QUALITY OF CARE MEASURES

ASTHMA MEDICATION RATIO (AMR)

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

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

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

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

DEFINITIONS:

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

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

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

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

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.
Use the Drug ID field in the National Drug Code (NDC) list to determine if the medications are the same or different.

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

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

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

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

**ELIGIBLE POPULATION:**

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

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

**Continuous Enrollment:** Rolling 24 months with a 45 day allowable gap during each year of continuous enrollement

**Exclusions:**

- Members who had a diagnosis of any of the following any time during the member’s history through December 31 of the measurement year:
  - Emphysema
  - COPD
  - Obstructive Chronic Bronchitis
  - Chronic Respiratory Conditions Due to Fumes/Vapors
  - Cystic Fibrosis
  - Acute Respiratory Failure

- Asthma members who had no asthma medications (controller or reliever) dispensed (Asthma Controller and Reliever Medications List) during the measurement year
• Members enrolled in Hospice services during the rolling 12 month measurement period
• Administrative Members at the end of the CBI measurement period
• Dual Coverage Members

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

**Step 1** - Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one ED visit with a principal diagnosis of asthma.
  - At least one acute inpatient encounter with a principal diagnosis of asthma without telehealth.
  - At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events. Visit type need not be the same for the four visits.
  - At least four asthma medication dispensing events for any controller medication or reliever medication.

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

**DENOMINATOR:** Eligible population (as defined above).

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

Follow the steps below to calculate the ratio.

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

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

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

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

\[
\text{Units of Controller Medications (step 1)} \div \text{Units of Total Asthma Medications (step 3)}
\]
Step 5 – Sum the total number of members who have a ratio of 0.50 or greater in step 4.

### ASTHMA CONTROLLER AND RELIEVER MEDICATIONS

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASTHMA CONTROLLER MEDICATIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Antiasthmatic combinations</td>
<td>• Dyphylline-guaifenesin</td>
</tr>
<tr>
<td>Antibody inhibitors</td>
<td>• Omalizum</td>
</tr>
<tr>
<td>Anti-interleukin-5</td>
<td>• Mepolizum • Reslizum</td>
</tr>
<tr>
<td>Inhaled steroid combinations</td>
<td>• Budesonide-formoterol • Fluticasone-salmeterol • Fluticasone-vilanterol • Mometasone-formoterol</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>• Beclomethasone • Flunisolide • Fluticasone CFC free • Mometasone</td>
</tr>
<tr>
<td>Leukotriene modifiers</td>
<td>• Montelukast • Zafirlukast • Zileuton</td>
</tr>
<tr>
<td>Methylxanthines</td>
<td>• Theophylline</td>
</tr>
<tr>
<td><strong>ASTHMA RELIEVER MEDICATIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Short-acting, inhaled beta-2 agonists</td>
<td>• Albuterol • Levalbuterol</td>
</tr>
</tbody>
</table>

Note: Please consult the Complete Formulary Guide and Epocrates for up to date Alliance information.

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

**DATA SOURCE**: Claims and Pharmacy

**CALCULATION FORMULA**: Number of members with a controller medication ratio of 0.50 or greater/total eligible population

**PROVIDER PORTAL**: The portal provides a list of members and their asthma care, including counts of controller and reliever medications, and the current asthma medication ratio.

Note: This list is subject to claims lag, and members on this list may include members that have not yet been seen at your office, but who are linked to your practice. We recommend cross referencing this list with your EHR.

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

**RESOURCES**:  
[2019 Programmatic Measure Benchmarks](#)  
[Asthma Medication Ratio Tip Sheet](#)
CODE SET LINKS:

AMR: Asthma Inclusion Codes
AMR: Asthma Exclusions Codes
AMR: Asthma Controller and Reliever Medication NDC Codes
CERVICAL CANCER SCREENING (CCS)

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

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

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

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology and human papillomavirus (HPV) co-testing performed every 5 years.

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

ELIGIBLE POPULATION:

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

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

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

Allowable gap: No more than one gap in enrollment of up to 45 days during each 12 months of continuous enrollment.

