2021 Care-Based Incentives (CBI) Workshop

Frequenty Asked Questions (FAQ)

1) **Will there be any changes to CBI this year due to COVID-19?**
Proposed changes have been brought to our Physician Advisory Group (PAG) in September, addressing two changes for the CBI 2020 Program. The first proposed change is to include Telehealth Visits for Well-Child Visits, and the second proposed change is to align with the Department of Health Care Services (DHCS) policy change for the temporary suspension of the 120-day requirement for the IHA visit during the public health emergency. For IHA, we would provide full points to any CBI group that had 5 eligible members in their denominator population, however for the performance improvement measure for IHA, the CBI group would still need to meet the 5% improvement or Plan Goal in order to receive those performance improvement points for the IHA measure.

2) **How will the Alliance compensate for the members who do not want to have an on-site visit due to Covid-19? Even with encouragement, patients are reluctant.**
Since the shelter in place orders, the Alliance has seen a drop-in visitation rates across the provider network. The current programmatic payment structure for CBI is based on your total CBI points compared to your peer group. With overall lower rates across peer group, the payments should normalize to the lower peer rate.

3) **How is the TB Risk Assessment tracked? We have a risk assessment built into preventive exams but the assessment is not reported to the Alliance. Is there a CPT code we should be adding or is the diagnosis Z11.1 enough for you to capture this?**
The TB Risk Assessment measure will be tracked using the ICD-10 diagnosis code Z11.1 attached to an office visit claim.

4) **We have used the purified protein derivative (PPD) skin test in the past. Should we use PPD or QuantiFERON (QFT), and how will you count the PPD reading?**
The Tuberculosis (TB) Risk Assessment measure will be only be looking for members 12 months to 21 years who have been screened for latent tuberculosis infection (LTBI) risk factors by staff at the PCP office during the measurement year using the ICD-10 Code Z11.1, encounter for screening for respiratory tuberculosis. If a member is screened positive using the risk assessment tool, the clinic can decide which testing methodology to use in compliance with current clinical guidelines.

5) **Do voice only phone calls count as Synchronous Telehealth visits?**
Yes, voice only phone call count as synchronous telehealth visits. For additional information on required telehealth modifier and telehealth Place of Service codes, please see the Alliance Provider Network Guidance on Telehealth Services.

6) **Does the alcohol screening have to be a full screening? For example, is the Audit C or questions answered on the Staying Healthy Assessment Form (SHA) form enough to qualify as performed?**

For members 18 years and older, the DHCS accepts the following validated screening tools:

- The Alcohol Use Disorders Identification Test (AUDIT);
- The abbreviated AUDIT-Consumption (AUDIT-C); and
- A single-question screening, such as asking, "How many times in the past year have you had 4 (for women and all adults older than 65 years) or 5 (for men) or more drinks in a day?" included in the SHA.

For adolescents, the AUDIT and AUDIT-C can be used in addition to the CRAFT tool recommended by Bright Futures/AAP, and CAGE allowable under the Health Resources & Services Administration (HRSA).

7) **Regarding Alcohol Screening: the tip sheet states patients 18 and over should be counseled if engaged in risky behavior. Since the measure is asking to screen ages 11 and up, should we also be counseling and using code G0443 for ages 11-17 if behavior is considered risky?**

If adolescents are screened positive for unhealthy alcohol use, they should be counseled by their PCP, however the HCPCS code G0443 is only billable for adults aged 18 years and older. The screening HCPCS code G0442 is billable for adolescents aged 11-17 years of age.

8) **For the Childhood Immunizations (Combo 10) Quality Report, there are no dates populated for the Pneumococcal (PCV) 1-4 columns, even for patients listed as compliant. Is this being fixed?**

The Provider Portal Quality Report for Childhood Immunization has an open ticket request to our IT staff to correct the missing PCV vaccine dates of service. An update will be made to the Provider Portal Home page when the report has been corrected.

9) **I understood that CHDP did not allow us to do Well-Child Care via Telemedicine. Has that changed? Does the billing place of service (POS) or the ICD-10 let Alliance know that we did a Well-Child Visits via telemedicine?**

Per DHCS previous guidance on Well-Child Care for CHDP, please see the below:
The routine well child preventive health assessment consist of a set of health screens, and are based on the age of the child. CHDP enrolled providers, at the time of enrollment, are informed/reminded of the recommended schedule of screens.

Due to the nature of the screens, some of the screens can only be performed in person.

Providers are encouraged to use their clinical judgement to determine which screens are appropriate for telephonic evaluation, then at a later date and when it is safe to do so, schedule an appointment for the child to receive the remaining screens in person. The comprehensive well child assessment must be completed at least annually for most ages. Services for which the provider receives reimbursement must be rendered and results documented in the child's medical record.

The vaccination administration also depends on the age of the child, the CHDP providers are required to be enrolled VFC providers, and at the time of enrollment and periodically thereafter, providers are informed/reminded of the recommended vaccination schedule by age.

Billers should refer to the provider to identify the services rendered and documented in the child's medical record by date. CHDP program questions may be referred to the local county CHDP program. The contact information for the local county CHDP program is available at the following link: https://www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx

In regards to CHDP services provided via telemedicine during the Public Health Emergency, please see DHCS's previously published guidance: https://www.dhcs.ca.gov/services/chdp/Pages/ProgramOverview.aspx

Enrolling Providers can utilize telephonic signatures for CHDP Gateway Applications, noting in the case file "COVID-19 protocol." If the individual is not at the provider's office and not experiencing an urgent health event which requires immediate care, providers should suggest to the individual to apply online using the Covered CA portal to establish ongoing eligibility for Medi-Cal or Covered California. Providers may also obtain an Authorized Representative form for the CHDP Gateway applicant, allowing an individual acting on behalf of the applicant, to provide the required information to assist with the enrollment of the individual in CHDP Gateway coverage, thereby minimizing direct contact with the individual and promoting physical distancing.

In order to accept a telephonic signature, the following procedure must be followed:

1. Read the consent language aloud to the individual/Authorized Representative as it is stated on the signature page of the CHDP Gateway Application:
    - I have read and understood this CHDP Medi-Cal Application.
    - The information I provided is true, correct, and complete.
    - I understand that I must complete and submit the insurance affordability application by the end of my CHDP Gateway PE period in order to be eligible for continued coverage.
    - I have received the insurance affordability application.
2. Ask that the individual/Authorized Representative verbally acknowledge their consent
3. In the signature line, type "Verbal consent – COVID-19"
4. Be sure to document and keep documentation for all verbal consent obtained.

As a general guidelines for Medi-Cal, a telehealth visit using the telehealth modifier and telehealth Place of Service code. Existing face-to-face codes apply when a Medi-Cal provider/clinician is billing the Alliance for video/ telephonic visits.

The CPT or HCPCS code(s) must be billed using:

- Place of Service (POS) Code "02"
- Use the appropriate telehealth modifiers:
  - **Synchronous**, interactive audio and telecommunications systems: Modifier 95
  - **Asynchronous** store and forward telecommunications systems: Modifier GQ

For additional information, please contact your Provider Relations Representative.