2020 CARE-BASED INCENTIVES (CBI) TECHNICAL SPECIFICATIONS

Table of Contents

CBI PROGRAM OVERVIEW ..................................................................................................................... 2
CBI PROGRAM SUPPORT ......................................................................................................................... 4
PROGRAMMATIC MEASURES OVERVIEW ............................................................................................. 8

CARE COORDINATION — ACCESS MEASURES ................................................................................. 9
ALCOHOL MISUSE SCREENING AND COUNSELING (AMSC) ............................................................. 9
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS ........................................................................ 11
INITIAL HEALTH ASSESSMENT (IHA) ..................................................................................................... 13
POST-DISCHARGE CARE .......................................................................................................................... 15

CARE COORDINATION — HOSPITAL & OUTPATIENT MEASURES ...................................................... 17
30-DAY READMISSIONS .......................................................................................................................... 17
AMBULATORY CARE SENSITIVE ADMISSIONS (ACSA) ...................................................................... 19
PREVENTABLE EMERGENCY VISITS .................................................................................................... 21

QUALITY OF CARE MEASURES ......................................................................................................... 23
ANTIDEPRESSANT MEDICATION MANAGEMENT .............................................................................. 23
ASTHMA MEDICATION RATIO .............................................................................................................. 26
BODY MASS INDEX (BMI) ASSESSMENT: ADULT ............................................................................... 30
BODY MASS INDEX (BMI) ASSESSMENT: CHILDREN & ADOLESCENT .............................................. 32
CERVICAL CANCER SCREENING ........................................................................................................... 34
DIABETIC HBA1C POOR CONTROL >9.0% .............................................................................................. 37
IMMUNIZATIONS: ADOLESCENTS ......................................................................................................... 41
IMMUNIZATIONS: CHILDREN (COMBO 10) ......................................................................................... 43
MATERNITY CARE: POSTPARTUM ......................................................................................................... 46
MATERNITY CARE: PRENATAL ............................................................................................................... 48
WELL-ADOLESCENT VISIT 12 — 21 YEARS ...................................................................................... 50
WELL-CHILD VISIT 3-6 YEARS ............................................................................................................... 52
WELL-CHILD VISIT FIRST 15 MONTHS ................................................................................................. 54

PERFORMANCE TARGET MEASURES ................................................................................................. 56
PERFORMANCE IMPROVEMENT MEASURE ......................................................................................... 56
MEMBER REASSIGNMENT THRESHOLD ............................................................................................... 59

EXPLORATORY MEASURES (Formerly Provisionary) ............................................................................ 60
90-DAY REFERRAL COMPLETION .......................................................................................................... 60
APPLICATION OF DENTAL FLUORIDE VARNISH ............................................................................... 62
BREAST CANCER SCREENING ............................................................................................................ 64
CHLAMYDIA SCREENING IN WOMEN .................................................................................................. 67
CONTROLLING HIGH BLOOD PRESSURE ............................................................................................ 70
IMMUNIZATIONS: ADULTS .................................................................................................................... 72
MEMBER SATISFACTION ....................................................................................................................... 74

FEE-FOR-SERVICE MEASURES ............................................................................................................. 76
BEHAVIORAL HEALTH INTEGRATION ................................................................................................. 77
BUPRENORPHINE LICENSE (X-LICENSE WAIVER) ............................................................................ 78
PATIENT CENTERED MEDICAL HOME (PCMH) RECOGNITION ......................................................... 79

KEY TERMS AND DEFINITIONS ........................................................................................................... 80
CBI PROGRAM OVERVIEW

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

- Care Coordination
- Quality of Care
- Performance Targets
- Practice Management

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

- Improve quality outcomes, as reflected in part by the Healthcare Effectiveness Data and Information Set (HEDIS) and The California Department of Health Care Services (DHCS) Managed Care Accountability Set based on the Centers for Medicare & Medicaid Services (CMS);
- Improve member experience;
- Reduce under and over-utilization;
- Improve access to primary care;
- Encourage use of disease registries to address population health;
- Encourage adoption of best-practice care guidelines as recommended by U.S. Preventive Services Task Force (USPSTF); and
- Reduce disparities in quality or service delivery between groups of members and/or geographic regions.

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

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

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

- Provider Bulletins, memorandums and email communication;
- Member and Quality Reports in the Provider Portal;
- Board Reports;
- CBI workshops and performance reviews including;
  - Plan–Do-Study-Act (PDSA) activities and on Performance Improvement Plan teams;
  - Medical Director and Provider Relations’ onsite and network communication;
  - External committee meetings; and
  - Alliance physician committees.
The Alliance is committed to cultivating a strong network of providers. Your support and feedback will help us continue to ensure excellent health outcomes for our members and a robust CBI program for our providers.

**CBI WORKGROUP:** The CBI Program internal workgroup consists of representatives from Finance, Provider Relations, Compliance Department, Analytics and Technology Department, Care Management, Quality Improvement, Pharmacy and Medical Affairs who reviews program policies and proposed measure ideas.

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

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

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

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

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

Note: Data on the Provider Portal is subject to claims lag.

The following reports are available on the Provider Portal:

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

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

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

**Quality Reports:** Monthly Quality reports are clinical measures to assist providers in monitoring their patient’s preventative health screenings and recommended care. The Quality reports include a mix of CBI and Healthcare Effectiveness Data and Information Set (HEDIS®) reports and are designed as a tool for providers to create patient recall lists only. All reports are now refreshed monthly.

### MONTHLY QUALITY REPORTS

<table>
<thead>
<tr>
<th>Adult Immunizations</th>
<th>Chlamydia and Gonorrhea Screenings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications</td>
<td>Diabetes Care</td>
</tr>
<tr>
<td>Asthma Medication Ratio</td>
<td>Immunizations for Adolescents</td>
</tr>
<tr>
<td>Body Mass Index Assessment: Children &amp; Adolescents</td>
<td>Prenatal Immunizations</td>
</tr>
<tr>
<td>Breast Cancer Screenings</td>
<td>Well-Adolescent Visits (12-21 years)</td>
</tr>
<tr>
<td>Cervical Cancer Screenings</td>
<td>Well-Child Visits (0-15 months)</td>
</tr>
<tr>
<td>Childhood Immunizations (Combo 10)</td>
<td>Well-Child Visits (3-6 years)</td>
</tr>
</tbody>
</table>
**Data Submission Tool:** The Data Submission Tool (DST) allows Alliance providers to upload data files via the Provider Portal. The DST was created to support providers in submitting data from their electronic health record and medical records to achieve compliance in the Care Based Incentive (CBI) Program, Health Effectiveness Data Information Set (HEDIS) audit, and quality improvement projects with our providers. Data can be uploaded for the following measures:

- Alcohol Misuse Screening and Counseling
- Annual Monitoring for Patients on Persistent Medications (lab panels)
- Controlling Blood Pressure (diastolic and systolic values)
- Body Mass Index Assessment (BMI percentiles and values)
- Cervical Cancer Screening (screening and hysterectomies)
- Depression Screening and Follow-up (depression screening tools and total score)
- Diabetic HbA1c lab values
- Diabetic Retinal Eye Exams
- Immunizations: Adults; Adolescents; and Children
- Initial Health Assessment (IHA)

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

### CBI Summary & Performance Report
Summary views show your site level performance in comparison to your peers.

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

### CBI Measure Detail & Dashboard Reports
Measure details provide member level reports for opportunities of patient outreach and integration of services into your practice. The CBI Dashboard provides trending throughout the history of the CBI measure.

<table>
<thead>
<tr>
<th>MEASURE CATEGORY</th>
<th>MEASURE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CARE COORDINATION — ACCESS MEASURES</strong></td>
<td>Alcohol Misuse Screening and Counseling (AMSC)</td>
</tr>
<tr>
<td></td>
<td>Developmental Screening in the First 3 Years</td>
</tr>
<tr>
<td></td>
<td>Initial Health Assessment (IHA)</td>
</tr>
<tr>
<td><strong>CARE COORDINATION — HOSPITAL &amp; OUTPATIENT MEASURES</strong></td>
<td>30-Day Readmissions</td>
</tr>
<tr>
<td></td>
<td>Ambulatory Care Sensitive Admissions</td>
</tr>
<tr>
<td></td>
<td>Preventable Emergency Visits</td>
</tr>
<tr>
<td>MEASURE CATEGORY</td>
<td>MEASURE NAME</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>QUALITY OF CARE</td>
<td>Antidepressant Medication Management</td>
</tr>
<tr>
<td></td>
<td>Asthma Medication Ratio</td>
</tr>
<tr>
<td></td>
<td>Body Mass Index (BMI) Assessment: Adult</td>
</tr>
<tr>
<td></td>
<td>Body Mass Index (BMI) Assessment: Children &amp; Adolescents</td>
</tr>
<tr>
<td></td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Diabetic HbA1c Poor Control &gt;9.0%</td>
</tr>
<tr>
<td></td>
<td>Immunizations: Adolescents</td>
</tr>
<tr>
<td></td>
<td>Immunizations: Children (Combo 10)*</td>
</tr>
<tr>
<td></td>
<td>Maternity Care: Postpartum Care</td>
</tr>
<tr>
<td></td>
<td>Maternity Care: Prenatal</td>
</tr>
<tr>
<td></td>
<td>Well-Adolescent Visit (12-21 Years)</td>
</tr>
<tr>
<td></td>
<td>Well-Child Visit (3-6 Years)</td>
</tr>
<tr>
<td></td>
<td>Well-Child Visit First 15 Months</td>
</tr>
<tr>
<td>PERFORMANCE TARGET MEASURES</td>
<td>Member Reassignment</td>
</tr>
<tr>
<td>EXPLORATORY MEASURES</td>
<td>90-Day Referral Completion</td>
</tr>
<tr>
<td></td>
<td>Application of Dental Fluoride Varnish</td>
</tr>
<tr>
<td></td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Chlamydia Screening in Women</td>
</tr>
<tr>
<td></td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td></td>
<td>Immunizations: Adults</td>
</tr>
<tr>
<td></td>
<td>Member Satisfaction</td>
</tr>
</tbody>
</table>