Eligible Member Event/Diagnosis: None

Exclusions:

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member’s history through the end of the measurement period.
- Members enrolled in Hospice services during the rolling 12 month measurement period
- Administrative Members at the end of the CBI measurement period
- Dual Coverage Members
Note: As a reminder, please document the following in the medical records:

- Documentation of “complete,” “total” or “radical” abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria:
  - Documentation of a “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.

**DENOMINATOR:** Eligible population, as defined above.

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

**Step 1** – Identify women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year.

**Step 2** – From the women who did not meet step 1 criteria, identify women 30–64 years of age as of December 31 of the measurement year who had cervical cytology and a human papillomavirus (HPV) test with service dates four or less days apart during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of both tests.

**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

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

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

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

If you do not have a Provider Portal account, go to [https://www.ccah-alliance.org/PortalRequestForm.html](https://www.ccah-alliance.org/PortalRequestForm.html) and complete the Provider Portal Request form. For questions regarding access to the Provider Portal email PortalRegister@ccah-alliance.org.
RESOURCES:
2019 Programmatic Measure Benchmarks
Cervical Cancer Screening Tip Sheet

CODE SET LINKS:
CCS: Cervical Cytology & HPV Test Codes
CCS: Cervical Cancer Screening Exclusion Codes
DEPRESSION SCREENING AND FOLLOW-UP CARE

Adequate follow up care is essential in caring for patients identified as experiencing depression. The CBI Program encourages PCPs to monitor patients with depression and establish routine follow-up care to reduce adverse occurrences and preventable healthcare expenditures.

MEASURE DESCRIPTION:
Members ages 12 years and older who screened positive for depression using an age appropriate standardized depression screening tool, who also received follow-up care within 30 days. Payment will be awarded only if follow-up care occurred within 30 days.

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

ELIGIBLE POPULATION:

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

Ages: All patients 12 years and older

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

Eligible Member Event/Diagnosis: N/A

Exclusions:
- Members with a diagnosis of Bipolar Disorder during the past 24 months
- Members diagnosed with Depression during the year prior to the rolling 12 month measurement period.
- Members enrolled in Hospice services during the rolling 12 month measurement period
- Dual Coverage Members

DENOMINATOR: Members in the Eligible Population who were screened positive for depression (indicated by LOINC and SNOMED codes)

NUMERATOR: Members who receive appropriate follow up care. Follow-up plan MUST include one or more of the following within 30 days. See below for list of qualifying care.
- A behavioral health encounter, including assessment, therapy, collaborative care, or medication management.
- An outpatient follow-up visit, with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter, with documented assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
- Receipt of an assessment on the same day and subsequent to the positive screen.
Documentary of additional depression screening indicating either no depression or no symptoms that require follow-up.

- For example, if the initial positive screen resulted from a PHQ-2 score, documentation of a negative finding from a subsequent PHQ-9 qualifies as evidence of follow-up.
- A dispensed an antidepressant medication. See medication list below.

