2025 Care-Based Incentive
Technical Specifications

PROVIDER INCENTIVES

January 2025

HEALTHY PEOPLE. **HEALTHY** COMMUNITIES.

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CBI PROGRAM OVERVIEW

The Care-Based Incentive (CBI) program is designed in collaboration with Alliance network providers to offer financial incentives and technical assistance to primary care providers (PCPs) to help them improve in the following areas:

- Care Coordination.
- Quality of Care.
- Exploratory Measure.

The financial incentive payments offered through the CBI program are an important mechanism to influence discretionary activities among the Alliance 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 the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) scores.
- Improving the member experience.
- Encouraging the delivery of high value care.
- Improving patient access and use 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).
- Reducing disparities in quality or service delivery between groups of members and/or geographic regions.

Although the CBI program evaluates performance on the Alliance Medi-Cal line of business only, the Alliance encourages the provision of quality, cost-efficient care for all your health center 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 through the following channels:

- The Provider Bulletin, Provider Digest, Provider Flash, and email communication.
- The Linked Member List, Quality Reports, HEDIS (MCAS) Reports, Data Submission Tool, and Care-Based Incentive Reports in the Provider Portal.
- Board reports.
- CBI workshops.
- Performance reviews including:
    - Performance improvement projects.
    - CBI forensics visits.
    - 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 help us continue to ensure excellent health outcomes for our members and a robust CBI program for our providers.

CBI WORKGROUP

CBI program internal workgroup consists of representatives from Finance, Provider Relations, Analytics and Technology Services, Pharmacy, Care Management, Quality Improvement and Population Health and Medical Affairs who reviews program policies and proposed measure ideas.

QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (QIHEC)

This committee consists of contracted external physicians and administrators in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties from a variety of practice types, and Alliance Directors and Medical Directors. The Continuous Quality Improvement Committee (CQIC) provides recommendations and feedback on measures and advises on CBI operations.

PHYSICIAN ADVISORY GROUP (PAG)

This committee consists of contracted external physicians and administrators in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties from a variety of practice types, and Alliance Directors, an Alliance Board member and Alliance Medical Directors. This is a Brown Act committee that 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 help providers succeed in the CBI program.

PROVIDER PORTAL

The Alliance Provider Portal offers reports that include claims and laboratory information, immunization registries, pharmacy information and provider portal-entered data received on relevant CBI measures to help providers monitor their patients and streamline 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 Report: This report offers up-to-date information on members who may be indicated for preventive health services and assists in monitoring linked members with recent ED and hospital admission or discharge information. These reports are based on enrollment, eCensus data, authorizations and claims data.

- Linked Member Roster.
- Newly Linked Members and 120-Day Initial Health Appointment (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.
- Linked Members Not Seen By PCP.

Quality Reports: Monthly quality reports include clinical measures to help providers monitor their patient's preventive 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. Some of the quality reports (e.g., childhood immunizations, well-child visits 0-15 months) vary from the CBI methodology to provide prospective information before the member ages out of the measure. The information section at the beginning of the report explains how each report is designed.

All reports are refreshed monthly with a **weekly refresh to the reports listed below with an asterisk (*).**

QUALITY REPORTS	
Adverse Childhood Experiences (ACEs) Screenings*	COVID-19 Immunizations*
Asthma Medication Ratio	Diabetes Care
Breast Cancer Screenings	Immunizations for Adolescents*
Cervical Cancer Screenings	Lead Screening in Children
Child & Adolescent Well-Care Visits (3-21 years)	Prenatal Immunizations*
Childhood Immunizations (Combo 10)*	Well Child Visits (0-15 Months)*
Chlamydia and Gonorrhea Screenings	Well Child Visits (15 Months-30 Months)*
Controlling Blood Pressure	

Data Submission Tool: The Data Submission Tool (DST) allows Alliance providers to upload data files via the Provider Portal. The DST was created for providers to submit data from their Electronic Health Record (EHR) system and paper records to achieve compliance in the Care-Based Incentive (CBI) program, annual MCAS audit, and quality improvement projects. This data should supplement what cannot be received through claims. 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 (includes FOBT, flexible sigmoidoscopy, colonoscopy, CT colonography and sDNA).
- Controlling High Blood Pressure (diastolic and systolic values).
- Depression Screening for Adolescents and Adults.
- Developmental Screening in the First Three Years of Life.
- Diabetic Poor Control >9% (lab values).
- Immunizations: Adolescents.
- Immunizations: Children (Combo 10).
- Initial Health Appointment (IHA).
- Well-Child Visits in the First 15 Months.
- Well-Child Visits for Age 15 Months-30 Months of Life.

CBI Reports: The CBI reports are a resource to monitor overall performance in the CBI program and identify opportunities for preventive care in your clinics. The CBI reports are available for review throughout the year.

CBI SUMMARY & PERFORMANCE REPORT
Provides site-level performance information with hyperlinks on the measure names to view performance trends over the past couple of years.

CBI MEASURE DETAIL REPORT	
Provides member-level reports to view opportunities for patient outreach and reconciliation of services into your practice.	
MEASURE CATEGORY	**MEASURE NAME**
CARE COORDINATION – ACCESS MEASURES	Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents
	Application of Dental Fluoride Varnish
	Developmental Screening in the First Three Years
	Initial Health Appointment (IHA)
	Post-Discharge Care

MEASURE CATEGORY	MEASURE NAME
CARE COORDINATION – HOSPITAL & OUTPATIENT MEASURES	Ambulatory Care Sensitive Admissions
	Plan All-Cause Readmission
	Preventable Emergency Visits
QUALITY OF CARE	Breast Cancer Screening
	Cervical Cancer Screening
	Child and Adolescent Well-Care Visits
	Chlamydia Screening in Women
	Colorectal Cancer Screening
	Depression Screening for Adolescents and Adults
	Diabetic Poor Control >9%
	Immunizations: Adolescents
	Immunizations: Children (Combo 10)
	Lead Screening in Children
	Well-Child Visit in the First 15 Months
	Well-Child Visits for Age 15 Months-30 Months of Life
EXPLORATORY MEASURE	Controlling High Blood Pressure
FEE-FOR-SERVICE MEASURES	Adverse Childhood Experiences (ACEs) Training and Attestation
	Cognitive Health Assessment Training and Attestation
	Diagnostic Accuracy and Completeness Training

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

CBI DASHBOARD REPORT
Provides a comparison graph of selected measures to your rate and minimum and high-performance levels for each CBI quarter.

HEDIS (MCAS) Reports: The California Department of Health Care Services (DHCS) requires that the Alliance perform an annual compliance audit with a subset of HEDIS measures, referred to as the Managed Care Accountability Set (MCAS). These reports are similar to CBI portal reports as they allow clinic sites to view their monthly performance in the MCAS measures that are held to the minimum performance level (MPL). All reports include continuous enrollment (CE) criteria per the measure specifications.