**Additional Provider Portal resources include:**
- Claims Search
- Member Eligibility Verification
- Authorization and Referral Requests
- Status of Processed Claims
- Provider Directory
- Member Prescription History

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

**CBI FORENSICS:** At the close of each CBI Program year, the Alliance reviews CBI performance for each provider site in our network. The Alliance conducts outreach efforts to sites that may benefit from additional program support, but Alliance staff are also available to meet with sites upon request to review their CBI data and offer support in improving performance in the CBI program. This is a valuable opportunity to receive additional support and training. Please contact us at CBI@ccah-alliance.org to schedule a CBI forensics visit with our CBI Quality Improvement staff.
CBI UPDATES: Through the CBI year any announcements or updates to the CBI measures will be announced through the following sources:
- Fax Announcements
- Email Announcements
- Provider Service Representative Visits
- Provider Bulletin Articles
- CBI Webinars

CBI PROGRAM CONTACT INFORMATION
QUALITY IMPROVEMENT (QI) EMAIL: CBI@ccah-alliance.org
QI PHONE: 831-430-2620
QI FAX: 831-430-5819
CBI WEBSITE: Care-Based Incentive (CBI) Resources
PROVIDER RELATIONS: (800) 700-3874 ext. 5504
PROGRAMMATIC MEASURES OVERVIEW

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

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

Point allocations for Programmatic Points are listed in the chart below. There is a total of 100 CBI programmatic points available each year. For a condensed listing of all CBI measures, refer to the CBI Incentive Summary. For yearly performance targets and a detailed explanation of point allocations by measure refer to the 2020 Programmatic Measure Benchmarks.

<table>
<thead>
<tr>
<th>Programmatic Measures</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination (CC) - Access Measures</td>
<td>15</td>
</tr>
<tr>
<td>Alcohol Misuse Screening and Counseling (AMSC)</td>
<td>2</td>
</tr>
<tr>
<td>Developmental Screening in First 3 Years of Life</td>
<td>2</td>
</tr>
<tr>
<td>Initial Health Assessment</td>
<td>5</td>
</tr>
<tr>
<td>Post-Discharge Care</td>
<td>6</td>
</tr>
<tr>
<td>Care Coordination (CC) – Hospital &amp; Outpatient Measures</td>
<td>40</td>
</tr>
<tr>
<td>30-Day Readmissions</td>
<td>15</td>
</tr>
<tr>
<td>Ambulatory Care Sensitive Admissions</td>
<td>10</td>
</tr>
<tr>
<td>Preventable Emergency Visits</td>
<td>15</td>
</tr>
<tr>
<td>Quality of Care (QoC) Measures</td>
<td>35</td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td></td>
</tr>
<tr>
<td>Asthma Medication Ratio</td>
<td></td>
</tr>
<tr>
<td>Body Mass Index (BMI) Assessment: Adult</td>
<td></td>
</tr>
<tr>
<td>Body Mass Index (BMI) Assessment: Children &amp; Adolescents</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td></td>
</tr>
<tr>
<td>Diabetic HbA1c Poor Control &gt;9.0%</td>
<td>35 points available between all Quality of Care Measures for which your practice qualifies</td>
</tr>
<tr>
<td>Immunizations: Adolescents</td>
<td></td>
</tr>
<tr>
<td>Immunizations: Children</td>
<td></td>
</tr>
<tr>
<td>Maternity Care: Postpartum Care</td>
<td></td>
</tr>
<tr>
<td>Maternity Care: Prenatal</td>
<td></td>
</tr>
<tr>
<td>Well-Adolescent Visit 12 – 21 Years</td>
<td></td>
</tr>
<tr>
<td>Well-Child Visit 3 – 6 Years</td>
<td></td>
</tr>
<tr>
<td>Well-Child Visit First 15 Months</td>
<td></td>
</tr>
<tr>
<td>Performance Target (PT) Measures</td>
<td>10</td>
</tr>
<tr>
<td>Performance Improvement</td>
<td>10</td>
</tr>
<tr>
<td>Total Points</td>
<td>100</td>
</tr>
</tbody>
</table>
CARE COORDINATION – ACCESS MEASURES

ALCOHOL MISUSE SCREENING AND COUNSELING (AMSC)

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

**MEASURE DESCRIPTION:** Members 18 years and older who are screened for alcohol misuse and persons who are engaged in risky or hazardous drinking were provided brief behavioral counseling interventions to reduce alcohol misuse. Based on the recommendation from United States Preventive Service Task Force (USPSTF), AMSC services are a Medi-Cal benefit for alcohol misuse only (no reimbursement for screenings related to drug abuse).

**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:** 18 years of age or older

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

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

**Exclusions:**
- Administrative Members as of end of CBI measurement period
- Dual Coverage Members
- Claims submitted to Beacon
- California Children’s Services (CCS) Members

**DENOMINATOR:** All linked members 18 years and older as of the end of the measurement period.

**NUMERATOR:** Linked members 18 years and older with a finalized paid claim for either:
- Annual alcohol misuse screening, 15 minutes
- Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Note: Members with either a screening or a brief intervention in the measurement year will qualify as CBI compliant. However, if a member has a screening and an intervention or multiple interventions, they will be counted multiple times in the numerator. This means it is possible that your site will see a rate of >100% in this measure. The maximum number of points awarded does not increase with an >100% score. The Alliance asks that providers use clinical judgment in assessing the needs of their patients.

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

DOCUMENTATION REQUIREMENTS:
Initial Screening: Providers are required to use a Medi-Cal approved screening instrument (AUDIT/AUDIT-C) for a full screening; a pre-screen or brief screen is not reimbursable.

Brief Intervention: The brief intervention may include an initial intervention, a follow-up intervention and/or a referral; and can take place on the same date of service as the full screen or on subsequent days.

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

DATA SOURCE: Claims, Data Submission Tool

CALCULATION FORMULA: Members with completed AMSC/total eligible members

PROVIDER PORTAL
Provider Portal Linked Members List- Providers can access complete listings of members who were admitted on the Alliance Provider Portal by accessing ‘Linked member lists’ and clicking on the tab ‘Linked Member Inpatient Admissions’ by month. Contact your Provider Relations Representative for assistance logging into the Provider Portal.

RESOURCES:
2020 Programmatic Measure Benchmarks
Alcohol Misuse Screening And Counseling Tip Sheet
Helping Patients Who Drink Too Much: A Clinician's Guide

CODE SET:
Alcohol Misuse Screening And Counseling Exlusion Code Set
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS

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

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

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

ELIGIBLE POPULATION:

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

Ages: 1 – 3 years of age

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

Eligible Member Event/Diagnosis: N/A

Exclusions:

- Administrative Members as of end of CBI measurement period
- Dual Coverage Members
- California Children’s Services (CCS) Members

DENOMINATOR: Eligible population as defined above.

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

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
**CALCULATION FORMULA:** Members 1 – 3 years of age who received developmental screenings/total eligible members

**RESOURCES:**
- [2020 Programmatic Measure Benchmarks](#)
- [Developmental Screening Tip Sheet](#)

**CODE SET:**
- [Developmental Screening Codes](#)
INITIAL HEALTH ASSESSMENT (IHA)

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

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

The IHA must be sufficiently comprehensive to assess and diagnose acute and chronic conditions including, but not limited to:

- History of present illness
- Past medical history
- Social history
- Review of organ systems
- Diagnoses and plan of care

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

**ELIGIBLE POPULATION:**

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

**Age:** N/A

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

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

**Exceptions/Exclusions:**

- Dual Coverage Members within 120 days after enrollment
- California Children’s Services (CCS) Members within 120 days after enrollment

**DENOMINATOR:** All new members linked to provider at the end the 120 days post enrollment. Members must be enrolled in the Medi-Cal Program on or between October 1, 2019 and September 1, 2020 to qualify for the measure denominator.
**NUMERATOR:** Claim showing IHA visit within 120 day of enrollment. IHA visit must be completed between October 2018-December 2019. Note this is a rolling 15-month measurement period to accommodate 120 days post enrollment date as indicated in the denominator above.