### ANTIDEPRESSANT MEDICATIONS

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous antidepressants</td>
<td>• Bupropion&lt;br&gt;• Vilazodone&lt;br&gt;• Vortioxetine</td>
</tr>
<tr>
<td>Monoamine oxidase inhibitors</td>
<td>• Isocarboxazid&lt;br&gt;• Phenelzine&lt;br&gt;• Selegiline&lt;br&gt;• Tranylcypromine</td>
</tr>
<tr>
<td>Phenylpiperazine antidepressants</td>
<td>• Nefazodone&lt;br&gt;• Trazodone</td>
</tr>
<tr>
<td>Psychotherapeutic combinations</td>
<td>• Amitriptyline-chlordiazepoxide&lt;br&gt;• Amitriptyline-perphenazine&lt;br&gt;• Fluoxetine-olanzapine</td>
</tr>
<tr>
<td>SNRI antidepressants</td>
<td>• Desvenlafaxine&lt;br&gt;• Duloxetine&lt;br&gt;• Levomilnacipran&lt;br&gt;• Venlafaxine</td>
</tr>
<tr>
<td>SSRI antidepressants</td>
<td>• Citalopram&lt;br&gt;• Escitalopram&lt;br&gt;• Fluoxetine&lt;br&gt;• Fluvoxamine&lt;br&gt;• Paroxetine</td>
</tr>
<tr>
<td>Tetracyclic antidepressants</td>
<td>• Maprotiline&lt;br&gt;• Mirtazapine</td>
</tr>
<tr>
<td>Tricyclic antidepressants</td>
<td>• Amitriptyline&lt;br&gt;• Amoxapine&lt;br&gt;• Clomipramine&lt;br&gt;• Desipramine&lt;br&gt;• Doxepin (&gt;6 mg)&lt;br&gt;• Imipramine&lt;br&gt;• Nortriptyline&lt;br&gt;• Protriptyline&lt;br&gt;• Trimipramine</td>
</tr>
</tbody>
</table>

Note: For up to date Alliance information, please consult the Complete Formulary Guide and Epocrates website.
SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at the end of the measurement period. The linked PCP site does not have to be the provider site that performed the screening or follow-up care.

DATA SOURCE: Claims, Data Submission Tool

PAYMENT FREQUENCY: Annually, following the end of quarter 4

CALCULATION: Number members with documented and appropriately billed depression screening follow-up care/total members with positive depression screening.

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

If you do not have a Provider Portal account, go to https://www.ccah-alliance.org/PortalRequestForm.html and complete the Provider Portal Request form. For questions regarding access to the Provider Portal email PortalRegister@ccah-alliance.org.

RESOURCES:
Depression Screening and Follow-up Tip Sheet
Beacon PCP Referral Form
Beacon Primary Care Provider Behavioral Health Communication Form (allows PCP and BH Specialist to share info)
Beacon - Why to give consent
Documentation must include a standardized Depression screening tool. Screening tools do not need to be sent to the Alliance. However, Eligible screening instruments with thresholds for positive findings include:

### Instruments for Adolescents (12–17 years)

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Results Considered as Positive Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Health Questionnaire (PHQ-9)*</td>
<td>Total Score ≥5</td>
</tr>
<tr>
<td>Patient Health Questionnaire Modified for Teens (PHQ-9M)*</td>
<td>Total Score ≥5</td>
</tr>
<tr>
<td>PRIME MD-PHQ2®</td>
<td>Total Score ≥3</td>
</tr>
<tr>
<td>Beck Depression Inventory-Fast Screen (BDI-FS)*</td>
<td>Total Score ≥4</td>
</tr>
<tr>
<td>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</td>
<td>Total Score ≥10</td>
</tr>
<tr>
<td>PROMIS Depression</td>
<td>Total Score (T Score) ≥52.5</td>
</tr>
</tbody>
</table>

### Instruments for Adults (18+ years)

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Results Considered as Positive Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Health Questionnaire (PHQ-9)*</td>
<td>Total Score ≥5</td>
</tr>
<tr>
<td>PRIME MD-PHQ2®</td>
<td>Total Score ≥3</td>
</tr>
<tr>
<td>Beck Depression Inventory-Fast Screen (BDI-FS)*</td>
<td>Total Score ≥4</td>
</tr>
<tr>
<td>Beck Depression Inventory (BDI-II)</td>
<td>Total Score ≥14</td>
</tr>
<tr>
<td>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</td>
<td>Total Score ≥10</td>
</tr>
<tr>
<td>Geriatric Depression Scale Short Form (GDS)</td>
<td>Total Score ≥5</td>
</tr>
<tr>
<td>Geriatric Depression Scale Long Form (GDS)</td>
<td>Total Score ≥10</td>
</tr>
<tr>
<td>Edinburgh Postnatal Depression Scale (EPDS)</td>
<td>Total Score ≥9</td>
</tr>
<tr>
<td>My Mood Monitor (M-3)*</td>
<td>Total Score ≥5</td>
</tr>
<tr>
<td>PROMIS Depression</td>
<td>Total Score (T Score) ≥52.5</td>
</tr>
<tr>
<td>Clinically Useful Depression Outcome Scale (CUDOS)</td>
<td>Total Score ≥11</td>
</tr>
</tbody>
</table>

DATA SOURCE: Claims, Provider Portal Data Submissions

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

**MEASURE DESCRIPTION:** The percentage of members 18–75 years of age with diabetes (type 1 and type 2) and an HbA1c score of <8%.

