.
- CT colonography within the last 5 years.
- Stool DNA (sDNA) with FIT test within the last 3 years.

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, San Benito, Mariposa, or Merced counties, excluding dual coverage members.

Age: Members 45-75 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. Members 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 who had colorectal cancer or total colectomy at any time in the member's history through December 31 of the measurement year.
- Members who died any time during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.
- Members receiving palliative care during the measurement year.
- Any of the following during the measurement year or year prior to the measurement period (count services that occur over both years):
    - At least **two** outpatient, observation, ED visits, e-visits or virtual check-ins, non-acute inpatient encounter, or nonacute inpatient discharge on a different date of service (DOS), with an advanced illness diagnosis. Visit types must be the same for the two visits.
    - At least one acute inpatient encounter or one acute inpatient discharge with an advanced illness diagnosis.
    - A dispensed dementia medication.

DENOMINATOR: Eligible population as defined above.

NUMERATOR: At least one colorectal screening as defined above 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, 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 2024.

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

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 colorectal 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Colorectal Cancer Screening – Exploratory Measure Tip Sheet.
- Tailoring Colorectal Cancer Screening Messaging A Practical Coalition Guide
- 2022 Messaging Guidebook for Black & African American People
- 2017 Asian Americans and Colorectal Cancer Companion Guide
- 2016 Hispanics/Latinos and Colorectal Cancer Companion Guide
- A Provider's Guide to Colorectal Cancer Screening
- Colorectal Cancer Alliance patient resources.

CODE SETS:

Colorectal Screening Inclusion Codes
Colorectal Screening Exclusion Codes
Colorectal Screening Medication Exclusion Codes
Dementia Medication NDC Exclusion Codes.
Hospice Exclusion Codes

REFERENCES:

[1] American Cancer Society. 2023. Cancer Facts & Figures 2023.

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, San Benito, Mariposa, 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. Members 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. The 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 in hospice or using hospice services anytime during the measurement year.
- Members receiving palliative care during the measurement year.
- Members who died during the measurement year.
- Members with a diagnosis of pregnancy during the measurement year
- Members with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant on or prior to December 31 of the measurement year.
- Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty on different dates of service

- Members 66-80 years of age and older as of December 31 of the measurement year with frailty **and** advanced illness:
  - At least two indications of frailty with different dates of service during the measurement year
  - Any of the following during the measurement year or year prior to the measurement period (count services that occur over both years):
    - At least **two** outpatient, observation, ED visits, e-visits or virtual check-ins, non-acute inpatient encounter, or nonacute inpatient discharge on a different date of service (DOS), with an advanced illness diagnosis. Visit types must be the same for the two visits.
    - At least one acute inpatient encounter or one acute inpatient discharge with an advanced illness diagnosis.
    - A dispensed dementia medication.

Note: Medi-Cal pharmacy benefits are 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: Most recent BP reading taken during an outpatient visit (Outpatient without UBREV codes on the claim), 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Controlling High Blood Pressure – Exploratory Measure Tip Sheet.

CODE SETS:

Blood Pressure Inclusion Codes.
Blood Pressure Exclusion Codes.
Hospice Exclusion Codes.
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

WELL-CHILD VISITS FOR AGE 15-30 MONTHS OF LIFE

Well-care visits provide an opportunity for PCPs to check if the child is meeting milestones and complete appropriate screenings and immunizations. 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 30 months old who had 2 or more well-child visits with a PCP between the child's 15-month birthday plus one day and the 30-month birthday.

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, San Benito, Mariposa, or Merced counties, excluding dual coverage members.

Ages: Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.

Continuous Enrollment: 15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days. No more than one gap in enrollment of up to 45 days during the continuous enrollment period.

Eligible Member Event/Diagnosis: None.

Exclusions:

- Administrative members.
- Dual coverage members.
- Members who died ant time during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.

DENOMINATOR: Eligible population age 30 months old, as defined above.

NUMERATOR: At least 2 well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday with a PCP during the measurement period.

Telehealth visits are 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 30 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 (15-30 Months)** provides a list of linked members who, according to our records may or may not have received the 2 well-child visits between 15 and one day and 30 months of life. This report looks prospectively before the child turns 30 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 Representative at 831-430-5518 or email portalhelp@ccah-alliance.org.