Additional Provider Portal resources include:

- Claims search.
- Overpayment letters search.
- Member eligibility verification.
- Prescription history.
- Provider directory.
- Procedure code lookup.
- Authorization and referrals search and entry.

If you do not have a Provider Portal account, submit a Provider Portal Account Request Form on the Provider Portal. For questions, concerns or training requests regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

CBI PROVIDER WORKSHOPS

The Alliance holds an annual CBI Workshop to share upcoming changes for the new program year. Please contact your Provider Relations Representative at 800-700-3874, ext. 5504, or CBI@thealliance.health for additional information on the CBI Workshop. The workshop recording is posted on the Alliance Webinars and Training page under Provider Resources.

CBI FORENSICS

At the close of each CBI program year, the Alliance reviews CBI performance for each network provider site. The Alliance conducts outreach efforts to sites that may benefit from additional program support, and Alliance staff is also available on request to meet with sites to review their CBI data and offer support to improve CBI program performance. This is a valuable opportunity to receive additional support and training. Please email CBI@thealliance.health to schedule a CBI forensics visit with our CBI Quality Improvement and Population Health staff.

CBI UPDATES

Throughout the year, announcements or updates to the CBI measures are announced through one or more of the following sources:

- Provider News.
    - Provider Bulletin: Published digitally and in print every quarter.
    - Provider Digest: Published digitally biweekly.
    - Provider Flash: Timely alerts via fax and email.
- Provider Relations Representative outreach.
- Email communication.
- CBI webinars.

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

CBI PROGRAM CONTACT INFORMATION

CBI team email: CBI@thealliance.health.
CBI website: Care-Based Incentive (CBI) Resources.
Provider Relations: 800-700-3874, ext. 5504.

PROGRAMMATIC MEASURES OVERVIEW

Payment based on the PCP site performance in programmatic measures occurs once yearly following the end of quarter four. 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.

The rates for each quarter are calculated using a rolling 12-month measurement period. Therefore, each quarter contains members eligible for measures within those 12 months, and the respective measure data (e.g., quarter one contains data from quarter two of prior year through quarter one of the current year). However some measure requirements look back further for numerator or denominator information (see the CBI Timeline on the CBI Summary page for more details). In quarter four, when programmatic payments are made, the report contains eligible data for the calendar year only, January through 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 the CBI measures, refer to the CBI Summary page. For yearly performance targets and a detailed explanation of point allocations by measure, refer to the 2025 CBI Programmatic Measure Benchmarks.

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 Three Years	2
Initial Health Appointment	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	**53**
Breast Cancer Screening	Points distributed based on measure eligibility
Cervical Cancer Screening	
Child and Adolescent Well-Care Visits (three to 21 years)	
Chlamydia Screening in Women	
Colorectal Cancer Screening	
Depression Screening for Adolescents and Adults	
Diabetic Poor Control >9%	
Immunizations: Adolescents	
Immunizations: Children (Combo 10)	
Lead Screening in Children	
Well-Child Visit in the First 15 Months	
Well-Child Visits for Age 15 Months-30 Months of Life	
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 experienced at least one ACE, and nearly one in six reported that they 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 one to 20 years of age who are screened for Adverse Childhood Experiences (ACEs) annually using a standardized screening tool.

MEMBER REQUIREMENT: The primary care provider (PCP) must have five members who meet the eligible population criteria as defined below.

ELIGIBLE POPULATION:

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

Ages: One to 20.99 years of age.

Continuous Enrollment: Member must be continuously enrolled for any four months during the CBI measurement period; no gap allowance.

Eligible Member Event/Diagnosis: N/A.

Exclusions:

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

DENOMINATOR: Eligible population as defined above.

NUMERATOR: Linked members ages one to 20.99 years of age with a paid claim for ACEs screening in the measurement year.

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

[1] About Adversе Childhood Experiences – CDC.

DOCUMENTATION REQUIREMENTS:
Documentation must include a standardized ACEs screening tool. Screening tools ***do not*** need to be sent to the Alliance. However, please make sure the medical record includes the standardized ACEs 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.

ACE screening tools:
- ACEs questionnaire for adults (18 years of age and older).
- Pediatric ACEs and Related Life-events Screener (PEARLS) for children (0-19 years of age).

For more information on screening tools, please see ACEs Aware Screening Tools.

SERVICING PCP SITE REQUIREMENT: Members need to be linked to a PCP at the end of the 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 ACEs screening/total eligible members.

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

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Adverse Childhood Experiences (ACEs) Screenings** provides a list of linked members who may be due for an ACEs screening. The Provider Portal quarterly **CBI Report** provides a roster of compliant and non-compliant members, trending graphs, and a comparison to benchmark performance.

If you do not have a Provider Portal account, submit a Provider Portal Account Request Form on the Provider Portal. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:
- 2025 CBI Programmatic Measure Benchmarks.
- Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents Tip Sheet.

CODE SET:

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

APPLICATION OF DENTAL FLUORIDE VARNISH

Fluoride varnish is an important component of primary care to help prevent dental caries, and in some cases, reverse early dental caries in young children. Not only can dental decay affect the level of pain experienced by a 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. The intention of this measure is to improve oral health management for at-risk members.

MEASURE DESCRIPTION: The percentage of members ages six months to five years of age (up to before their sixth birthday) who received at least one topical fluoride application by staff at the primary care provider (PCP) office during the measurement year.

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

ELIGIBLE POPULATION:

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

Age: Six months to five years of age (up to before their sixth birthday) at the end of the measurement period.

Continuous Enrollment: Member must be continuously enrolled for any four months during the CBI measurement period; no gap allowance.

Eligible Member Event/Diagnosis: Paid claim or DST submission for dental fluoride application performed by staff at the PCP site.

Exclusions:

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

DENOMINATOR: Eligible population as defined above.

NUMERATOR: Number of members who received one application of dental fluoride varnish by staff at the PCP site 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 four.

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

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

If you do not have a Provider Portal account, submit a Provider Portal Account Request Form on the Provider Portal. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Application of Fluoride Varnish Tip Sheet.

CODE SET:

- **CPT Code:** 99188.

DEVELOPMENTAL SCREENING IN THE FIRST THREE 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 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: The percentage of members one to three years of age screened for risk of developmental, behavioral and social delays using a standardized tool in the 12 months preceding, or on their first, second or third birthday.

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

ELIGIBLE POPULATION:

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

Ages: One to three years of age.

Continuous Enrollment: Children who are enrolled continuously for 12 months prior to their first, second, or third birthday, with no more than one gap in enrollment of up to 45 days. Children must be enrolled on their first, second, or third birthday.

Eligible Member Event/Diagnosis: None.

Exclusions:

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

DENOMINATOR: Eligible population as defined above.