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

**ELIGIBLE POPULATION:**

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

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

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

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

  - **Claim/encounter data:** Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):
    
    - At least one acute inpatient encounter with a diagnosis of diabetes **without** telehealth.
    - At least two outpatient visits, observation visits, ED visits or non-acute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.

Only include nonacute inpatient encounters **without** telehealth.
Pharmacy data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medication List).

### DIABETES MEDICATION

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PRESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alpha-glucosidase inhibitors</strong></td>
<td>• Acarbose  • Miglitol</td>
</tr>
<tr>
<td><strong>Amylin analogs</strong></td>
<td>• Pramlinitide</td>
</tr>
<tr>
<td><strong>Antidiabetic combinations</strong></td>
<td>• Alogliptin-metformin  • Alogliptin-pioglitazone  • Canagliflozin-metformin  • Dapagliflozin-metformin  • Empagliflozin-linagliptin  • Empagliflozin-metformin  • Glimepiride-pioglitazone  • Glimepiride-rosiglitazone  • Glipizide-metformin  • Glyburide-metformin  • Linagliptin-metformin  • Metformin-pioglitazone  • Metformin-repaglinide  • Metformin-rosiglitazone  • Metformin-saxagliptin  • Metformin-sitagliptin  • Sitagliptin-simvastatin</td>
</tr>
<tr>
<td><strong>Insulin</strong></td>
<td>• Insulin aspart  • Insulin aspart-insulin aspart protamine  • Insulin degludec  • Insulin detemir  • Insulin glargine  • Insulin glulisine  • Insulin isophane human  • Insulin isophane-insulin regular  • Insulin lispro  • Insulin lispro-insulin lispro protamine  • Insulin regular human  • Insulin human inhaled</td>
</tr>
<tr>
<td><strong>Meglitinides</strong></td>
<td>• Nateglinide  • Repaglinide</td>
</tr>
<tr>
<td><strong>Glucagon-like peptide-1 (GLP1) agonists</strong></td>
<td>• Dulaglutide  • Liraglutide  • Albiglutide</td>
</tr>
<tr>
<td><strong>Sodium glucose cotransporter 2 (SGLT2) inhibitor</strong></td>
<td>• Canagliflozin  • Dapagliflozin  • Empagliflozin</td>
</tr>
<tr>
<td><strong>Sulfonylureas</strong></td>
<td>• Chlorpropamide  • Glimepiride  • Glipizide  • Glyburide  • Tolazamide  • Tolbutamide</td>
</tr>
<tr>
<td><strong>Thiazolidinediones</strong></td>
<td>• Pioglitazone  • Rosiglitazone</td>
</tr>
<tr>
<td><strong>Dipeptidyl peptidase-4 (DDP-4) inhibitors</strong></td>
<td>• Alogliptin  • Linagliptin  • Saxagliptin  • Sitagliptin</td>
</tr>
</tbody>
</table>

Note: For up to date Alliance information, please consult the Complete Formulary Guide and Epocrates website

Exclusions:
- Members who do not have a diagnosis of diabetes in any setting during the measurement year or the year prior to the measurement year and who had a
diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

- Members enrolled in Hospice services during the rolling 12 month measurement period
- Administrative Members
- Dual Coverage Members
- Members 66 years of age and older as of the end of the measurement year with frailty and advanced illness. To identify members with advanced illness, any of the following criteria during the measurement year or the year prior to the measurement year are eligible:
  - At least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter with an advanced illness diagnosis.
  - A dispensed dementia medication.