If two phone calls and one written attempt are made to schedule a member to complete an IHA and the provider site is unable to schedule the member, the provider may submit a claim indicating inability to schedule member. These members will be considered compliant for the IHA CBI measure. All three attempts to reach the member must be documented in the medical record and will be subjected to random audits through medical record review. See [IHA Tip Sheet](#) for more information on billing “inability to schedule member” claims.

Note: SHA forms are a required component of the IHA visit. Providers **do not** need to fax the SHA form to the Alliance. SHA forms should be maintained in the patient’s chart and will be audited as part of the routine Facility Site Review (FSR) requirements. More information on SHA forms can be found on the [IHA and Staying Healthy Assessment Resources](#) page.

**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.

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

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

**CALCULATION FORMULA:** Number of members with IHA/eligible members as detailed above.

**PROVIDER PORTAL**

[Provider Portal](#) Linked Members List- Providers can access complete listings of members due for an IHA on the Alliance Provider Portal by accessing ‘Linked member lists’ and clicking on the tab ‘New Members/120-day IHA’ by month. Contact your Provider Relations Representative for assistance logging into the Provider Portal.

**RESOURCES:**

- [2020 Programmatic Measure Benchmarks](#)
- [IHA Tip Sheet](#)
- [IHA and Staying Healthy Assessment Resources](#)
- [2020 Programmatic Measure Benchmarks](#)

**CODE SET LINKS:**

IHA Codes: See [IHA Tip Sheet](#)
POST-DISCHARGE CARE

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

The Alliance offers the Post-Discharge incentive to compliment the 30-Day Readmission incentive and support providers in reducing hospital readmissions.

MEASURE DESCRIPTION: Members who receive a post-discharge visit within 14 days of discharge from a hospital inpatient stay. This measure pertains to acute hospital discharges only. Emergency room visits do not qualify.

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

ELIGIBLE POPULATION:

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

Ages: N/A

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

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

Exclusions:
- Postpartum and healthy newborn care visits are excluded. NICU newborns are included.
- Administrative Members at the end of the CBI measurement period
- Dual Coverage Members
- California Children’s Services (CCS) Members

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

If provider has 0 inpatient admissions during the measurement period, they receive full points for the measure. >1 inpatient admission is measured based on a rate of post discharge visits/inpatient
admissions, and compared to the established benchmarks to determine point allocations. See 2020 Programmatic Measure Benchmarks for more details.

**NUMERATOR:** Instances of members who received qualified post discharge visit within 14 days of discharge from hospital inpatient stay.

**SERVICING PCP SITE REQUIREMENT:** Member must be seen for post discharge visit by the linked PCP provider site. Visits completed by specialists or a PCP at a site where the member is not linked will not be counted.

**DATA SOURCE:** Claims

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

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

**PROVIDER PORTAL**

Provider Portal - Providers can access a real time report of their members with inpatient admissions at participating hospitals. To access this report, visit the Provider Portal-Reports-Linked Member List-Linked Member Inpatient Admissions.

Note: Because these reports are populated using eCensus data, they only include members who indicated a provider site as their linked PCP during their inpatient admission. eCensus reports are to be used as a recall tool to contact members for post discharge follow-up; they do not reflect performance in the CBI program. Data in these reports is generated by the admitting hospital and does not reflect the finals claims data that is used in the CBI program.

**RESOURCES:**

2020 Programmatic Measure Benchmarks

**CODE SET LINKS:**

Post-Discharge Care Codes
CARE COORDINATION – HOSPITAL & OUTPATIENT MEASURES

30-DAY READMISSIONS

Discharge from a hospital is a critical transition point in a patient’s care. Poor care coordination at discharge can lead to adverse events for patients and avoidable readmissions. Unplanned readmissions are associated with increased mortality and increased healthcare costs. The CBI Program seeks to improve the communication and coordination of care during an admission stay and to improve communication with caregivers at the time of discharge. The Alliance offers the Post Discharge incentive to compliment the 30-Day Readmission incentive and support providers in reducing hospital readmissions.

MEASURE DESCRIPTION: The rate of readmissions within 30 days of discharge from an inpatient hospital stay per 1,000 members per year.

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

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

ELIGIBLE POPULATION:

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

Age: All, excluding newborns

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

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

Exclusions:

- Admissions related to pregnancy or delivery
- Newborns
- Admissions associated with organ transplants
- Admissions associated with chemotherapy
- Admissions associated with surgical complications
- Members who change PCPs between the date of discharge and readmission
- Hospital and other inpatient health facility transfers
- Administrative Members at date of service
- Dual Coverage Members
- California Children’s Services (CCS) Members
- Denied Claims

DENOMINATOR: Total linked member months.
**NUMERATOR:** Count of readmissions that occur within 30 days of an acute inpatient discharge. PCP at time of readmission must be the same as the PCP at time of initial admission discharge to qualify.

**SERVICING PCP SITE REQUIREMENT:** Member must be linked to PCP at time of initial admission and time of readmission.

**DATA SOURCE:** Claims

**CALCULATION FORMULA:** \((\# 30\text{-Day Readmissions}/\text{Total member months}) \times 12,000\)

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

**PROVIDER PORTAL**

[Provider Portal] - Providers can access a real time report of their members with inpatient admissions at participating hospitals. To access this report, visit the Provider Portal-Reports-Linked Member List- Linked Member Inpatient Admissions.

Note: Because these reports are populated using eCensus data, they only include members who indicated a provider site as their linked PCP during their inpatient admission. ECensus reports are to be used as a recall tool to contact members for post discharge follow-up; they do not reflect performance in the CBI program. Data in these reports is generated by the admitting hospital and does not reflect the finals claims data that is used in the CBI program.

**RESOURCES:**

- [2019 Programmatic Measure Benchmarks]
- [30-Day Readmission Tip Sheet]

**CODE SET LINK:**

- [30-Day Readmission Exclusion Codes]
AMBULATORY CARE SENSITIVE ADMISSIONS (ACSA)

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

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

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

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

ELIGIBLE POPULATION:

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

Age: Condition specific as outlined by the AHRQ

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

Denominator Event/Diagnosis: None

Exclusions:
- Condition specific as outlined by the AHRQ
- Administrative Members
- Dual Coverage Members
- California Children’s Services (CCS) Members

DENOMINATOR: Total linked member months

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

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

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

**RESOURCES:**
- 2020 Programmatic Measure Benchmarks
- Ambulatory Care Sensitive Diagnosis List

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

- Ambulatory Care Sensitive Admissions Inclusion Codes
- Ambulatory Care Sensitive Admissions Exclusion Codes

Measure Derived From:
- AHRQ PQI Tech Specs
- AHRQ PDI Tech Specs
PREVENTABLE EMERGENCY VISITS

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

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

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

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

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

ELIGIBLE POPULATION:

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

Age: Greater than one year old at date of service

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

Eligible Member Event/Diagnosis: None

Exclusions:
- ED visits that result in inpatient admissions
- Members less than one year of age at date of service
- Administrative Members
- Dual Coverage Members
- California Children’s Services (CCS) Members

DENOMINATOR: Total linked member months

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

CALCULATION FORMULA: (# of Preventable ED visits/Total member months) *12,000

PAYMENT FREQUENCY: Annually, following the end of quarter 4

PROVIDER PORTAL

Provider Portal - Providers can access a real time report of their members with ED visits at participating ED locations. To access this report, visit the Provider Portal-Reports-Linked Member List-Linked Member ED Visits. Providers can also view high ED utilizers found under Linked Member High ED Utilizers report.

NOTE: The data in Linked Member ED Visit report is populated using different methodology than CBI. This data is an outreach tool and does not reflect your final CBI reports. This report is populated using eCensus data; they only include members who indicated a provider site as their linked PCP during their inpatient admission.

RESOURCES:
2020 Programmatic Measure Benchmarks
Preventable Emergency Visit Diagnosis
Preventable Emergency Visits Tip Sheet

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

CODE SET LINKS:
Preventable Emergency Visits Codes
QUALITY OF CARE MEASURES

ANTIDEPRESSANT MEDICATION MANAGEMENT

Depression is a very common disorder. Major depression can seriously impair a member’s ability to function, including disrupted sleep patterns, appetite, concentration, energy and self-esteem, and possible suicide. Suicide is the 10th leading cause of death in the United States each year. 1,2

Effective medication treatment of major depression can improve a member’s daily function and their well-being, as well as can reduce their risk of suicide. 3

MEASURE DESCRIPTION: The percentage of members 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression diagnosis and who remained on an antidepressant medication treatment for a least 84 days or 12 weeks.