NUMERATOR: Linked members one to three years of age 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 include the following 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 **nine, 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	One month to 5 ½ years	10 to 15 minutes
Parents' Evaluation of Developmental Status – Revised (PEDS-R®)	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 to 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 that was linked during the child's first, second or third 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 one to three 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 four.

PROVIDER PORTAL: The Provider Portal monthly **Quality Report – Developmental Screening in the First Three Years** provides a list of linked members who may be due for a developmental screening.

PCPs can submit developmental screenings from their electronic health record (EHR) system or paper records via the Data Submission Tool. Log in 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Developmental Screening Tip Sheet.
- 2025 Child Core Set Reporting Resources – Medicaid.gov.

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 member enrollment with the Alliance. IHAs support PCP practices by establishing strong physician-patient relationships and are a valuable tool to bring new members up to date on preventive health screenings and health interventions to reduce future healthcare expenditures.

MEASURE DESCRIPTION: New members who receive a comprehensive IHA within 120 days of enrollment with the Alliance.

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

ELIGIBLE POPULATION:

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

Age: N/A.

Continuous Enrollment: Member must be enrolled 120 days following enrollment (four 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.

Exclusions:

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

DENOMINATOR: All new members linked to a provider at the end of 120 days post-enrollment. Members must be enrolled in the Medi-Cal program on or between October 1, 2024 and September 1, 2025 to qualify for the measure denominator.

NUMERATOR: Claim showing IHA visit within 120 days of enrollment. IHA visit must be completed between October 2024 and December 2025. 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 - This should include at least one of the following risk assessment domains:
    - Health Risk Assessment.
    - Social Determinants of Health (e.g., housing instability, functioning, quality of life outcomes and risk, utility needs, interpersonal safety, etc.). An example tool is 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.
- Diagnosis and a plan of care.

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

The Alliance implemented the **IHA dummy code** combination to allow providers to report certain exemptions to perform the IHA. These exemptions include the following:

IHA 12 months prior to Medi-Cal enrollment
If the member's plan PCP did not perform the IHA within the last 12 months because another provider performed it, the PCP must record that the findings were reviewed and updated in the member's 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 member's medical record.

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

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

Three attempts to schedule
Providers can make three documented, unsuccessful scheduling attempts (two telephone attempts and one written attempt) to qualify for the measure.

The following coding combination is required for all the above listed exemptions:

Procedure code: 99499
Modifier: KX
ICD-10 code: Z00.00

Members are compliant for an IHA, with the use of the dummy code if the provider uploaded to the Data Submission Tool on the Alliance Provider Portal. The Alliance no longer accepts dummy code submissions from claims.

***Note*:** IHA visit notes should be maintained in the member's medical record and are audited as part of the routine Facility Site Review (FSR) requirements. The Alliance performs biannual audits to ensure that IHA dummy codes were submitted appropriately, review records to ensure the CPT and ICD-10 codes billed are supported by the documentation, and review against current DHCS All Plan Letters (APLs) guidance to ensure policy requirements are followed.

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 four.

PROVIDER PORTAL: The Provider Portal monthly **Newly Linked Members and 120-Day Initial Health Assessment** reports provide a list of linked members due for an IHA.

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

PCPs can submit IHA or outreach data from their Electronic Health Record (EHR) system and paper records via the Data Submission Tool. Log in 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.org.

RESOURCES:

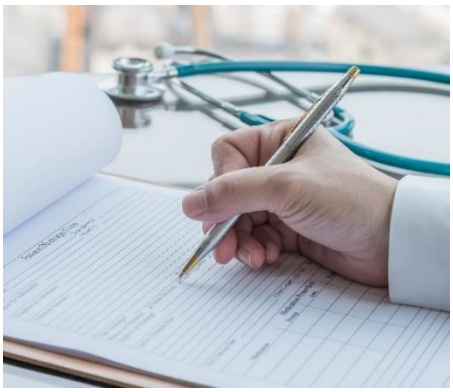
- 2025 CBI Programmatic Measure Benchmarks
- Initial Health Appointment Tip Sheet

CODE SET:
IHA Codes: See Initial Health Appointment Tip Sheet

POST-DISCHARGE CARE

Members who were 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 adequate post-hospital support. This is a critical transition that can prevent adverse events and reduce the probability of hospital readmission.

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



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

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

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

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Mariposa, Merced, Monterey, San Benito and Santa Cruz 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 four months during the CBI measurement period; no gap allowance. Member must be enrolled for 14 days following the qualifying inpatient discharge.

Exclusions:

- Administrative members at the end of the measurement period or during hospitalization.
- Dual coverage members.
- Members discharged and admitted to a Skilled Nursing Facility (SNF) on the same day.
- Postpartum and healthy newborn care visits are excluded. NICU newborns are ***included***.

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

If the provider has zero inpatient admissions during the measurement period, they receive full points for the measure. Greater than one 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 2025 CBI Programmatic Measure Benchmarks for more details.

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

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

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

SERVICING PCP SITE REQUIREMENT: Member must be seen for a 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 also count.

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 four.

PROVIDER PORTAL: The Provider Portal **Linked Member List- Linked Member Inpatient Admissions** report provides a real-time report of 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 provide a roster of compliant and non-compliant members, trending graphs, and a 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Post-Discharge Care Tip Sheet.

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 number of ambulatory care sensitive admissions per 1,000 eligible 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: The 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 Mariposa, Merced, Monterey, San Benito and Santa Cruz counties, excluding dual coverage members.

Age: N/A

Continuous Enrollment: Member must be continuously enrolled for any four months during the CBI measurement period; no gap allowance.

Denominator Event/Diagnosis: None.

Exclusions:

- Administrative members at the end of the measurement period.
- Dual coverage members.
- Condition-specific as outlined by the AHRQ.
- 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 with 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 four.

PROVIDER PORTAL: The Provider Portal **Linked Member List - Linked Member Inpatient Admissions** report provides a real-time report of 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 provide a roster of compliant and non-compliant members, trending graphs, and a 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Ambulatory Care Sensitive Admissions Tip Sheet.

Measure derived from:
AHRQ PQI Individual Measure Technical Specifications (v2024 coding).
AHRQ PDI Individual Measure Technical Specifications (v2024 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 and 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 improve communication with caregivers at the time of discharge. The Alliance offers the post-discharge incentive to complement the Plan All-Cause Readmissions incentive and support providers to reduce hospital readmissions.

MEASURE DESCRIPTION: The number of members 18 years of age and older with acute inpatient and observation stays during the measurement year followed by an unplanned acute readmission for any diagnosis within 30 days.

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

MEMBER REQUIREMENT: The 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 Mariposa, Merced, Monterey, San Benito and Santa Cruz counties, excluding dual coverage members.

Age: Eighteen to 64 years of age.