**TABLE: DEMENTIA MEDICATIONS**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PRESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha-glucosidase inhibitors</td>
<td>• Acarbose</td>
</tr>
<tr>
<td></td>
<td>• Miglitol</td>
</tr>
<tr>
<td>Amylin analogs</td>
<td>• Pramlinitide</td>
</tr>
</tbody>
</table>

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

**NUMERATOR:** The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Only the most recent test in the measurement period is used to determine compliance for this measure.

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

**DATA SOURCE:** Laboratory Data, Data Submission Tool, Claims

**CALCULATION FORMULA:** # of members with a most recent HbA1c score <8%/total linked diabetic members. Note member is considered non-compliant if no HbA1c test was completed during the measurement period.

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

**PROVIDER PORTAL:** The portal provides a list of members and their diabetes care, including screenings for A1c, Nephropathy and Retinal Eye Exams.
Note: This list is subject to claims lag, and members on this list may include members that have not yet been seen at your office, but who are linked to your practice. We recommend cross referencing this list with your EHR.

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

If you do not have a Provider Portal account, go to https://www.ccah-alliance.org/PortalRequestForm.html and complete the Provider Portal Request form. For questions regarding access to the Provider Portal email PortalRegister@ccah-alliance.org.

RESOURCES:
2019 Programmatic Measure Benchmarks
Diabetic HbA1c Good Control Tip Sheet

CODE SET LINKS:
CDC: Diabetes Identification Codes
CDC: HbA1c Inclusion Codes
CDC: Diabetes Exclusion Codes
DIABETIC RETINAL EXAM (CDC)

Diabetes increases a patient’s risk of developing diabetic retinopathy, glaucoma and other eye problems. Regular eye exams can assist in early detection and provide an opportunity for interventions and education to prevent further damage.

The CBI Program assists PCPs to monitor eye exam visits and establish routine preventive care to reduce healthcare expenditures.

**MEASURE DESCRIPTION:** The percentage of members 18 – 75 years of age with diabetes (type 1 and type 2) who had either of the following criteria:

- A retinal or dilated eye exam during the measurement year
- A negative retinal or dilated eye exam in the 12 months prior to the measurement year.
- A Bilateral eye enucleation anytime in the member’s history.

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

**ELIGIBLE POPULATION:**

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

**Ages:** 18 – 75 years of age as of the last day of the measurement quarter.

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

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

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

- At least one acute inpatient encounter with a diagnosis of diabetes **without** telehealth.
- At least two outpatient visits, observation visits, ED visits or non-acute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.

Only include nonacute inpatient encounters **without** telehealth.
**Pharmacy data:** Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medication List).

### DIABETES MEDICATIONS

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PRESCRIPTION</th>
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<tbody>
<tr>
<td>Alpha-glucosidase inhibitors</td>
<td>• Acarbose</td>
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<td></td>
<td>• Miglitol</td>
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<tr>
<td>Amylin analogs</td>
<td>• Pramlintide</td>
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<tr>
<td>Antidiabetic combinations</td>
<td>• Alogliptin-metformin</td>
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<td></td>
<td>• Alogliptin-pioglitazone</td>
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<td></td>
<td>• Canagliflozin-metformin</td>
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<td>• Dapagliflozin-metformin</td>
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<td>• Empagliflozin-metformin</td>
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<td>• Empagliflozin-linaglizin</td>
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<td></td>
<td>• Glimepiride-pioglitazone</td>
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<td>• Glimepiride-rosiglitazone</td>
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<td>• Glyburide-metformin</td>
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<td>• Linaglizin-metformin</td>
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<td>• Metformin-repaglinide</td>
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<td>• Metformin-saxagliptin</td>
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<td>• Sitagliptin-simvastatin</td>
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<td>Insulin</td>
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<td>• Insulin aspart-insulin aspart protamine</td>
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<td>Meglitinides</td>
<td>• Nateglinide</td>
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<td>• Repaglinide</td>
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<tr>
<td>Glucagon-like peptide-1 (GLP1) agonists</td>
<td>• Dulaglutide</td>
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<td>• Exenatide</td>
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<td>Sodium glucose cotransporter 2 (SGLT2) inhibitor</td>
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<td>Sulfonylureas</td>
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<td>Thiazolidinediones</td>
<td>• Pioglitazone</td>
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<td>Dipeptidyl peptidase-4 (DDP-4) inhibitors</td>
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<td>• Saxagliptin</td>
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<td>• Sitagliptin</td>
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</tbody>
</table>