RESOURCES:

- 2024 CBI Programmatic Measure Benchmarks & Performance Improvement.
- Well-Child Visits for Age 15-30 Months of Life – Exploratory Measure Tip Sheet.
- The Child & Adolescent Health Measurement Initiative (CAHMI) Family Resource Sheets by child age
- Medicaid Maternal Infant Health Initiative: Infant Well-Child Visit Learning Collaborative
- Center for Health Care Strategies (CHCS) Improving Preventive Care Services for Children Toolkit
- AAP's A Stepped Intervention Increases Well-Child Care and Immunization Rates in a Disadvantaged Population
- AAFP Remove Roadblocks and Improve Access to Preventive Care
- "Medi-Cal for Kids and Teens" DHCS developed child and teen focused brochures

CODE SETS:
Well Child 0-15 Month Visit Codes.
Hospice Exclusion Codes.

REFERENCES:

1. Bright Futures. 2021. https://brightfutures.aap.org/
2. Lipkin, Paul H., Michelle M. Macias, Section on Developmental and Behavioral Pediatrics Council on Children with Disabilities, Kenneth W. Norwood Jr, Timothy J. Brei, Lynn F. Davidson, Beth Ellen Davis, et al. 2020. "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening." Pediatrics 145 (1): e20193449. https://publications.aap.org/pediatrics/article/145/1/e20193449/36971/Promoting-Optimal-Development-Identifying-Infants?autologincheck=redirected

FEE-FOR-SERVICE MEASURES

Fee-for-Service (FFS) Measures provide a single payment incentive to PCP sites. All 2024 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.

ADVERSE CHILDHOOD EXPERIENCES (ACES) TRAINING AND ATTESTATION

ACEs and toxic stress are associated with increased risk of a wide range of health conditions in both pediatric and adult populations, known as ACE-Associated Health Conditions. The ACEs Aware online training is required to receive Medi-Cal payment for ACE screenings. Physicians and clinical team members will receive 2.0 Continuing Medical Education (CME) credits and 2.0 Maintenance of Certification (MOC) credits upon completion. Providers are also required to complete the Adverse Childhood Experiences (ACEs) Provider Training Attestation to qualify for Medi-Cal and CBI payments.

MEASURE DESCRIPTION: This measure is intended to provide compensation for the time spent in completing the ACE Aware Core Training and Attestation with the goal of expanding ACE screenings performed in our provider network.

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: $200 per provider, for PCPs and non-physician medical practitioners, credentialed as primary care providers, and/or qualifying residents, for completing ACEs Aware Core Training and Attestation on the ACEs Aware Website. Plan shall pay for each CBI group that the clinician practices under. Mid-level providers and qualifying residents must be practicing under a supervising PCP physician with an ACEs training attestation to be eligible for incentive payment.

Second- or Third-year residents who are licensed, are eligible to qualify for this Fee-For-Service measure if the hospital associated with the PCP clinic is participating in the CBI Program. The hospital must submit a roster of qualified residents to your Provider Relations Representative with the following information:

- Name of resident.
- Name of supervising physician and their NPI.
- Practice name
- Date of the completed attestation.

PAYMENT FREQUENCY: Quarterly. Payments are made a single time after the attestation or roster is received. Payments do not reoccur yearly or quarterly. Providers should start billing for ACE screenings the month after they completed their attestation.

DATA SOURCE: Receipt of State file with provider NPI noting attestation of ACEs training or receipt of roster for qualifying residents.

RESOURCES:

- Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents Tip Sheet
- Provider training (PCPs, physician assistants, nurse practitioner)**:** Becoming ACEs Aware in California Training.
- Adverse Childhood Experiences (ACEs) Provider Training Attestation

CODE SET: N/A.

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.

COGNITIVE HEALTH ASSESSMENT TRAINING AND ATTESTATION

Normal brain aging may result in slower processing speeds and having trouble multitasking, but dementia and Alzheimer's are not a normal part of aging. Symptoms of cognitive decline interfere with member's daily life, such as memory, thinking, and reasoning. Finding early signs of dementia is important and allows you a chance to get access to treatments, support services, and enroll in clinical trials.

The Dementia Care Aware online training is required to receive Medi-Cal payment for cognitive health screenings. Physicians and clinical team members will receive 1.5 Continuing Medical Education (CME) credits.

MEASURE DESCRIPTION: This measure is intended to provide compensation for the time spent in completing the Dementia Care Aware Training with the goal of expanding ACE screenings performed in our provider network.