MEMBER REQUIREMENT: PCP Site must have at least 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 years or older as of April 30th of the measurement year.

Continuous Enrollment: 105 days prior to Index Prescription Start Date (IPSD) through 231 days after IPSD with a 45-day allowable gap during each year of continuous enrollment

Exclusions:
- Members who did not have a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD through the IPSD, and the 60 days after the IPSD.
- Members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.
- Administrative Members at the end of the CBI measurement period
- Dual Coverage Members
- Members enrolled in Hospice services during the rolling 12-month measurement period
ELIGIBLE MEMBER EVENT/DIAGNOSIS: The following criteria with a diagnosis of major depression will make the member eligible for this measure:

- Acute or non-acute inpatient stay with diagnosis on discharge claim
- Acute or non-acute inpatient encounter
- Outpatient visit (Visit Setting Unspecified with Outpatient POS or BH Outpatient codes)
- Intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified with Partial Hospitalization POS or Partial Hospitalization or Intensive Outpatient codes)
- Community mental health center visit (Visit Setting Unspecified with Community Mental Health Center POS codes)
- Electroconvulsive therapy
- Transcranial magnetic stimulation visit
- Emergency Department visit (ED or Visit Setting Unspecified with ED POS codes)
- Observation visit
- Telephone visit

DENOMINATOR: Eligible population (as defined above).

NUMERATOR: At least 84 days (12 weeks) of treatment with an antidepressant medication (see Antidepressant Medication List), beginning on the IPSD through 114 days after the IPSD (115 days total).

Note: This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous antidepressants</td>
<td>Bupropion</td>
</tr>
<tr>
<td></td>
<td>Vilazodone</td>
</tr>
<tr>
<td></td>
<td>Vortioxetine</td>
</tr>
<tr>
<td>Monoamine oxidase inhibitors</td>
<td>Isocarboxazid</td>
</tr>
<tr>
<td></td>
<td>Phenelzine</td>
</tr>
<tr>
<td></td>
<td>Selegiline</td>
</tr>
<tr>
<td></td>
<td>Tranylcypromine</td>
</tr>
<tr>
<td>Phenylpiperazine antidepressants</td>
<td>Nefazodone</td>
</tr>
<tr>
<td></td>
<td>Trazodone</td>
</tr>
<tr>
<td>Psychotherapeutic combinations</td>
<td>Amitriptyline-chlordiazepoxide</td>
</tr>
<tr>
<td></td>
<td>Amitriptyline-perphenazine</td>
</tr>
<tr>
<td></td>
<td>Fluoxetine-olanzapine</td>
</tr>
<tr>
<td>SNRI antidepressants</td>
<td>Desvenlafaxine</td>
</tr>
<tr>
<td></td>
<td>Duloxetine</td>
</tr>
<tr>
<td></td>
<td>Venlafaxine</td>
</tr>
<tr>
<td>SSRI antidepressants</td>
<td>Citalopram</td>
</tr>
<tr>
<td></td>
<td>Escitalopram</td>
</tr>
<tr>
<td></td>
<td>Fluoxetine</td>
</tr>
<tr>
<td></td>
<td>Fluvoxamine</td>
</tr>
<tr>
<td></td>
<td>Paroxetine</td>
</tr>
<tr>
<td></td>
<td>Sertraline</td>
</tr>
<tr>
<td>Tetracyclic antidepressants</td>
<td>Maprotiline</td>
</tr>
<tr>
<td></td>
<td>Mirtazapine</td>
</tr>
<tr>
<td>Tricyclic antidepressants</td>
<td>Amitriptyline</td>
</tr>
<tr>
<td></td>
<td>Amoxapine</td>
</tr>
<tr>
<td></td>
<td>Clomipramine</td>
</tr>
<tr>
<td></td>
<td>Desipramine</td>
</tr>
<tr>
<td></td>
<td>Doxepin (&gt;6 mg)</td>
</tr>
<tr>
<td></td>
<td>Imipramine</td>
</tr>
<tr>
<td></td>
<td>Nortriptyline</td>
</tr>
<tr>
<td></td>
<td>Protriptyline</td>
</tr>
<tr>
<td></td>
<td>Trimipramine</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 who are diagnosed with major depression and stayed on a major depressant medication for at least 84 days (12 weeks) using criteria above/total eligible linked members.

PROVIDER PORTAL: The portal provides a list of members eligible for the measure and compliance status.

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:
2020 Programmatic Measure Benchmarks
Antidepressant Medication Management (AMM) Tip Sheet

REFERENCES:

CODE SET LINKS:
AMM: Depression Eligible Population Codes
AMM: Depression Medication NDC Codes
Hospice Exclusion Codes
ASTHMA MEDICATION RATIO

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

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

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

MEMBER REQUIREMENT: PCP Site must have at least 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 indicate the dispensed amount is 30 g, this designates 3 inhaler canisters were dispensed.

**ELIGIBLE POPULATION:**

- **Membership:** Linked members enrolled in the Medi-Cal program in Santa Cruz, Monterey or Merced counties, excluding Dual Coverage members.
- **Age:** 5 – 64 as of the last day of the measurement period
- **Continuous Enrollment:** Rolling 24 months with a 45-day allowable gap during each year of continuous enrollment

**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 one acute inpatient discharge with a principal diagnosis of asthma
- 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.

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

**Step 5** – Sum the total number of members who have a ratio of 0.50 or greater in step 4.
## ASTHMA CONTROLLER AND RELIEVER MEDICATIONS

### ASThma Controller Medications

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiasthmatic combinations</td>
<td>Dyphylline-guaifenesin</td>
</tr>
<tr>
<td>Antibody inhibitors</td>
<td>Omalizumab</td>
</tr>
<tr>
<td>Anti-interleukin-5</td>
<td>Benralizumab, Mepolizumab, Reslizumab</td>
</tr>
<tr>
<td>Inhaled steroid combinations</td>
<td>Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, Formoterol-mometasone</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>Beclomethasone, Flunisolide</td>
</tr>
<tr>
<td>Leukotriene modifiers</td>
<td>Montelukast, Zafirlukast, Zileuton</td>
</tr>
<tr>
<td>Methylxanthines</td>
<td>Theophylline</td>
</tr>
</tbody>
</table>

### ASThma Reliever Medications

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<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:**
- 2020 Programmatic Measure Benchmarks
- Asthma Medication Ratio Tip Sheet

**Code Set Links:**
- AMR: Asthma Exclusions Codes
- AMR: Inclusion Codes
- AMR: Asthma Controller and Reliever Medication NDC Codes
- Hospice Exclusion Codes
BODY MASS INDEX (BMI) ASSESSMENT: ADULT

Obesity can cause complications such as metabolic syndrome, high blood pressure, heart disease, diabetes, cancers and sleep disorders and is a leading cause of premature death. Recent studies found that obesity contributes to nearly 1 in 5 deaths in the United States. Careful monitoring of member’s BMI will help in identifying if members are at risk and give providers an opportunity to provide focused advice and services to help members reach and maintain their healthier weight.

The CBI Program assists PCPs to monitor BMI screenings and establish routine preventive care to decrease to reduce proximal healthcare expenditures.

**MEASURE DESCRIPTION:** Members 18 – 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior.

**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 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year.

- **Continuous Enrollment:** The measurement year and the year prior to the measurement year 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:** Members who had an outpatient visit during the measurement year or the year prior.

**Exclusions:**
- 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
- Female members who had a diagnosis of pregnancy during the measurement year or the year prior to the measurement year.

**DENOMINATOR:** Eligible population, as defined above.
NUMERATOR: For members 20 years of age or older on the date of service, BMI value documented during the measurement year or the year prior to the measurement year.

For members younger than 20 years of age on the date of service, BMI percentile documented during the measurement year or the year prior to the measurement year.

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

DATA SOURCE: Claims, Data Submission Tool

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

PAYMENT FREQUENCY: Annually, following the end of quarter 4

PROVIDER PORTAL: PCPs can submit BMI 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:
2020 Programmatic Measure Benchmarks
BMI Tip Sheet

REFERENCES:

CODE SET LINKS:
Adult BMI Assessment Inclusion Codes
Adult BMI Assessment Exclusion Codes
Hospice Exclusion Codes
BODY MASS INDEX (BMI) ASSESSMENT: CHILDREN & ADOLESCENT

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

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

**MEASURE DESCRIPTION:** Members 3 - 17 years of age who had an outpatient visit with a PCP or OB/GYN and had BMI percentile documented.

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

Continuous Enrollment: The measurement year and the year prior to the measurement year 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: Members who had an outpatient visit during the measurement year or the year prior.

Exclusions:
- 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
- Female members who had a diagnosis of pregnancy during the measurement year.