### EXCLUSIONS:
- Members who do not have a diagnosis of diabetes in any setting during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.
EXCLUSIONS CONTINUED:

- Members enrolled in Hospice services during the rolling 12 month measurement period
- Administrative Members
- Dual Coverage Members
- Members 66 years of age and older as of the end of the measurement year with frailty and advanced illness. To identify members with advanced illness, any of the following criteria during the measurement year or the year prior to the measurement year are eligible:
  - At least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter with an advanced illness diagnosis.
  - A dispensed dementia medication.

NUMERATOR: Number of members who receive:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the 12 months prior to the measurement year.
- Bilateral eye enucleation anytime in the member’s medical history.

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

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.

PAYMENT FREQUENCY: Annually, following the end of quarter 4

DATA SOURCE: Claims

Tip for PCP sites that contract with outside eye providers, such as EyePACS, for e-consult retinal images: report one of the following measurement codes to ensure CBI incentive is received.

- 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
- 2024F: 7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
- 2026F: Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos results documented and reviewed

CALCULATION FORMULA: Number of members who received a retinal exam/total number of members with a diagnosis of type (1 or 2) diabetes.
**PROVIDER PORTAL:** The portal provides a list of members and their diabetes care, including screenings for A1c, Nephropathy and Retinal Eye Exams.

Note: This list is subject to claims lag, and members on this list may include members that have not yet been seen at your office, but who are linked to your practice. We recommend cross referencing this list with your EHR.

**RESOURCES:**
- Diabetic Retinal Exam Tip Sheet
- 2019 Programmatic Measure Benchmarks
- Vision Service Providers for Retinal Exams
- Diabetes Prevention and Self-Management Education Benefit

**CODE SET LINKS:**
- CDC: Diabetes Identification Codes
- CDC: Retinal Eye Codes
- CDC: Diabetes Exclusion Codes
IMMUNIZATIONS: ADOLESCENTS (IMA)

Adolescence is a dynamic period of development where effective preventive care measures can promote safe behaviors and growth of lifelong health habits. One of the foundations of adolescent care is timely vaccination, and every visit can be used as an opportunity to update and complete necessary immunizations. The HPV vaccine in particular 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 tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

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

**ELIGIBLE POPULATION:**

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

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

- **Continuous Enrollment:** 12 months prior to the member’s 13th birthday

- **Eligible Member Event/Diagnosis:** N/A

**Exclusions:**

- Administrative Members on date of 13th birthday
- Members enrolled in Hospice services during the rolling 12 month measurement period
- Dual Coverage Members
- Encephalopathy / adverse reaction
- Anaphylactic reaction to the vaccine or its components any time on or before the member’s 13th birthday.

**DENOMINATOR:** The eligible population as defined above

**NUMERATOR:** Members who received one dose of Meningococcal, one dose of Tdap, and completed HPV series on or before their 13th birthday.
**SERVICING PCP SITE REQUIREMENT:** Credit is given to the linked PCP site at the date when the member turns 13 years old. The linked PCP site does not have to be the provider site who administered the vaccinations. We encourage providers to enter all vaccination history, from those vaccines administered at your site, or another provider office, into the immunization registry.

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

**DATA SOURCE:** Claims, immunization registries (CAIR & RIDE) for the prior 4 years (child’s 9th-12th year of life), CHDP, Data Submission Tool

**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.

**PROVIDER PORTAL:** The portal provides a list of your linked members who, according to our records, may not have had a one or more of the vaccinations listed above. This list is based on submitted claims and immunization registry information.