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: $200 per provider, for PCPs and non-physician medical practitioners, credentialed as primary care providers, and/or qualifying residents, for completing the Cognitive Health Assessment Training through DHCS using the Dementia Care Aware website. Plan shall pay for each CBI group that the clinician practices under. Mid-level providers and qualifying residents must be practicing under a supervising PCP physician with an Cognitive Health Assessment Training to be eligible for incentive payment.

Second- or Third-year residents who are licensed, are eligible to qualify for this Fee-For-Service measure if the hospital associated with the PCP clinic is participating in the CBI Program. The hospital must submit a roster of qualified residents to your Provider Relations Representative with the following information:

- Name of resident.
- Name of supervising physician and their NPI.
- Practice name
- Date of the completed attestation.

PAYMENT FREQUENCY: Quarterly. Payments are made a single time after the training is completed, and the certificate is received. Payments do not reoccur yearly or quarterly. Providers should start billing for cognitive assessment trainings screenings the month after they completed their training.

DATA SOURCE: Receipt of State file with provider NPI noting completed Cognitive Assessment training or receipt of roster for qualifying residents.

RESOURCES:

- Dementia Care Aware
- Provider training (PCPs, physician assistants, nurse practitioner)**:** Cognitive Health Assessment Webinars.
- Dementia Care Aware Program Offerings.
- Dementia Care Aware Warmline (Primary Care Team Support and Consultation Service).
- Practice Support Consultation.

CODE SET: N/A.

DIAGNOSTIC ACCURACY AND COMPLETENESS TRAINING

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

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

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

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: $200 per provider, for PCPs and non-physician medical practitioners, credentialed as primary care providers, and/or qualifying residents, for completing the CMS Medicare Learning Network (MLN) diagnosis training with a score of 70% or higher.

Second- or Third-year residents who are licensed, are eligible to qualify for this Fee-For-Service measure if the hospital associated with the PCP clinic is participating in the CBI Program. The hospital must submit a roster of qualified residents to your Provider Relations Representative with the following information:

- Name of resident.
- Name of supervising physician and their NPI.
- Practice name
- Date of the completed MLN diagnosis training certificate.

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

DATA SOURCE: Receipt of the completed CMS MLN Web training for Diagnosis Coding to your Provider Relations Representative.

RESOURCES:

- CMS MLN Web training- Diagnosis Coding
- Social Determinates of Health, Diagnosis Accuracy, and CPT II Coding Tip Sheet

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.

QUALITY PERFORMANCE IMPROVEMENT PROJECTS

MEASURE DESCRIPTION: PCP sites will be awarded $1000 for each office who complete an Alliance offered Quality Performance Improvement Project. Only offices with metrics that are below the minimum performance level, measured at the 50th percentile for the CBI 2023 year programmatic payment are eligible for payment for completion of Quality Performance Improvement Projects.

Offices will be notified by the Alliance of their eligibility for participation in this Fee-For-Service measure no sooner than April 1, 2024. At that time, eligible offices will be directed to a list of Quality Performance Improvement Projects offered on the Alliance's website where they will be instructed as to the details regarding participation and completion.

MEMBER REQUIREMENT: N/A.

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: If a CBI Provider has multiple eligible offices participating in Quality Performance Improvement Projects, each office must be represented by their own practice representative. Completion of Quality Performance Improvement Projects must occur within the CBI Term

FEE-FOR-SERVICE AMOUNT:

- $1,000 for each office that completes an Alliance offered Quality Performance Improvement Project.

PAYMENT FREQUENCY: Quarterly, following the completion of the Quality Performance Improvement Project.

DATA SOURCE: Notification of completed project.

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

CODE SET: N/A.

SOCIAL DETERMINANTS OF HEALTH (SDOH) ICD-10 Z-CODE SUBMISSION

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

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

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

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

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: Provider must have billed at least one of the 25 DHCS priority Social Determinants of Health (SDOH) ICD-10 Z-Codes listed on All-Plan Letter 21-009.

FEE-FOR-SERVICE AMOUNT:

- $250 per qualifying quarter.

PAYMENT FREQUENCY: Quarterly. Payment is not reimbursable on a per code basis.

DATA SOURCE: Claims.

RESOURCES:

- Social Determinates of Health, Diagnosis Accuracy, and CPT II Coding Tip Sheet
- APL 21-009: Collecting Social Determinants of Health Data.

CODE SET:
Social Determinates of Health Codes.

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.