Continuous Enrollment: Three hundred sixty-five 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 at the Index Discharge Date.
- Dual coverage members.
- Members in hospice, receiving hospice services, or who died during the measurement year.
- Acute hospitalizations with any of the following on the discharge claim:
    - A principal diagnosis of pregnancy or perinatal condition.
    - A 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. For example, coronary artery bypass, drainage of the upper extremity and fusion of the lumbosacral joint without a principal acute diagnosis.

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 the Index Discharge Date).

NUMERATOR: Count of acute readmissions that occur within 30 days of an acute inpatient discharge.

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

DATA SOURCE: Claims.

CALCULATION FORMULA: # Readmissions/Index Discharge Date.

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

PROVIDER PORTAL: The Provider Portal **Linked Member List - Linked Member Inpatient Admissions** report provides a real-time report of 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 provide a roster of compliant and non-compliant members, trending graphs, and a 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Plan All-Cause Readmission Tipsheet

Measure derived from NCQA HEDIS Plan All-Cause Readmission.

CODE SET:
Plan All-Cause Readmissions Exclusion Codes.

PREVENTABLE EMERGENCY VISITS

Research has found that a substantial proportion of visits to the emergency department (ED) could be avoided through timely primary care. Health centers play a vital role in reducing preventable ED 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 visits.

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

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

MEMBER REQUIREMENT: The PCP must have an average of 100 members who meet the eligible population criteria during the measurement period ***or*** a minimum of 100 members who 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 Mariposa, Merced, Monterey, San Benito and Santa Cruz counties, excluding dual coverage members.

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

Continuous Enrollment: Member must be continuously enrolled for any four months during the CBI measurement period; no gap allowance.

Eligible Member Event/Diagnosis: None.

Exclusions:

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

DENOMINATOR: All emergency visits for eligible members with a date of service within the measurement period.

NUMERATOR: ED 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/Total member months) x 12,000.

Note: Urgent visits count as one-half of a visit.

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

PROVIDER PORTAL: The Provider Portal **Linked Member List - Linked Member ED Visits** provides a real-time report of linked members recently seen at the emergency department at regional hospitals using eCensus data. Under the same **Linked Member List** is a **Linked Members High ED Utilizers** report that lists members who received services in the ED three or more times in a 90-day period.

Note: Not all hospitals participate in eCensus.

The Provider Portal quarterly CBI reports provide a roster of compliant and non-compliant members, trending graphs, and a 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Preventable Emergency Visit Diagnoses.
- Preventable Emergency Visits Tip Sheet.
- 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. It can occur at any age, but the risk of getting it increases with age.[2] Early breast cancer is typically without symptoms and survival rates are highest when breast cancer is found early.

MEASURE DESCRIPTION: The percentage of members 50-74 years of age who had a mammogram to screen for breast cancer on or between October 1 two years prior to the measurement period and the end of the measurement period.

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

ELIGIBLE POPULATION:

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

Age: Fifty-two to 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 the end of the measurement period.
- Dual coverage members.
- Members in hospice, receiving hospice services or palliative care, or who died during the measurement year.
- Members who had a bilateral mastectomy or both left and right unilateral mastectomies at any time through the end of the measurement year.
- Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria any time through the end of the measurement period.

[2] Division of Cancer Prevention and Control, Centers for Disease Control and Prevention. Breast Cancer Statistics. September 16, 2024.

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

Note: Laboratory claims with POS 81 are not included to identify eligible members with diagnostic codes for frailty or advanced illness, or encounters for palliative care.

***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.

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

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, Data Submission Tool, DHCS Fee-For-Service encounter claims.

CALCULATION FORMULA: Number of 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 four.

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 screening and their screening date.

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

Providers can submit breast cancer screening and bilateral mastectomy data from the Electronic Health Record (EHR) system or paper records via the Data Submission Tool. Log in 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Breast Cancer Screening Tip Sheet.

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.

CERVICAL CANCER SCREENING

Every year in the United States, about 11,500 new cases of cervical cancer are diagnosed, and 4,000 women die of this cancer.[3] In 2021, this accounted for about seven new cervical cancer cases reported in 100,000 women.[4] Cervical cancer can be detected in its early stages by regular screening with a cytology (Pap smear) test. The American College of Obstetricians and Gynecologists and the American Medical Association recommend a Pap smear test every three years for all members over 21 with a cervix. For members 30-65 years of age with a cervix, screening with a combination of a cytology and human papillomavirus (HPV) test or cervical high-risk human papillomavirus (hrHPV) test is recommended every five years.

The CBI program helps PCPs monitor cervical cancer screening and establish routine preventive care to decrease morbidity and mortality from cervical cancer, with reduced proximal healthcare expenditures.

MEASURE DESCRIPTION:
The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members 21-64 years of age who had cervical cytology performed within the last three years.
- Members 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing within the last five years.
- Members 30–64 years of age who had cervical cytology/hrHPV cotesting within the last five years.

Note: When testing for hrHPV or cotesting for cervical cancer, members must be 30-64 years of age or older on the date of the test.

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

ELIGIBLE POPULATION:

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

Ages: Members 24-64 as of the last day of the measurement period.

Continuous Enrollment: The measurement year and 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.

[3] Centers for Disease Control and Prevention. Cervical Cancer Statistics. Retrieved December 12, 2024.
[4] Centers for Disease Control and Prevention. United States Cancer Statistics: Data Visualizations. Cancer Statistics At a Glance. Retrieved December 12, 2024.

Members recommended for routine cervical cancer screening: Members recommended for routine cervical cancer screening with the following criteria:

- Administrative Gender of Female any time in the member's history captured on the member's Medi-Cal enrollment file.

Exclusions:

- Administrative members at the end of the measurement period.
- Dual coverage members.
- Members in hospice, receiving hospice services or palliative care, had an encounter for palliative care, or 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 members who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members 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.
- Members 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year ***and*** who were 30 years of age 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 remains in the denominator for the compliant lab screening.

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

- A note that indicates the date of the cervical cytology or hrHPV test and the result or finding. "Unknown" is not considered a result/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 Fee-For-Service encounter claims.

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

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

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 screening and their screening date.

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

PCPs can submit cervical cancer screening and hysterectomy data from their Electronic Health Record (EHR) system or paper records via the Data Submission Tool. Log in 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Cervical Cancer Screening Tip Sheet.

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 (THREE TO 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 three to 21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.

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

ELIGIBLE POPULATION:

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

Age: Three to 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 at the end of the measurement period.
- Dual coverage members.
- Members in hospice, receiving hospice services or palliative care, who had an encounter for palliative care or who died during the measurement year.

DENOMINATOR: Eligible population three to 21 years of age as defined above.

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

Note: ICD-10 Z codes that indicate well-visits do not count if they are on a claim with a lab place of service code 81 for CBI 2025.

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 Fee-For-Service encounter claims.

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

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

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 provide a roster of compliant and non-compliant members, trending graphs, and a comparison to benchmark performance.