Note: This list is subject to claims lag, and members on this list may include members that have not yet been seen at your office, but who are linked to your practice. We recommend cross referencing this list with your EHR.

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

If you do not have a Provider Portal account, go to [https://www.ccah-alliance.org/PortalRequestForm.html](https://www.ccah-alliance.org/PortalRequestForm.html) and complete the Provider Portal Request form. For questions regarding access to the Provider Portal email PortalRegister@ccah-alliance.org.

**RESOURCES:**
- Immunization: Adolescents (IMA) Tip Sheet
- RIDE (Healthy Futures) Immunization Registry [http://www.myhealthyfutures.org/](http://www.myhealthyfutures.org/)
- California Immunization Coalition

**CODE SET LINKS:**
- IMA: [Immunizations - Adolescents Codes](#)
- IMA: [Immunizations - Adolescents Exclusion Codes](#)
IMMUNIZATIONS: CHILDREN (COMBO 3)

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

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

MEASURE DESCRIPTION: The percentage of children who have received all of the following vaccines (Combo 3) by their second birthday:

- 4 Diphtheria, Tetanus, acellular pertussis (DTaP)
- 3 Inactivated Polio Vaccine (IPV)
- 1 Measles, Mumps and Rubella (MMR), or history of illness;
- 3 Haemophilus Influenzae Type B (HiB)
- 3 Hepatitis B (HepB) or history of hepatitis B illness;
- 1 Varicella (VZV) or History of varicella zoster (e.g. chicken pox) illness;
- 4 Pneumococcal Conjugate (PCV)

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

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

ELIGIBLE POPULATION:

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

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

Continuous Enrollment: 12 months prior to child’s 2nd birthday with a 45 day allowable gap

Eligible Member Event/Diagnosis: None

Exclusions:

- Children with a valid contraindication for a specific vaccine (see exclusion code set below).
- Administrative members on day of child’s 2nd birthday
- Members enrolled in Hospice services during the rolling 12 month measurement period
- Dual Coverage Members

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

**NUMERATOR:** Members who received all Combo 3 immunizations by their second birthday

**SERVICING PCP SITE REQUIREMENTS:** Credit is given to the linked PCP site on the day when the member turns 2 years old. The linked PCP site does not have to be the provider site that provided the vaccinations.

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

**DATA SOURCE:** Claims, Immunization Registries (CAIR or RIDE), CHDP and Data Submission Tool.

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

**CALCULATION FORMULA:** Number of members who had all combo 3 vaccines by their 2nd birthday /total number of members who turned 2 during the measurement period

**PROVIDER PORTAL:** The portal provides a list of your linked members who, according to our records, may not have had a one or more of the vaccinations listed above. This list is based on submitted claims and immunization registry information.

Note: This list is subject to claims lag, and members on this list may include members that have not yet been seen at your office, but who are linked to your practice. We recommend cross referencing this list with your EHR.

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

If you do not have a Provider Portal account, go to https://www.ccah-alliance.org/PortalRequestForm.html and complete the Provider Portal Request form. For questions regarding access to the Provider Portal email PortalRegister@ccah-alliance.org.

**RESOURCES:**
- 2019 Programmatic Measure Benchmarks
- CDC Vaccination Schedule
- CAIR Immunization Registry - http://cairweb.org/
RIDE (Healthy Futures) Immunization Registry - http://www.myhealthyfutures.org/
California Immunization Coalition

CODE SET LINKS:
CIS: Immunizations: Children Codes
CIS: Immunizations: Children Exclusion Codes
MATERNITY CARE: POST-PARTUM CARE (PPC)

Receiving appropriate postpartum care can address many concerns and prevent medical complications that can occur after a woman has given birth, such as persistent bleeding, inadequate iron levels, blood pressure, pain, mental health changes, infections or breastfeeding.

This measure encourages PCPs to ensure that every woman who delivered a live birth completes a postpartum visit between 21 days and 56 days after delivery on a routine, outpatient basis. These visits can prevent future emergent events and reduce healthcare expenditures.