**DENOMINATOR:** Eligible population, as defined above.
NUMERATOR: BMI percentile during the measurement year

SERVING 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

CALCULATION FORMULA: Number of members who had an outpatient visit using criteria above/total eligible linked members

PAYMENT FREQUENCY: Annually, following the end of quarter 4

PROVIDER PORTAL: The portal provides a list of members 3-17 years of age, allowing providers an opportunity to monitor who have and have not received their annual BMI screening.

PCPs can also submit BMI 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:
2020 Programmatic Measure Benchmarks
BMI Tip Sheet

REFERENCES:

CODE SET LINKS:
Children & Adolescent BMI Assessment Inclusion Codes
Children & Adolescent BMI Assessment Exclusion Codes
Hospice Exclusion Codes
CERVICAL CANCER SCREENING

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

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

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

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

**MEMBER REQUIREMENT:** PCP must have 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 high-risk human papillomavirus (hrHPV) test during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of 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:** Number of women who screened for cervical cancer using criteria above/total eligible linked members

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

**PROVIDER PORTAL:** The portal provides a list of linked members who, according to our records may or may not have received cervical cancer screenings and their screening date.

PCPs can also submit cervical cancer screening and hysterectomy data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account - Data Submissions- Data Submission Tool Guide to assist you through your submission steps and validation.
If you do not have a Provider Portal account, 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:
2020 Programmatic Measure Benchmarks
Cervical Cancer Screening Tip Sheet

CODE SET LINKS:
Cervical Cytology & HPV Test Codes
Cervical Cancer Screening Exclusion Codes
Hospice Exclusion Codes
DIABETIC HBA1C POOR CONTROL >9.0%

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

**MEASURE DESCRIPTION:** The percentage of members 18 – 75 years of age with diabetes (type 1 and type 2) with an HbA1c score of >9%. Members with no lab result submitted will be considered non-compliant for this measure. (This is a reverse measure: lower rate is better)

**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 one acute inpatient discharge with a diagnosis of diabetes on the discharge claim.
  - At least two outpatient visits, observation visits, ED visits or non-acute inpatient encounters on different dates of service, with a diagnosis of diabetes on the discharge claim. Visit type need not be the same for the two visits.

Only include nonacute inpatient encounters without telehealth.
**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>Alpha-glucosidase inhibitors</td>
<td>• Acarbose</td>
</tr>
<tr>
<td></td>
<td>• Miglitol</td>
</tr>
<tr>
<td>Amylin analogs</td>
<td>• Pramlinitide</td>
</tr>
<tr>
<td>Antidiabetic combinations</td>
<td>• Alogliptin-metformin</td>
</tr>
<tr>
<td></td>
<td>• Alogliptin-pioglitazone</td>
</tr>
<tr>
<td></td>
<td>• Canagliflozin-metformin</td>
</tr>
<tr>
<td></td>
<td>• Dapagliflozin-metformin</td>
</tr>
<tr>
<td></td>
<td>• Empagliflozin-metformin</td>
</tr>
<tr>
<td></td>
<td>• Metformin-metformazone</td>
</tr>
<tr>
<td></td>
<td>• Metformin-repaglinide</td>
</tr>
<tr>
<td></td>
<td>• Metformin-rosiglitazone</td>
</tr>
<tr>
<td></td>
<td>• Metformin-saxagliptin</td>
</tr>
<tr>
<td></td>
<td>• Metformin-sitagliptin</td>
</tr>
<tr>
<td>Insulin</td>
<td>• Insulin aspart</td>
</tr>
<tr>
<td></td>
<td>• Insulin aspart-insulin aspart protamine</td>
</tr>
<tr>
<td></td>
<td>• Insulin degludec</td>
</tr>
<tr>
<td></td>
<td>• Insulin detemir</td>
</tr>
<tr>
<td></td>
<td>• Insulin glargine</td>
</tr>
<tr>
<td></td>
<td>• Insulin glulisine</td>
</tr>
<tr>
<td></td>
<td>• Insulin isophane human</td>
</tr>
<tr>
<td></td>
<td>• Insulin isophane-insulin regular</td>
</tr>
<tr>
<td></td>
<td>• Insulin lispro</td>
</tr>
<tr>
<td></td>
<td>• Insulin lispro-insulin lispro protamine</td>
</tr>
<tr>
<td></td>
<td>• Insulin regular human</td>
</tr>
<tr>
<td></td>
<td>• Insulin human inhaled</td>
</tr>
<tr>
<td>Meglitinides</td>
<td>• Nateglinide</td>
</tr>
<tr>
<td></td>
<td>• Repaglinide</td>
</tr>
<tr>
<td>Glucagon-like peptide-1 (GLP1) agonists</td>
<td>• Dulaglutide</td>
</tr>
<tr>
<td></td>
<td>• Exenatide</td>
</tr>
<tr>
<td></td>
<td>• Liraglutide</td>
</tr>
<tr>
<td></td>
<td>• Albiglutide</td>
</tr>
<tr>
<td>Sodium glucose cotransporter 2 (SGLT2)</td>
<td>• Canagliflozin</td>
</tr>
<tr>
<td>inhibitor</td>
<td>• Dapagliflozin</td>
</tr>
<tr>
<td></td>
<td>• Empagliflozin</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>• Chlorpropamide</td>
</tr>
<tr>
<td></td>
<td>• Glimepiride</td>
</tr>
<tr>
<td></td>
<td>• Glyburide</td>
</tr>
<tr>
<td></td>
<td>• Tolazamide</td>
</tr>
<tr>
<td></td>
<td>• Tolbutamide</td>
</tr>
<tr>
<td>Thiazolidinediones</td>
<td>• Pioglitazone</td>
</tr>
<tr>
<td></td>
<td>• Rosiglitazone</td>
</tr>
<tr>
<td>Dipeptidyl peptidase-4 (DDP-4) inhibitors</td>
<td>• Alogliptin</td>
</tr>
<tr>
<td></td>
<td>• Linagliptin</td>
</tr>
<tr>
<td></td>
<td>• Saxagliptin</td>
</tr>
<tr>
<td></td>
<td>• 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, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter 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>Cholinesterase inhibitors</td>
<td>• Donepezil</td>
</tr>
<tr>
<td></td>
<td>• Galantamine</td>
</tr>
<tr>
<td></td>
<td>• Rivastigmine</td>
</tr>
<tr>
<td>Miscellaneous central nervous system agents</td>
<td>• Memantine</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 >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Only the most recent test in the measurement period is used to determine compliance for this measure.

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

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

**CALCULATION FORMULA:** Number of members with a most recent HbA1c score >9.0%/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 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](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:**
- 2020 Programmatic Measure Benchmarks
- Diabetic HbA1c Poor Control Tip Sheet

**CODE SET LINKS:**
- Diabetes Identification 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 vaccination, and every visit can be used as an opportunity to update and complete necessary immunizations. The HPV vaccine is also the best way to protect against most of the cancers caused by the Human Papillomavirus (HPV) infection that can affect male and female patients.

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

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

**MEMBER REQUIREMENT:** PCP must have 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), CHDP, 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 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 and complete the Provider Portal Request form. For questions regarding access to the Provider Portal email PortalRegister@ccah-alliance.org.

**RESOURCES:**
- 2020 Programmatic Measure Benchmarks
- Immunization: Adolescents (IMA) Tip Sheet
- CAIR Immunization Registry http://cairweb.org/
- RIDE (Healthy Futures) Immunization Registry http://www.myhealthyfutures.org/
- California Immunization Coalition

**CODE SET LINKS:**
- Immunizations - Adolescents Codes
- Immunizations - Adolescents Exclusion Codes
- Hospice Exclusion Codes
IMMUNIZATIONS: CHILDREN (COMBO 10)

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

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

**MEASURE DESCRIPTION:** The percentage of children who have received all of the following vaccines (Combo 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)
- 2 or 3 Rotavirus (RV)**
- 1 Hepatitis A (HepA)*
- 2 Influenza (flu)

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

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

- 3 doses for RotaTeq
- 2 doses Rotarix
- 1 Rotarix AND two RotaTeq (not the other way around)

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

**MEMBER REQUIREMENT:** PCP Site must have at least 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 10 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 10 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:
2020 Programmatic Measure Benchmarks
Immunizations: Children (Combo 10) Tip Sheet
CDC Vaccination Schedule
CAIR Immunization Registry - http://cairweb.org/
RIDE (Healthy Futures) Immunization Registry - http://www.myhealthyfutures.org/
California Immunization Coalition

CODE SET LINKS:
Immunizations: Children Codes
Immunizations: Children Exclusion Codes
Hospice Exclusion Codes
**MATERNITY CARE: POSTPARTUM**

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 7 days and 84 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 7 and 84 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 60 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 84 of postpartum time period
  - 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 postpartum visit within 7 – 84 days after delivery.

**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

CALCULATION FORMULA: Number of members who completed a postpartum visit within 7 – 84 days post-partum/ total number of members who delivered a live birth during the CBI year.