PCPs can submit well-child visit data from their Electronic Health Record (EHR) system or paper records via the Data Submission Tool. Log in 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

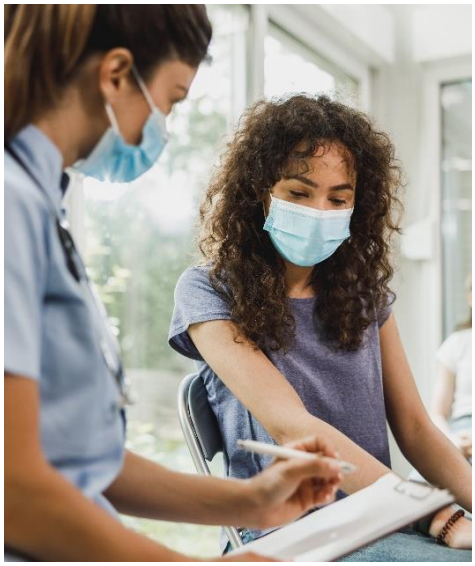
RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Child and Adolescent Well-Care Visits Tip Sheet.

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

CHLAMYDIA SCREENING IN WOMEN

Chlamydia is one of the most frequently reported bacterial infectious diseases in the United States, and asymptomatic infection is common among both men and women.[5] The United States Preventive Services Task Force (USPSTF) recommends screening for chlamydia and gonorrhea in sexually active women ages 24 years of age and younger and in older women who are at an increased risk for infection. The USPSTF also 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 adults who are at an increased risk for STIs. These recommendations are available on the USPSTF web site.



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

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

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

ELIGIBLE POPULATION:

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

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

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

Note: Laboratory claims with POS 81 are not included to identify eligible members through claims with a sexual activity diagnosis.

[5] Centers for Disease Control and Prevention. Sexually Transmitted Infections Treatment Guidelines, 2021. Chlamydial Infections. Retrieved December 12, 2024.

Exclusions:

- Administrative members at the end of the measurement period.
- Dual coverage members.
- Members in hospice, receiving hospice services, or who died during the measurement year.
- Members identified as eligible for the measure based on a pregnancy test alone are removed from the measure for any of the following:
    - A pregnancy test during the measurement year and an X-ray on the date of the pregnancy test or six days after the pregnancy test.
    - A pregnancy test during the measurement year and a prescription for isotretinoin (retinoid) on the date of the pregnancy test or six days after the pregnancy test.

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 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: Annually, following the end of quarter four.

PROVIDER PORTAL: The Provider Portal **Quality Report - Chlamydia and Gonorrhea Screenings** provides a list of 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 provide a roster of compliant and non-compliant members, trending graphs, and a comparison to benchmark performance.

PCPs can submit chlamydia screening data from their Electronic Health Record (EHR) system or paper records via the Data Submission Tool. Log in 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Chlamydia Screening in Women Tip Sheet.

CODE SETS:

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

COLORECTAL CANCER SCREENING

Colorectal cancer is the fourth most common cancer in men and women, outside of some kinds of skin cancer.[6] Of cancers that affect both men and women, in 2023, an estimated 106,970 cases of colon cancer and 46,050 cases of rectal cancer were diagnosed in the US. A total of 52,550 people will die from those cancers.[7] 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 of age, use any of the following criteria:

- Fecal occult blood test within the last year.
- Flexible sigmoidoscopy within the last five years.
- Colonoscopy within the last ten years.
- CT colonography within the last five years.
- Stool DNA (sDNA) with FIT test within the last three years.

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

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Mariposa, Merced, Monterey, San Benito and Santa Cruz 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.

Exclusions:

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

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

[6] Centers for Disease Control and Prevention. Colorectal Cancer Statistics. Retrieved December 13, 2024.
[7] American Cancer Society. 2023. Cancer Facts & Figures 2023. Retrieved 12/13/2024.

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: Annually, following the end of quarter four.

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

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

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form on the Provider Portal. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Colorectal Cancer Screening Tip Sheet.

CODE SETS:
Colorectal Screening Inclusion Codes.
Colorectal Screening Exclusion Codes.
Colorectal Screening Medication.

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%.[8] Fifteen to 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.[9] 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: The primary care provider (PCP) must have 30 members who meet the eligible population criteria.

ELIGIBLE POPULATION:

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

Ages: Members 12 years of age 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.

Exclusions:

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

DENOMINATOR: The initial population.

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.

[8] NCQA. Depression Screening and Follow-Up for Adolescents and Adults (DSF). Retrieved 12/09/21.
[9] Postpartum Support International. 2015. Perinatal Mood and Anxiety Disorders FACT SHEET. Retrieved December 16, 2024.

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

Documented follow up can include any of the following:

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

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

INSTRUMENTS FOR ADOLESCENTS (≤17 years of age)	RESULTS CONSIDERED AS POSITIVE FINDING
Patient Health Questionnaire (PHQ-9)	Total Score ≥ 10
Patient Health Questionnaire Modified for Teens (PHQ-9M)	Total Score ≥10
Patient Health Questionnaire-2 PHQ2	Total Score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)	Total Score ≥ 8
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥ 17
Edinburgh Postnatal Depression Scale (EPDS)	Total Score › 10
PROMIS Depression	Total Score (T Score) ≥ 60

INSTRUMENTS FOR ADULTS (18+ years of age)	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 FORMULA: Number of 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/initial population.

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

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

PCPs can submit depression screenings from their electronic health records (EHR) system and paper records via the Data Submission Tool. Log in to your Provider Portal account and click 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

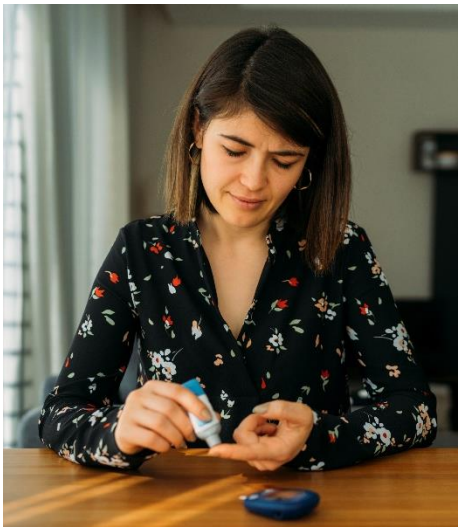
RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Depression Screening for Adolescents and Adults Tip Sheet.

CODE SETS:
Screening for Depression Inclusion Codes.
Screening for Depression Exclusion Codes.

DIABETIC POOR CONTROL >9%

Diabetes is one of the costliest chronic conditions in the United States, with one in three Americans estimated to develop diabetes sometime in their lifetime.[10] 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.[11]



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

The measure goal is for members to be non-compliant by having an HbA1C or GMI of less than 9% and being in good control. A lower rate indicates better performance.

