CREATING HEALTHCARE SOLUTIONS

2019 Care-Based Incentive (CBI) Program

Frequently Asked Questions

1. **How will the Alliance check for the Staying Healthy Assessment (SHA) forms?**

   The Staying Healthy Assessment (SHA) form is a component of the Initial Health Assessment and a requirement by the Department of Health Care Services (DHCS). All provider sites are audited to ensure SHA completion is occurring during the routine Medical Record Reviews (MRR). Providers have access to the Staying Healthy Assessment forms on the DHCS website.

2. **If patients decline the Initial Health Assessment (IHA), should providers let the Alliance know? Are there any codes providers should use?**

   The Alliance has implemented the IHA Dummy Code combination to allow providers to report when they've attempted to schedule a member **at least** three times for their IHA appointment. Members will be compliant for an IHA if the provider has documented the following 3 unsuccessful scheduling attempts with documentation of attempts in the medical record.

   - 2 telephone attempts
   - 1 written attempt

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

   For more information, please see the IHA Tip Sheet from the CBI Resources website.

3. **Where can providers access the Depressions Measurement tools?**

   There are a variety of depression measurement tools and providers can find that information in the CBI 2019 Depression Screening and Follow-Up tip sheet.

4. **In the past, providers used G Codes for depression screening, what has changed?**

   The National Committee for Quality Assurance (NCQA)'s strategic direction is to reduce the burden on the health plans, providers, and other entities involved by digitalizing measures like the HEDIS® Depression Screening and Follow-Up measure using LOINC direct reference codes. As such, last year's measure specifications changed from G codes to LOINC direct reference codes for the depression screening tools because the code identifies the presence of a "total score" for that particular tool and can be calculated more easily.

5. **Is there a tool providers should use for the Alcohol Misuse Screening and Counseling (AMSC) measure?**

   Providers are required to use a Medi-Cal approved screening instrument for the initial full screening (G0442):

   - The Alcohol Use Disorders Identification Test (AUDIT)
   - The abbreviated AUDIT-Consumption (AUDIT-C)

The brief intervention (G0443) 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 initial screening (G0442) or on subsequent days. Brief interventions may be offered in-person, by telephone, or by telehealth modalities. Check out all the resources on the CBI website.

6. **Can providers use PHQ-9's for the teenage population?**

   A PHQ-9 is acceptable for the teenage population. Please see the Depression Screening and Follow-Up Tip Sheet for a complete list of depression screening tools for adolescent and adult populations.

7. **Is it acceptable to do a PHQ-2 then a PHQ-9?**

   Yes, it's clinically accepted to perform the expanded PHQ-9 following a positive screening from the PHQ-2.

8. **Regarding the adolescent immunizations, if the member is one day past their 13th birthday, will the member show as compliant?**

   No. We follow the NCQA HEDIS® methodology which states, the immunizations need to be completed by the member's 13th birthday.

9. **If providers screened a member for Cervical Cancer Screening but didn't use the Q code, can the provider go back and submit this information and if so, how?**

   A provider is capable of resubmitting a claim using billing code Q0091. While the Alliance does encourage providers to submit a claim using code Q0091, the Alliance also receives lab claims that may be captured when a cervical cancer screening was performed. If a provider does not want to rely on lab claims, please bill using Q0091. It is recommended that providers check the member's status in the portal before taking time to resubmit any claims.

10. **What should providers do if a member's name comes up on a list but the member already received the service?**

    Providers who are accessing the CBI Reports must know that this is archived data and does not update routinely as services are completed. Providers are encouraged to download the Quarterly and Monthly reports under the Quality Report tab on the portal for more up to date information on certain Quality of Care measures. Please allow 60 – 90 days for claims lag.

11. **What is the Nurse Advice Line (NAL) and how can providers remind members to access the NAL?**

    The Nurse Advice Line (NAL) is a free and easy way for Alliance members to discuss health problems with a registered nurse in a one-on-one conversation. The NAL is available 24 hours a day and seven days a week. The Alliance also encourages members to call the NAL to help them decide when to see a doctor and what do to if symptoms worsen. Research has shown that patients who call the NAL are less likely to go to the Emergency Department (ED). The Alliance has NAL resources available in the form of business cards, post cards, and magnets. Please contact your Provider Relations Representative for materials at (800) 700-3874 ext. 5504. The Nurse Advice Line number is: 1 (844) 971-8907.