RESOURCES:
2020 Programmatic Measure Benchmarks
Postpartum Tip Sheet
Healthy Moms Healthy Babies Program

CODE SET LINKS:
Postpartum Eligibility Codes
Postpartum Inclusion Codes
Postpartum Exclusion Codes
Hospice Exclusion Codes
MATERNITY CARE: PRENATAL

Timely prenatal care is an important component in reducing complications and ensuring the physical and emotional wellbeing of pregnant women and their babies. Women on Medi-Cal continue to have lower rates of timely prenatal care than privately insured women. The CBI program seeks to support providers in closing this gap and ensuring Medi-Cal women and babies receive quality timely prenatal care for every pregnant woman within the first trimester to avoid adverse outcomes and reduce costs.

**MEASURE DESCRIPTION:** Members who received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with the Alliance.

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

**ELIGIBLE POPULATION:**

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

**Age:** N/A

**Eligible Member Event/Diagnosis:** Diagnosis of a pregnancy

**Continuous Enrollment:** 43 days prior to delivery through 60 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:**
- Dual Coverage Members
- Administrative members on date of service
- Members enrolled in Hospice services during the rolling 12-month measurement period

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

**NUMERATOR:** Number of members who completed a prenatal visit in the first trimester (by the end of the 13th week), or within 42 days of enrollment with the Alliance.

**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

CALCULATION FORMULA: Number of members who completed a prenatal visit in the first trimester (by the end of the 13th week), or within 42 days of enrollment with the Alliance / total number of members who delivered a live birth during the CBI year.

PROVIDER PORTAL: The Prenatal Immunization report includes a list of linked members who, according to our records, may or may not have received the recommended immunizations as part of prenatal care. This monthly Quality Report compliments the prenatal care measure, but does not meet the criteria for the CBI measure.

RESOURCES:
2020 Programmatic Measure Benchmarks
Prenatal Tip Sheet

CODE SET LINKS:
Prenatal Eligibility Codes
Prenatal Inclusion Codes
Prenatal Exclusion Codes
Hospice 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 enrolled 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

**Note:** As a reminder, please document following in the medical records:
- Health History
- Physical Developmental History
- Mental Developmental History
- Physical Exam
- Health Education/Anticipatory Guidance

**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: Number 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:
2020 Programmatic Measure Benchmarks
Well Adolescent Visit 12 – 21 Years Tip Sheet

CODE SET LINKS:
Adolescent Well-Care Visits Codes
Hospice Exclusion Codes
WELL-CHILD VISIT 3-6 YEARS

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

**Note:** As a reminder, please document following in the medical records:
- Health History
- Physical Developmental History
- Mental Developmental History
- Physical Exam
- Health Education/Anticipatory Guidance

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

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

**PROVIDER PORTAL:** The 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:**
- [2020 Programmatic Measure Benchmarks](#)

**CODE SET LINKS:**
- [Well Child Visit Codes](#)
- [Hospice Exclusion Codes](#)
WELL-CHILD VISIT 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. Behaviors established during early childhood such as eating habits and physical activity often extend into adulthood. Well-child 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:** Members age 15 months old who had 6 or more well-child visits with a PCP during the first 15 months of life.

**MEMBER REQUIREMENT:** PCP must have 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:** Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child’s first birthday plus 90 days.

**Continuous Enrollment:** 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

**Note:** As a reminder, please document following in the medical records:

- Health History
- Physical Developmental History
- Mental Developmental History
- Physical Exam
- Health Education/Anticipatory Guidance

**DENOMINATOR:** Eligible population age 15 months old, as defined above.
NUMERATOR: At least 6 well-child visits on or before 15 months of age with a PCP during the measurement period.

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, Data Submission Tool.

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

PAYMENT FREQUENCY: Annually, following the end of quarter 4

PROVIDER PORTAL: The provider portal report provides you with an opportunity to monitor well-child visits by showing your linked members (ages 0-15 months), and according to our records, the number of well-child visits that were completed in the last 15 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:
2020 Programmatic Measure Benchmarks
Well-Child Visits for the First 15 Months of Life Tip Sheet

REFERENCES:

CODE SET LINKS:
Well Child Visit Codes
Hospice Exclusion Codes
PERFORMANCE TARGET MEASURES

PERFORMANCE IMPROVEMENT MEASURE

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

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

- Meeting the Plan Goal (see the 2020 Performance Improvement Plan Goals for this year’s Plan Goals for each measure), or
- Achieve a 5% improvement in Care Coordination - Hospital & Outpatient Measures or five percentage point improvement in either Care Coordination- Access Measures or Quality of Care measures compared to the prior year.

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

- Antidepressant Medication Management
- BMI Index Assessment: Adult
- BMI Index Assessment: Children & Adolescent
- Developmental Screening in the First Three Years
- Diabetic HbA1c Poor Control >9.0%
- Immunizations: Children (Combo 10)
- Well-Child Visits First 15 Months

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

- Alcohol Misuse Screening and Counseling
- Initial Health Assessment
- Post-Discharge
- Ambulatory Care Sensitive Admissions
- Preventable Emergency Visits
- 30-Day Readmissions
- Asthma Medication Ratio
- Cervical Cancer Screening
- Immunizations: Adolescents
- Maternity Care: Postpartum Well-Adolescent Visit (12-21)
- Maternity Care: Prenatal
- Well-Child Visit (3-6)
**MEMBER REQUIREMENT:** The Performance Improvement measure is worth a total of 10 potential CBI points, divided among all measures for which the PCP qualifies. PCPs qualify for measures by meeting the applicable member requirements set out by the measure:

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

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

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

<table>
<thead>
<tr>
<th>Performance Improvement Points</th>
<th>Number of Qualifying Measures</th>
<th>Maximum Points per Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>10.00</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>5.00</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>3.33</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>2.50</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>1.67</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>1.43</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>1.25</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>1.11</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>0.91</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>0.83</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>0.71</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>0.67</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>0.63</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>0.58</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>0.55</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>0.52</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>0.50</td>
</tr>
</tbody>
</table>
ELIGIBLE POPULATION:

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

Ages: Measure specific

Continuous Enrollment: Measure specific

Eligible Member Event/Diagnosis: Measure specific

Exclusions: Measure specific

DENOMINATOR: Measures specific

NUMERATOR: Measure specific

SERVICING PCP SITE REQUIREMENTS: Measure specific

PAYMENT FREQUENCY: Annually, following the end of quarter 4

RESOURCES:

2020 Performance Improvement Plan Goals

DATA SOURCE: Measure specific
MEMBER REASSIGNMENT THRESHOLD

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

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

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

Exclusions:
- Dual Coverage Members on date of reassignment
- Administrative Members on date of reassignment

Not all member reassignments count as part of the CBI member reassignment measure. Member reassignments for the following reasons are exempt and do not count against the PCP site.
- Medication Management (BA)
- Abusive/Disruptive Behavior (AB)
- Fraud (FR)
- Aged Out (AO)
- Member Requested (MI)
- Non Medi-Cal member reassignments

SERVICING PCP SITE REQUIREMENTS: Members who are linked to provider at time of reassignment are counted toward the reassignment threshold.
EXPLORATORY MEASURES (Formerly Provisionary)

90-DAY REFERRAL COMPLETION

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

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

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

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

ELIGIBLE POPULATION:

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

Age: N/A

Continuous Enrollment: Continuously enrolled 4 months of the measurement year

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

Exclusions:

- Administrative Members at end of the measurement period
- Dual Coverage Members
- Denied and pending claims
- California Children’s Services (CCS) Members
- Denied or pending claims

DENOMINATOR: Eligible population as defined above.
Members must have referrals written on or between October 1, 2019 and September 30, 2020 to qualify for the measure denominator.

NUMERATOR: Number of paid claims received from the specialist with a referral claim number listed on the claim within 90 days. Referral visit must be completed between October 2019-December 2020. Note this is a rolling 15 month measurement period to accommodate 90 days post referral start date as indicated in the denominator above.
Data Elements must include:

- Member ID
- Member’s Full Name
- DOB
- PCP’s Group NPI
- Referral number on claim
- PCP linked to member at time referral is written, and at time of specialist visit

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

DATA SOURCE: Claims

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

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2020.

RESOURCES:
90-Day Referral Completion Tip Sheet

CODE SET: N/A
APPLICATION OF DENTAL FLOURIDE VARNISH

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

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

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

ELIGIBLE POPULATION:

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

Age: 6 months to under 6 years at the end of the measurement period.

Continuous Enrollment: Continuously enrolled 4 months

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

Exclusions:

- Administrative Members at end of the measurement period
- Dual Coverage Members
- Denied and pending claims
- California Children’s Services (CCS) Members

DENOMINATOR: Eligible population as defined above.

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

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

DATA SOURCE: Claims
CALCULATION FORMULA: Number of paid claims/total linked eligible members.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2020.