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

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

ELIGIBLE POPULATION:

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

Age: Eighteen to 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: Members with diabetes are identified by either claim/encounter data or by pharmacy data.

- **Claim/encounter data:** Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims.
- **Pharmacy data**: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior.

[10] National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Health and Economic Benefits of Diabetes Interventions. 2024. Retrieved December 16, 2024.
[11] National Committee for Quality Assurance. Comprehensive Diabetes Care. Retrieved December 16, 2024.

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

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

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

NUMERATOR: The member is numerator compliant if the most recent glycemic status assessment (HbA1c or GMI) has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is ≤9.0%.

Note: This measure will not include CPT II codes with a modifier.

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

DATA SOURCE: Claims, laboratory data, Data Submission Tool, DHCS Fee-For-Service encounter claims.

CALCULATION FORMULA: Number of members with the most recent glycemic status assessment (GMI or HbA1c) in poor control/total linked diabetic members. Member is considered to be in poor control if no GMI or HbA1c test was completed during the measurement period, a test was performed with no value, or if the GMI or HbA1c value was >9%.

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

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 an HbA1c screening or a diabetic retinal eye exam in the past year, or a negative diabetic retinopathy screening in the year prior.

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

PCPs can submit GMI or HbA1c data from their Electronic Health Records (EHR) system and paper records via the Data Submission Tool. Log in to your Provider Portal account - Data Submissions - Data Submission Tool Guide to assist you through 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Diabetic 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.

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 vaccinations , and every visit can be used as an opportunity to update and complete necessary immunizations. The HPV vaccine is 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 dose of tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

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

ELIGIBLE POPULATION:

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

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

Continuous Enrollment: Three hundred sixty-five days 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, receiving hospice services, or who died during the measurement year.

DENOMINATOR: The eligible population as defined above.

NUMERATOR: Members who received one dose of meningococcal vaccine, 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 on or before the member's 13th birthday.
- **Tdap**: At least one 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 on or before the member's 13th birthday.
- **HPV**: Any of the following meet criteria
    - At least two HPV vaccines 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.

DOCUMENTATION REQUIREMENTS:
Providers must document each member's need for Advisory Committee on Immunization Practices (ACIP) recommended immunizations as part of all regular health visits, including, but not limited to the following types of encounters:

- Illness, care management, or follow-up appointments
- Initial Health Appointments (IHAs)
- Pre-travel visits
- Sports and school physicals
- Visits to local health departments
- Well patient checkups

All California healthcare providers who administer vaccines must also enter immunization information for each patient into the local immunization registry within 14 calendar days, in accordance with state and federal laws.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP at the date when the member turns 13 years old. The linked PCP does not have to be the provider who administered the vaccinations.

DATA SOURCE: Claims, immunization registries (CAIR & RIDE), Data Submission Tool, DHCS Fee-For-Service encounter claims.

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'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 four.

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 provide a roster of compliant and non-compliant members, trending graphs, and a comparison to benchmark performance.

PCPs can submit immunization data from their Electronic Health Records (EHR) system and paper records via the Data Submission Tool. Log in 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Immunization: Adolescents Tip Sheet.

CODE SETS:

Immunizations - Adolescents 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 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 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 received ***all*** the following vaccines (Combo 10) by their second birthday:

- **4 diphtheria, tetanus, and acellular pertussis (DTaP)** (first dose 42 days or more 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 42 days or more after birth).
- **1 measles, mumps and rubella (MMR)** (on or between child's first and second birthday), history of measles, mumps and rubella illness, or anaphylaxis due to the MMR vaccine.
- **3 haemophilus influenzae type b (Hib)** (first dose 42 days or more after birth) or anaphylaxis due to the Hib vaccine.
- **3 hepatitis B (HepB)** (first dose zero to four weeks of age), history of hepatitis B vaccine, or anaphylaxis due to the hepatitis B vaccine.
- **1 varicella (VZV)** (on or between child's first and second birthday), history of varicella zoster (chicken pox) illness, or anaphylaxis due to the VZV vaccine.
- **4 pneumococcal conjugate vaccine (PCV)** (first dose 42 days or more after birth) or anaphylaxis due to the pneumococcal conjugate vaccine.
- **2 or 3 rotavirus (RV)*** (first dose 42 days or more after birth) or anaphylaxis due to the rotavirus vaccine.
- **1 hepatitis A (HepA)** (on or between child's first and second birthday), history of hepatitis A illness, or anaphylaxis due to the hepatitis A vaccine.
- **2 influenza (Flu)**** (vaccines given 180 days or more after birth up to or on the child's second 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 first dose of either vaccine should be given before a child is 15 weeks of age. Children should receive all doses of rotavirus vaccine before they turn eight months old.

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

Note: These vaccines are the minimum recommended CDC vaccines for children under two years of age. Please follow the ACIP/CDC Recommended Child and Adolescent Immunization Schedule for ages 18 or younger for minimum ages and dosage spacing. Laboratory claims will not be included.

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

ELIGIBLE POPULATION:

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

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

Continuous Enrollment: Three hundred sixty-five days 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 date of child's second birthday.
- Dual coverage members.
- Members in hospice, receiving hospice services, or who died during the measurement year.
- Members who had a contraindication to a childhood vaccine on or before their second birthday. Examples include severe combined immunodeficiency, immunodeficiency, HIV, multiple myeloma, leukemia, or intussusception.

Note: Laboratory claims with POS 81 are not included to identify eligible members with contraindications to childhood vaccines.

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

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

Note: All codes indicating anaphylaxis or encephalitis from vaccines are SNOMED codes that cannot be sent through a claim and must be received electronically. Claims with POS 81 are not used in capture history of illness for hepatitis B, varicella zoster (chicken pox), hepatitis A, measles, mumps, or rubella.

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

DOCUMENTATION REQUIREMENTS:
Providers must document each member's need for Advisory Committee on Immunization Practices (ACIP) recommended immunizations as part of all regular health visits, including, but not limited to, the following types of encounters:

- Illness, care management, or follow-up appointments
- Initial Health Appointments (IHAs)
- Pre-travel visits
- Sports and school physicals
- Visits to local health departments
- Well-patient checkups

All California healthcare providers who administer vaccines must also enter immunization information for each patient into the local immunization registry within 14 calendar days, in accordance with state and federal laws.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP site on the day the member turns two years old. The linked PCP site does not have to be the provider site that provided the vaccinations.

DATA SOURCE: Claims, immunization registries (CAIR or RIDE), Data Submission Tool, DHCS Fee-For-Service encounter claims.

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'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 second birthday/total number of members who turned two during the measurement period.

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

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 provide a roster of compliant and non-compliant members, trending graphs, and a comparison to benchmark performance.

PCPs can submit immunization data from their Electronic Health Record (EHR) system and paper records via the Data Submission Tool. Log in to your Provider Portal account - Data Submissions - Data Submission Tool Guide to assist you through 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Immunizations: Children (Combo 10) Tip Sheet.