MEASURE DESCRIPTION: The percentage of members who receive a postpartum visit on or between 21 and 56 days after delivery.

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

ELIGIBLE POPULATION:

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

Age: N/A

Continuous Enrollment: 43 days prior to delivery through 56 days after delivery. No allowable gap during the continuous enrollment period.

Eligible Member Event/Diagnosis: Delivered a live birth. Includes women who delivered in any setting. Women who had multiple live births during one pregnancy count only once.

Exclusions:
- Non-live births.
- Administrative Members on day 56 postpartum
- Members enrolled in Hospice services during the rolling 12 month measurement period
- Dual Coverage Members

DENOMINATOR: Eligible population who delivered a live birth during the CBI year, as defined above.

NUMERATOR: Number of members who completed a post-partum visit within 21 – 56 days after delivery.

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site at day 56 after delivery The linked PCP site does not have to be the provider site that performed the service.
PAYMENT FREQUENCY: Annually, following the end of quarter 4

DATA SOURCE: Claims

CALCULATION FORMULA: Number of members who completed a post-partum visit within 21 – 56 days post-partum/ total number of members who delivered a live birth during the CBI year.

RESOURCES:
2019 Programmatic Measure Benchmarks
Healthy Moms Healthy Babies Program

CODE SET LINKS:
PPC: Postpartum Codes
PPC: Postpartum Exclusion Codes
WELL ADOLESCENT VISIT 12 — 21 YEARS

The transition between childhood and adult life is accompanied by dramatic changes. Annual preventative health care visits offer an opportunity to addresses the physical, emotional and social aspects of this important phase of life.

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 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

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

**ELIGIBLE POPULATION:**

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

- **Age:** 12 – 21 years as of the last day of the measurement period.

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

- **Eligible Member Event/Diagnosis:** None

- **Exclusions:**
  - Administrative Members at end of the measurement period
  - Dual Coverage Members
  - Members enrolled in Hospice services during the rolling 12 month measurement period

**DENOMINATOR:** Eligible population age 12-21 years, as defined above

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

**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, DHCS Fee-For-Service (FFS) encounter claims
**CALCULATION FORMULA:** # of members with a qualifying adolescent well-care visit/total eligible linked members

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

**PROVIDER PORTAL:** The portal provides a list of your linked adolescent members with birthdays in the coming 3 months, who, according to our records, may not have had a well-care visit in the last 12 months.

Note: This list is subject to claims lag, and members on this list may include members that have not yet been seen at your office, but who are linked to your practice. We recommend cross referencing this list with your EHR.

**RESOURCES:**
- [2019 Programmatic Measure Benchmarks](#)

**CODE SET LINKS:**
- [AWC: Adolescent Well-Care Visits Codes](#)
WELL CHILD VISIT 3-6 YEARS (W34)

Assessing physical, emotional, and social development is important at every stage of life. Well-child visits during the preschool and early school years are particularly important. Behaviors established during early childhood such as eating habits and physical activity often extend into adulthood. 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 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.

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

ELIGIBLE POPULATION:

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

Ages: 3 – 6 years of age as of the last day of the measurement period.

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

Eligible Member Event/Diagnosis: None

Exclusions:
- Administrative Members
- Dual Coverage Members
- Members enrolled in Hospice services during the rolling 12 month measurement period

DENOMINATOR: Eligible population age 3-6 years old, as defined above.

NUMERATOR: At least one well-child visit with a PCP during the measurement period.
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, DHCS FFS encounter claims

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

PAYMENT FREQUENCY: Annually, following the end of quarter 4

PROVIDER PORTAL: The portal provides a list of your linked members (ages 3-6) with birthdays in the coming 3 months, who, according to our records, may not have had a Well-Child Exam in the last 12 months.

Note: This list is subject to claims lag, and members on this list may include members that have not yet been seen at your office, but who are linked to your practice. We recommend cross referencing this list with your EHR.

RESOURCES:
2019 Programmatic Measure Benchmarks

CODE SET LINKS:
W34: Well Child Visit Codes