RESOURCES:
Application of Dental Fluoride Varnish Tip Sheet

CODE SET:
CPT Code: 99188
CDT Code: D1206
BREAST CANCER SCREENING

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

**MEASURE DESCRIPTION:** The percentage of women 50 – 74 years of age who had a mammogram to screen for breast cancer on or between October 1 two years prior to the Measurement Period and the end of the Measurement Period.

**MEMBER REQUIREMENT:** PCP must have 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:** 52–74 years of age by the end of the measurement period

**Continuous Enrollment:** October 1 two years prior to the measurement year through December 31 of the measurement year. In the rolling 12 months there is an allowable gap of 45 days.

**Eligible Member Event/Diagnosis:** Paid claim for mammography.

**Exclusions:**

- Administrative Members at end of the measurement period
- Dual Coverage Members
- Members enrolled in Hospice services during the rolling 12-month measurement period
- A bilateral mastectomy or two separate unilateral mastectomy procedures on right and left side any time during the member’s history through the end of the measurement period. Example:

<table>
<thead>
<tr>
<th>LEFT MASTECTOMY (ANY OF THE FOLLOWING)</th>
<th>RIGHT MASTECTOMY (ANY OF THE FOLLOWING)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral mastectomy with a left-side modifier (same procedure)</td>
<td>Unilateral mastectomy with a right-side modifier (same procedure)</td>
</tr>
<tr>
<td>Unilateral mastectomy found in clinical data with a left-side modifier (same procedure)</td>
<td>Unilateral mastectomy found in clinical data with a right-side modifier (same procedure)</td>
</tr>
<tr>
<td>Absence of the left breast</td>
<td>Absence of the right breast</td>
</tr>
<tr>
<td>Left unilateral mastectomy</td>
<td>Right unilateral mastectomy</td>
</tr>
</tbody>
</table>
- 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, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter 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>Cholinesterase inhibitors</td>
<td>• Donepezil</td>
</tr>
<tr>
<td></td>
<td>• Galantamine</td>
</tr>
<tr>
<td></td>
<td>• Rivastigmine</td>
</tr>
<tr>
<td>Miscellaneous central nervous system agents</td>
<td>• Memantine</td>
</tr>
</tbody>
</table>

**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.

**DATA SOURCE:** Claims, DST for exclusions

**CALCULATION FORMULA:** Number of paid claims/total linked eligible members.

**PAYMENT FREQUENCY:** This is an exploratory measure; there is no payment for 2020.

**PROVIDER PORTAL:** The portal provides a list of linked members who, according to our records may or may not have received breast cancer screenings and their screening date.

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

If you do not have a Provider Portal account, 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.

**CODE SET:**
- Breast Cancer Screening Inclusion Codes
- Hospice Exclusion Codes
- Dementia Medication NDC Exclusion Codes
REFERENCE:


CHLAMYDIA SCREENING IN WOMEN

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

MEASURE DESCRIPTION: Members ages 16 to 24 years old who are identified as sexually active and who had at least one screening for chlamydia 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:** Women 16–24 years old as of December 31 of the measurement year

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

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

Exclusions:

- Administrative Members at end of the measurement period
- Dual Coverage Members
- Members enrolled in Hospice services during the rolling 12-month measurement period
- Exclude members who qualified for the measure based on a pregnancy test alone and who meet either of the following:
  - A pregnancy test during the measurement year and a prescription for isotretinoin on the date of the pregnancy test or the six days after the pregnancy test.
  - A pregnancy test during the measurement year and an x-ray on the date of the pregnancy test or the six days after the pregnancy test.

### RETINOID MEDICATION

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PRESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinoid</td>
<td>Isotretinoin</td>
</tr>
</tbody>
</table>
## CONTRACEPTIVE MEDICATIONS

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PRESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraceptives</strong></td>
<td>• Desogestrel-ethinyl estradiol</td>
</tr>
<tr>
<td></td>
<td>• Dienogest-estradiol multiphasic</td>
</tr>
<tr>
<td></td>
<td>• Drospirenone-ethinyl estradiol</td>
</tr>
<tr>
<td></td>
<td>• Drospirenone-ethinyl estradiol-levomefolate biphasic</td>
</tr>
<tr>
<td></td>
<td>• Ethinyl estradiol-ethynodiol</td>
</tr>
<tr>
<td></td>
<td>• Ethinyl estradiol-etonogestrel</td>
</tr>
<tr>
<td></td>
<td>• Ethinyl estradiol-levonorgestrel</td>
</tr>
<tr>
<td></td>
<td>• Ethinyl estradiol-norelgestromin</td>
</tr>
<tr>
<td></td>
<td>• Ethinyl estradiol-norethindrone</td>
</tr>
<tr>
<td></td>
<td>• Ethinyl estradiol-noretynodiol</td>
</tr>
<tr>
<td></td>
<td>• Ethinyl estradiol-norgestimate</td>
</tr>
<tr>
<td></td>
<td>• Ethinyl estradiol-norgestrel</td>
</tr>
<tr>
<td></td>
<td>• Etonogestrel</td>
</tr>
<tr>
<td></td>
<td>• Levonorgestrel</td>
</tr>
<tr>
<td></td>
<td>• Medroxyprogesterone</td>
</tr>
<tr>
<td></td>
<td>• Mestranol-norethindrone</td>
</tr>
<tr>
<td></td>
<td>• Norethindrone</td>
</tr>
<tr>
<td><strong>Diaphragm</strong></td>
<td>• Diaphragm</td>
</tr>
<tr>
<td><strong>Spermicide</strong></td>
<td>• Nonoxynol 9</td>
</tr>
<tr>
<td></td>
<td>•</td>
</tr>
<tr>
<td></td>
<td>•</td>
</tr>
<tr>
<td><strong>Meglitinides</strong></td>
<td>• Nateglinide</td>
</tr>
<tr>
<td></td>
<td>• Repaglinide</td>
</tr>
<tr>
<td><strong>Glucagon-like peptide-1 (GLP1) agonists</strong></td>
<td>• Dulaglutide</td>
</tr>
<tr>
<td></td>
<td>• Exenatide</td>
</tr>
<tr>
<td><strong>Sodium glucose cotransporter 2 (SGLT2) inhibitor</strong></td>
<td>• Canagliflozin</td>
</tr>
<tr>
<td></td>
<td>• Dapagliflozin</td>
</tr>
<tr>
<td></td>
<td>• Empagliflozin</td>
</tr>
<tr>
<td><strong>Sulfonylureas</strong></td>
<td>• Chlorpropamide</td>
</tr>
<tr>
<td></td>
<td>• Glimepiride</td>
</tr>
<tr>
<td></td>
<td>• Glipizide</td>
</tr>
<tr>
<td></td>
<td>• Glyburide</td>
</tr>
<tr>
<td></td>
<td>• Tolazamide</td>
</tr>
<tr>
<td></td>
<td>• Tolbutamide</td>
</tr>
<tr>
<td><strong>Thiazolidinediones</strong></td>
<td>• Pioglitazone</td>
</tr>
<tr>
<td></td>
<td>• Rosiglitazone</td>
</tr>
<tr>
<td><strong>Dipeptidyl peptidase-4 (DPP-4) inhibitors</strong></td>
<td>• Alogliptin</td>
</tr>
<tr>
<td></td>
<td>• Linagliptin</td>
</tr>
<tr>
<td></td>
<td>• Saxagliptin</td>
</tr>
<tr>
<td></td>
<td>• Sitagliptin</td>
</tr>
</tbody>
</table>

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

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

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

**DATA SOURCE:** Claims and pharmacy data

**CALCULATION FORMULA:** Number of paid claims/total linked eligible members.

**PAYMENT FREQUENCY:** This is an exploratory measure; there is no payment for 2020.

**PROVIDER PORTAL:** The portal provides a list of linked members who, according to our records may or may not have received chlamydia screenings and their screening date.
PCPs can submit chlamydia screening data from their Electronic Health Records (EHR) and paper charts via the Data Submission Tool. Log on to your Provider Portal account - Data Submissions - Data Submission Tool Guide to assist you through your submission steps and validation.

If you do not have a Provider Portal account, 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:
Chlamydia Screening Tip Sheet

CODE SET:
Chlamydia Screening Inclusion Codes
Contraceptive Eligible Population NDC Codes
Exclusion Codes
Exclusion Retinoid Medications NDC Codes
Eligible Population Codes
Hospice Exclusion Codes
CONTROLLING HIGH BLOOD PRESSURE

High blood pressure or hypertension is known as the “silent killer.” Hypertension increases the risk of heart disease and stroke, which are the leading causes of death in the United States. 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 BP 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: 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: 18–85 years old as of December 31 of the measurement year

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

Eligible Member Event/Diagnosis: Members who had at least 2 visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year. Visit type needs to be the same for the two visits. Includes outpatient visits and one telehealth visit.