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 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 and lead poisoning may go unrecognized.[12]

MEASURE DESCRIPTION: The percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

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

ELIGIBLE POPULATION:

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

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

Continuous Enrollment: Twelve 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 on date of child's second birthday.
- Dual coverage members.
- Members in hospice, receiving hospice services, or who died anytime 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.

[12] National Center for Quality Assurance. Lead Screening in Children (LSC). Retrieved December 30, 2024.

DOCUMENTATION REQUIREMENTS:
Document the date the test was performed and the 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 who perform 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 six years of age who were not tested at 12 and 24 months.

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

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

- 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 the reason for not obtaining a signed statement in the child's medical record. For example, when services are provided via telehealth or the party declines to sign.

For more information, reference the California Dept. of Public Health 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 two years old.

DATA SOURCE: Claims, laboratory data, DHCS Fee-For-Service encounter claims.

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

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

PROVIDER PORTAL: The Provider Portal monthly **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 in 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 provide a roster of compliant and non-compliant members, trending graphs, and a 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Lead Screening in Children Tip Sheet.

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.[13] Behaviors established during early childhood, such as eating habits and physical activity, often extend into adulthood.[14] 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 15 months of age who had six or more well-child visits with a PCP during the first 15 months of life.

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

ELIGIBLE POPULATION:

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

Ages: Children who turn 15 months of age 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 on date of 15-month birthday.
- Dual coverage members.
- Members in hospice, receiving hospice services, or who died during the measurement year.

DENOMINATOR: Eligible population 15 months of age as defined above.

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

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

[13] Bright Futures. 2021.

[14] 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.

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

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

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

DATA SOURCE: Claims, DHCS Fee-For-Service encounter claims, Data Submission Tool..

Note: Laboratory claims with POS 81 are not included to identify well-child visits.

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

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

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 six well-child visits in the last 15 months. This report looks prospectively before the child turns 15 months.

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

PCPs can submit well-child visit data from their Electronic Health Records (EHR) system and paper records via the Data Submission Tool. Log in to your Provider Portal account - Data Submissions - Data Submission Tool Guide to assist you through 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Well-Child Visits in the First 15 Months Tip Sheet.

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

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

Well-child visits provide an opportunity for PCPs to check if the child is meeting milestones and to 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 30 months of age who had two 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: The PCP must have 30 members who meet the eligible population criteria as defined below.

ELIGIBLE POPULATION:

Membership: Linked members enrolled in the Medi-Cal program in Mariposa, Merced, Monterey, San Benito and Santa Cruz 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: Fifteen months plus one day to 30 months of age. Calculate the 15-month birthday plus one 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 on date of 30-month birthday.
- Dual coverage members.
- Members in hospice, receiving hospice services, or who died during the measurement year.

DENOMINATOR: Eligible population 30 months of age as defined above.

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

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

Note: Laboratory claims with POS 81 are not included in identifying well-child visits.

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

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

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP on the day when the member turns 30 months old. The linked PCP does not have to be the provider that performed the service.

DATA SOURCE: Claims, DHCS Fee-For-Service 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 four.

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 two 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 provide a roster of compliant and non-compliant members, trending graphs, and a comparison to benchmark performance.

PCPs can submit well-child visit data from their Electronic Health Record (EHR) system and paper records 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- Well-Child Visits for Age 15 Months-30 Months of Life Tip Sheet.

CODE SETS:
Well-Child 15-30 Month Visit Codes.
Well-Child 15-30 Months Exclusion Codes.
Hospice Exclusion Codes.

MEMBER REASSIGNMENT

MEMBER REASSIGNMENT THRESHOLD

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

MEASURE DESCRIPTION: The number of linked members a PCP reassigns from their practice during a calendar year. The member reassignment threshold is a maximum of one reassignment per 150 linked members. PCPs who exceed one reassignment per year per average 150 linked members are at risk of losing half of their CBI programmatic payments.

MEMBER REQUIREMENT: The 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:

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

- 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 the provider at the time of reassignment are counted toward the reassignment threshold.

RESOURCES:

Request for Member Reassignment Form.

EXPLORATORY MEASURES

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.[15] 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) during the measurement year.
BP reading must occur on or after the date of the second HTN diagnosis.

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

ELIGIBLE POPULATION:

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

Age: Eighteen to 85 years of age 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 two outpatient visits, telephone visits, e-visits or virtual check-ins 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. This includes outpatient visits (outpatient without UBREV codes) and telehealth visits (telephone, online assessments).

[15] Centers for Disease Control and Prevention (CDC). 2012. "About High Blood Pressure."
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.

Exclusions:

- Administrative members at the end of the measurement period.
- Dual coverage members.
- Members in hospice, receiving hospice services or palliative care, or who died during the measurement year.
- Members with a procedure or diagnosis that indicates evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant on or prior to December 31 of the measurement year.
- Members with a diagnosis of pregnancy during the measurement year.
- Members 66-80 years of age and older as of December 31 of the measurement year with frailty ***and*** advanced illness:
    - Frailty: At least two indications of frailty with different dates of service during the measurement year.
    - Advanced Illness: Any of the following during the measurement year or year prior to the measurement period (count services that occur over both years):
        - Advanced illness on at least two different dates of service.
        - A dispensed dementia medication.
- 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 during the measurement year.

Note: Laboratory claims with POS 81 are not included to identify members with frailty or advanced illness diagnosis.

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 the 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.** Category II codes with modifiers are not included.

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

DATA SOURCE: Claims, Data Submission Tool, DHCS Fee-For-Service encounter claims.

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 2025.

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

PCPs can submit blood pressure values from their Electronic Health Records (EHR) system and paper records via the Data Submission Tool. Log in to your Provider Portal account - Data Submissions - Data Submission Tool Guide to assist you through 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. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Representative at 831-430-5518 or email portalhelp@thealliance.health.

RESOURCES:

- 2025 CBI Programmatic Measure Benchmarks.
- 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.

FEE-FOR-SERVICE MEASURES

Fee-for-Service (FFS) measures provide a single payment incentive to PCP sites. FFS incentives are paid on a quarterly basis, at the end of the quarter in which the attestation form is received, if the date of service is 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 sites 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 an increased risk of a wide range of health conditions in both pediatric and adult populations, known as ACE-Associated Health Conditions.

The Becoming ACEs Aware in California Core Training is required to receive Medi-Cal payment for ACE screenings. Physicians and clinical team members 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 compensate for the time spent to complete the Becoming ACEs Aware in California training and attestation with the goal to expand ACEs 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 Becoming ACEs Aware in California training and attestation on the ACEs Aware Learning Center. The plan shall pay for each CBI group that the clinician practices under. Mid-level providers and qualifying residents must practice under a supervising PCP physician with an ACEs Provider Training Attestation to be eligible for incentive payment.