12. **What are the recommended best practices to keep members from using the Emergency Department (ED)?**

    Research has shown that patients who call the Nurse Advice Line (NAL) are less likely to go to the ED, so the Alliance encourages providers to emphasis the importance of using the NAL to members. Some clinics add the NAL to their phone tree so when alliance members call in after hours, they can be routed to the NAL to speak to a RN. Others have used extended

Office Hours to help open access to members. Another tip would be to include NAL information in the member's after-visit summary.

Providers can use the Provider Portal to monitor the Linked Member ED Visits Report, which is a list of linked members who, according to our records, have been recently seen at the ED. This list is based on eCensus data, and does not represent a complete listing of ED visits made by your members and may include members who have not yet been seen in your office, but who are linked to your practice. We recommend cross-referencing this list with your own health records system before contacting members. The Alliance also has a Care Management team that assists members with coordination of care and education.

13. **Some hospitals' data under the ED Visit and Inpatient linked lists in the Portal are not showing. Why is that?**

    The Alliance uses eCensus to capture the ED and Inpatient visits. Hospitals must participate and use eCensus in order for the Alliance to capture the data.

14. **What are best practices around tracking members' HbA1c levels?**

    The Alliance receives A1c values through laboratory files and the data submission tool which can be tracked through either the quarterly Diabetes Care Report which will show all of the relevant diabetes metrics or just the HbA1c relevant information through the CBI Report's Measure Details. See the CBI Tip Sheet for more information.

15. **Can providers refer Diabetic members to the Alliance Care Management team?**

    Yes, the Alliance recommends that providers refer members who are non-compliant with their diabetic care, experiencing complications or repeat hospitalizations from diabetes to the Care Management team. The Alliance also offers the 'Live Better with Diabetes Program' where Alliance staff will refer members to approved clinical diabetes management education providers. Please see more information on the Alliance webpage about Care Management or the Health Education and Disease Management Programs.

16. **How does a provider sign up for the eConsult measure?**

    Providers will need to individually sign up with each eConsult vendor that they are interested in. If there are any questions regarding the upcoming April DHCS policy on telemedicine, please contact your Provider Relations Representative for more information.

17. **How does eConsult work, and how does the eConsult get documented for credit?**

    The linked PCP requesting the eConsult from an Alliance contracted vendor will receive $20 per eligible member's referral. Providers will need to contact the vendor directly to determine which organization(s) best fit their needs. If there's a particular local specialist that you work with, you can encourage them to sign up with one of the eConsult vendors. In April 2019, all eConsult Vendors will also need their providers to have a license in the state of California and enrolled as a Medi-Cal provider. For more information, please visit the Alliance's eConsult web page, email telehealth@ccah-alliance.org, or contact your Provider Relations Representative at (800) 700- 3874 ext. 5504. The Alliance will receive documentation from the contract eConsult vendor.

18. **Will there be a new measure in 2020 to incentivize providers who offer Urgent Care Access to non-linked members?**

    Currently, there is nothing planned to incentivize providers who offer urgent visit access to non-linked members. To reduce unnecessary visits to the emergency department, the Alliance is expanding the urgent visit resources and removing previous referral requirements. For the Preventable Emergency Visits measure, both preventable ED and urgent visit are counted against the PCP, but we encourage members to always contact their PCP first for a

walk-in appointment with the goal to help providers strengthen the PCP/member relationship. If the PCP cannot see the member, the member should be given the Alliance's NAL phone number who can provide medical advice and referral.

19. **You mentioned a possible provisionary CBI measure in 2020 to address Member Satisfaction. Is this a measure the Alliance can assist providers with such as providing template scripts we can share with staff? Will the Alliance offer provider trainings on how to implement these scripts to PCP offices?**

    There is an Alliance workgroup developing the resources now. Providers will be notified of new or updated resources.

20. **What codes are used for the various measures and what are the exclusions for each measure?**

    Each measure will have the corresponding codes and exclusion lists under Code Set links found in the CBI 2019 Technical Specifications on the CBI Resources website.