Exclusions:

- Administrative Members at end of the measurement period
- Dual Coverage Members
- Members enrolled in Hospice services during the rolling 12-month measurement period
- Members 81 years of age and older as of the end of the measurement year with frailty during the measurement year.
- Members 66 years of age and older as of the end of the measurement year with frailty and advanced illness. To identify members with 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, nonacute inpatient encounters, or nonacute inpatient discharges on different dates of service, with an advanced illness diagnosis (diagnosis must be on the discharge claim). Visit type need not be the same for the two visits.
  - At least one acute inpatient encounter with an advanced illness diagnosis on the discharge claim.
  - A dispensed dementia medication
TABLE: DEMENTIA MEDICATIONS

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PRESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholinesterase inhibitors</td>
<td>• Donepezil</td>
</tr>
<tr>
<td></td>
<td>• Galantamine</td>
</tr>
<tr>
<td></td>
<td>• Rivastigmine</td>
</tr>
<tr>
<td>Miscellaneous central nervous system agents</td>
<td>• Memantine</td>
</tr>
</tbody>
</table>

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

**NUMERATOR:** Most recent BP reading taken during an outpatient visit, nonacute inpatient visit, or remote blood pressure monitoring event.

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

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

**CALCULATION FORMULA:** Number of paid claims/total linked eligible members.

**PAYMENT FREQUENCY:** This is an exploratory measure; there is no payment for 2020.

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

**RESOURCES:**
[Controlling High Blood Pressure Tip Sheet](#)

**REFERENCES:**

**CODE SET:**
[Blood Pressure Inclusion Codes](#)
[Blood Pressure Exclusion Codes](#)
[Hospice Exclusion Codes](#)
[Dementia Medication Exclusion Codes](#)
IMMUNIZATIONS: ADULTS

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

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

Members 19 years of age or older should receive all of the following vaccines:
- Influenza
- Tetanus, diphtheria toxoids and acellular pertussis (Tdap)

Members 50 years of age or older:
- Zoster

MEMBER REQUIREMENT: PCP must have 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: 19 years or older as of December 31 of the measurement year

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

Exclusions:
- Administrative Members at end of the measurement period
- Dual Coverage Members
- Members enrolled in Hospice services during the rolling 12-month measurement period
- Active chemotherapy any time during the measurement period.
- Bone marrow transplant any time during the Measurement Period.
- History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia and HB-S disease or cerebrospinal fluid leaks any time during the member’s history through the end of the Measurement Period.
- In hospice or using hospice services during the Measurement Period.

DENOMINATOR: Eligible population as defined above.
NUMERATOR: Immunizations completed by 19 years of age or older:

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

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

DATA SOURCE: Claims, Data Submission Tool

CALCULATION FORMULA: Number of paid claims/total linked eligible members.

PAYMENT FREQUENCY: This is an exploratory measure; there is no payment for 2020.

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:
- Immunizations: Adults Tip Sheet
- CAIR Immunization Registry - http://cairweb.org/
- RIDE (Healthy Futures) Immunization Registry - http://www.myhealthyfutures.org/
- California Immunization Coalition

CODE SET:
- Adult immunization Inclusion Codes
- Adult Immunization Exclusion Codes
- Hospice Exclusion Codes
MEMBER SATISFACTION

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician & Group (CG) Survey (CG – CAHPS) is a member satisfaction survey that assesses patients’ experiences with their health care provider and staff in the doctors’ office. The survey was created by the Agency for Healthcare Research and Quality (AHRQ) and the National Committee for Quality Assurance (NCQA), and was administered by SPH Analytics (SPH) for Central California Alliance for Health. The survey includes standardized questions for adults and children. The child survey is completed by the parents or guardians of members under the age of 18 years old. The surveys are offered in English and Spanish, depending on the members’ language preference. Survey results can be used by primary care practices to identify their strengths and weaknesses and help develop strategies for improving patients’ experiences with care delivered in their offices.

MEASURE DESCRIPTION: Member satisfaction survey results for linked PCPs as they relate to two composite categories:

- Getting Timely Appointments, Care, and Information
- How Well Providers Communicate with Patients

MEMBER REQUIREMENT: Only Tax IDs with claims from more than 333 unique households.

ELIGIBLE POPULATION:

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

Age: N/A

Continuous Enrollment: Active member for 30 days during the survey period

Eligible Member Event/Diagnosis: Members with one or more visits in the calendar year are eligible to be surveyed. Active member during the survey period.

Exclusions:

- Administrative Members on Date of Service
- Members without a visit

DENOMINATOR: Eligible population as defined above.

NUMERATOR: Most recent member satisfaction survey results collected by mail and phone follow-up.

SERVICING PCP SITE REQUIREMENTS: Credit is given to the linked PCP on the date of service.

DATA SOURCE: SPH Analytics
**CALCULATION FORMULA:** Number of respondents answering with “always/usually” to composite category questions/total number of respondents.

**PAYMENT FREQUENCY:** This is an exploratory measure; there is no payment for 2020.

**RESOURCES:**
- Member Satisfaction Tip Sheet
- Member Satisfaction Tool Kit

**CODE SET:** N/A
**Fee-for-Service Measures**

Fee-for-Service (FFS) Measures provide a single payment incentive to PCP sites. All 2020 measures require providers to submit a form to the Alliance attesting the completion of certification to receive CBI incentive payment. FFS incentives are paid on a quarterly basis, at the end of the quarter in which the attestation form was received, as long as the date of service was within the calendar year. There is no rate calculation for FFS measures; PCP Sites are paid each time a qualifying service is performed.

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

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

MEASURE DESCRIPTION: CBI Groups who have achieved Patient Centered Medical Home (PCMH) behavioral health integration recognition.

MEMBER REQUIREMENT: N/A

ELIGIBLE POPULATION:

- Membership: N/A
- Ages: N/A
- Continuous Enrollment: N/A
- Eligible Member Event/Diagnosis: N/A

EXCLUSIONS: N/A

SERVICING PCP SITE REQUIREMENTS: N/A

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

Note: Providers that achieve PCMH recognition through TJC certification shall receive reimbursement under this measure without providing additional documentation to Plan as behavioral health integration is included in TJC PCMH certification.

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

DATA SOURCE: Receipt of behavioral health certification or email of completion from NCQA.

RESOURCES:
Contact your Provider Relations Representative for instructions on submitting behavioral health integration certification.

CODE SET LINKS: N/A
BUPRENORPHINE LICENSE (X-LICENSE WAIVER)

Buprenorphine is a medication-assisted treatment drug for people diagnosed with opioid use disorder. In order to prescribe or dispense buprenorphine, physicians must qualify for a physician waiver, which includes completing the required training and applying for the physician waiver.

**MEASURE DESCRIPTION:** This measure is intended to provide compensation for the amount of time spent in training and the cost of the X-License certification with the goal of expanding our provider network for medication-assisted treatment therapy.

**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 per provider, which includes mid-level Providers, for the obtaining an X License through the DEA. Plan shall pay for each CBI group that the clinician practices under. Mid-level providers must be practicing under a supervising PCP physician with an X-Licensure to be eligible for incentive payment.

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

**DATA SOURCE:** Receipt of X-License Waiver certification with license number included.

**RESOURCES:**

Contact your Provider Relations Representative for instructions on submitting X-License Waiver Certification and X-License number.

**CODE SET LINKS:** N/A
PATIENT CENTERED MEDICAL HOME (PCMH) RECOGNITION

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

MEASURE DESCRIPTION: PCP Sites who receive NCQA or The Joint Commission (TJC) documentation validating achievement of Patient Centered Medical Home (PCMH) recognition will receive incentive payment. PCMH recognition payment is made per NCQA/TJC application that results in PCMH recognition, 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
  - $2,500 (The Joint Commission) TJC PCMH recognition

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

DATA SOURCE: Receipt of NCQA or TJC documentation of achievement

RESOURCES: Contact your Provider Relations Representative for instructions on submitting PCMH recognition documentation.

CODE SET LINKS: N/A
KEY TERMS AND DEFINITIONS

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

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

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

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

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

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

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

- Eligible Population criteria for Care Coordination measures and Fee-for-Service incentives are Alliance-defined.
- Eligible Population criteria for Quality of Care measure are based on the HEDIS 2020 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, will not be included in rate calculations. Members with Dual Coverage are excluded from all CBI measures.
HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS): Is a tool developed by the National Committee for Quality Assurance (NCQA), and is used by health plans across United States to measure performance on important dimensions of healthcare and services. HEDIS is a compliance audit period that is monitored by Health Services Advisory Group (HSAG) to ensure accurate, reliable measure performance that is publicly reported across health plans. Several of the CBI measures are also HEDIS measures. As a result, CBI performance can impact provider’s HEDIS performance and vice versa.

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

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

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

- Ambulatory Care Sensitive Admissions
- 30 Day Readmissions
- Preventable Emergency Visits

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

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

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

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

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