Licensed second- or third-year residents are eligible to qualify for this FFS 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 their 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: 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 ACEs screenings the month after they complete 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
- Becoming ACEs Aware in California Training - Provider training (PCPs, physician assistants, nurse practitioner)**.**
- 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 cost 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 achieved the NCQA Distinction in Behavioral Health Integration after completing the NCQA Patient-Centered Medical Home (PCMH) Recognition program.

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: 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 to submit 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 trouble multitasking, but dementia and Alzheimer's disease are not a normal part of aging. Symptoms of cognitive decline interfere with a member's daily life, such as their memory, thinking and reasoning. Finding early signs of dementia is important and allows members the chance to access treatments and support services and enroll in clinical trials.[16]

The Cognitive Health Assessment: The Basics training is required to receive Medi-Cal payment for cognitive health screenings. Physicians and clinical team members receive 1.5 Continuing Medical Education (CME) credits.

MEASURE DESCRIPTION: This measure is intended to provide compensation for the time spent to complete the Cognitive Health Assessment training with the goal to expand cognitive health 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 Dementia Care Aware. The plan shall pay for each CBI group that the clinician practices under. Mid-level providers and qualifying residents must practice under a supervising PCP with Cognitive Health Assessment training to be eligible for incentive payment.

Licensed second- or third-year residents 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 their Provider Relations Representative with the following information:

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

[16] Signs and Symptoms of Dementia – CDC.

PAYMENT FREQUENCY: 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 screenings the month after they complete their training.

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

RESOURCES:

- Dementia Care Aware.
- Dementia Care Aware Online Course Catalog.
- Dementia Care Aware Webinars.
- Dementia Care Aware Program Offerings.
- Dementia Care Aware Warmline: A Primary Care Team Support and Consultation Service.
- Practice Support Consultation.

CODE SET: N/A.

DIAGNOSTIC ACCURACY AND COMPLETENESS TRAINING

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

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

MEASURE DESCRIPTION: This measure aims to help providers improve diagnostic coding accuracy in preparation for future rate adjustments. Providers who complete the CMS Medicare Learning Network (MLN) Diagnosis Coding training with a score of 70% or higher receive a single payment of $200. Providers must submit the certificate of completion 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 MLN Diagnosis Coding training with a score of 70% or higher.

Licensed second- or third-year residents are eligible to qualify for this FFS 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 their 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 Coding training certificate.

PAYMENT FREQUENCY: 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 Diagnosis Coding training to the Provider Relations Representative.

RESOURCES:

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

CODE SET: N/A.

PATIENT-CENTERED MEDICAL HOME (PCMH) RECOGNITION

This measure encourages PCPs 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: PCPs who receive NCQA or The Joint Commission (TJC) documentation validating achievement of the Patient-Centered Medical Home (PCMH) recognition or certificate 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 – TJC PCMH certification.

PAYMENT FREQUENCY: 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 the PCMH Recognition program through NCQA, use the Alliance discount code **CCAAHA** to save 20% on your initial application fee.
    - Annual Reporting for PCMH Recognition Q&A.
    - Renewing PCMH Recognition.
    - Getting Started Toolkit: Get Started with NCQA PCMH Recognition.
    - The Joint Commission PCMH Resources.
    - AAP National Resource Center Pediatric Medical Home Resources.
    - National Resource Center for Patient/Family-Centered Medical Home.

Contact your Provider Relations Representative if you have additional questions.

CODE SET: N/A.

QUALITY PERFORMANCE IMPROVEMENT PROJECTS

MEASURE DESCRIPTION: PCPs are awarded $1,000 for each office that completes an Alliance-offered quality performance improvement project. Only offices with metrics below the minimum performance level, measured at the 50th percentile for the CBI 2024-year programmatic payment, are eligible for payment for completion of quality performance improvement projects.

The Alliance notifies offices of their eligibility to participate in this FFS measure no sooner than April 1, 2025. At that time, eligible offices are directed to a list of offered quality performance improvement projects on the Alliance website where they can find 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 period.

FEE-FOR-SERVICE AMOUNT: $1,000 for each office that completes an Alliance-offered quality performance improvement project.

PAYMENT FREQUENCY: Payments are made a single time after 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 PCPs and their patients. PLAD aims to improve the quality of care provided to patients with diabetes by collaborating with clinicians to implement evidence-based pharmacologic clinical guidelines in diabetes care management. The interactive sessions with clinicians are tailored to their specific needs and interests, making it a personalized and effective approach. Sessions involve interactive discussions, case studies, and useful tools to implement best practices in the clinical setting. For more information, please email pharmacy@thealliance.health 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 Determinants of Health (SDOH) are environmental factors that can influence health outcomes. SDOH are conditions where people are born, live and work, and these factors can include housing, transportation, discrimination, education, literacy and access to food.

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

MEASURE DESCRIPTION: The addition of SDOH Z-codes supports the development of Alliance health equity and population health programs. The SDOH codes 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 Determinants of Health, Diagnosis Accuracy, and CPT II Coding Tip Sheet
- APL 21-009: Collecting Social Determinants of Health Data.

CODE SET:
Social Determinants 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 service area.

CALIFORNIA CHIDREN'S SERVICES (CCS): Plan 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 Record (EHR) system and paper records using the Data Submission Tool on the Provider Portal. Step-by-step instructions are available in the Data Submission Tool Guide on the Provider Portal.

DENOMINATOR: The count of all members eligible for the measure as defined by the measure specification (e.g., 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, servicing PCP requirements, and medical event or diagnosis requirements.

- Eligible population criteria for Care Coordination measures are Alliance-defined and based on the CMS Core Measure Set.
- Eligible population criteria for Quality of Care measures are based on the HEDIS Technical Specifications.

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, are not 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.

EXPLORATORY MEASURES: Exploratory 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.

FEE-FOR-SERVICE (FFS) MEASURES: FFS measures provide a single payment to PCPs. To receive payment, all 2025 measures require providers to submit an attestation form to the Alliance confirming completion of the recognition or certification. FFS incentives are paid at the end of the quarter in which the attestation form is received, if the date of service is within the calendar year.

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, therefore, CBI performance can impact a 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 the measurement year, as identified in the denominator.

INDEX ADMISSION DATE: 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 linked member of the Alliance is an individual who has selected or been assigned to a PCP.

MEASUREMENT PERIOD: The period in which the Alliance measures data to calculate the applicable CBI rates. For some measures this may include a look-back period which is a defined timeframe 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 Appointment.
- Post-Discharge Care.

MEASUREMENT YEAR: The rolling 12-month timeframe back from the current quarterly run.

MINIMUM MEMBER REQUIREMENT: The minimum number of qualifying members (defined as eligible population) per measure required for the provider to be eligible for programmatic measures. FFS measures have no minimum member requirement.

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

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