21. **What is a rolling 12-month measurement period?**

    The rates for each quarter are calculated using a rolling 12 month measurement period. Therefore, each quarter contains 12 months of data. For example: Quarter 1 (Q1) contains data from Q3 of the prior year through Q1 of the current year (Q3 2018 to Q1 2019). In Q4, when programmatic payments are made, the report will contain data for the calendar year, January – December. Different measures use different time frames. Refer to the Technical Specifications for more information.

22. **Are providers only compared to specific provider types in the specific practicing county?**

    No. Care Coordination measures are based on the degree to which a provider meets or exceeds comparison group's prior year median score. There are three comparison groups: Family Medicine, Internal Medicine, and Pediatrics. The comparison groups include contracted Primary Care Providers in all three counties. Quality of Care measures are based on national benchmarks (HEDIS Medicaid Median Score).

23. **If providers maintain excellent performance, will the practice receive points on Performance Improvement?**

    Providers will receive Performance Improvement incentives for either maintaining a high level of performance (above the established Plan Goal) or for improving their score by 5% or five percentile points over the prior year. For example, if a provider receives a 42% rate for Well Child Visits last year and a rate of 48% in the current CBI measurement year, this provider will receive performance improvement points for improving their rate by at least 5%. New measures and 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:

    - Depression Screening and Follow-Up
    - Immunizations: Adolescents

24. **Do you have a report on high utilizers?**

    There is a monthly report on high ED utilizers that can be made available upon request (please e-mail: CBI@ccah-alliance.org). The goal for 2019 is to move the high ED utilizer report to the provider portal.

25. **Are reminders going out to members on services due from the Alliance?**

    The Alliance's Health Programs Department has recently started working on member education for Tdap, Flu, and Childhood Immunization screenings. Based on need, there have been ad hoc educational mailings for immunization, diabetes, and prenatal information, focused articles in the member bulletin, and call campaigns to increase diabetes screening rates. A broader campaign to address United States Preventive Services Task Force (USPSTF) recommendations is currently under review.

26. **How do members receive their incentive gift cards?**

    Member incentives can be earned when providers submit claims data or forms. Awards are in the form of gift cards and are paid directly to the member on a monthly or quarterly basis depending upon the incentive type. Member Incentives are intended to increase member compliance with disease management and PCP appointments, improve healthy behavior and improve education on appropriate ED utilization.

27. **Do you have a report on members assigned to the Alliance case managers?**

    The Alliance is currently working on a report that will describe whether a member is enrolled in or referred to care management.

28. **I cannot remember all the members I reassigned this year. Is Member Reassignment tracked in the Portal?**

    Yes, the provider portal has a report under CBI Measure Details that includes a list of member reassignments for your practice.

29. **Does the Alliance keep track of the Member Reassignments and will providers be alerted when reaching the threshold?**

    The Alliance tracks all Member Reassignments, but will not reach out to providers when approaching the threshold. Every quarter, providers will be notified of the Member Reassignment threshold on practice profiles as well as on the provider portal reports under CBI Measure Details: Measure Category of Performance of Target Measures. Keep in mind, if a provider has 150 members or less, only one member reassignment is allowed for the entire year unless the member meets one of the exclusions. Please contact your Provider Relations Representative for more information.

30. **Can clinics that use paper charts submit data on the provider portal?**

    You do not have to be on an EHR to submit data on the provider portal. You can submit data from a paper chart by selecting non-standard data in the submission tool. For a complete step-by-step guide please use the Data Submission Tool Guide located under Data Submissions on the Provider Portal.

31. **Where can providers find measure specific CBI tip sheets for the office?**

    Providers have access to all CBI tip sheets on the Central California Alliance for Health (CCAH) provider website under the 2019 Care-Based Incentives Resources. Providers can also reach out to the Provider Relations Representatives for further information.

32. **What are some best practices for using the Provider Portal?**

    The Alliance encourages providers to regularly download and compare the provider portal reports to see the members who may be indicated for preventative health services, compare cumulative summaries and detail information on your clinic's CBI performance, as well as submit supplemental information for:

- Alcohol Misuse Screening and Counseling (AMSC)
- Monitoring for Member on Persistent Medications
- Cervical Cancer Screenings
- Depression Screenings
- HbA1c Results
- Immunizations
- Initial Health Assessments (Coming Soon in 2019)

Contact your Provider Relations Representative for an on-site Provider Portal training.