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Section L: Quality Management

L1: Quality Improvement System

CenCal Health is firmly committed to the delivery of quality healthcare services to its membership. The purpose of CenCal Health's Quality Improvement System is to define a process to continuously improve the quality of care, quality of service, patient safety, and member experience provided by CenCal Health and/or its contracted provider network. This includes actions to monitor, evaluate, and take effective and timely action to address any needed improvements in the quality of care delivered by CenCal Health providers rendering services in any setting. The QI process is described in detail below:

- Define the scope of quality of care, quality of service, patient safety, and patient experience.
- Establish staff accountability for monitoring and evaluating quality improvement activities.
- Use measurable indicators to systematically monitor aspects of care, service, safety and patient experience, based on current and proven industry-standard methodologies.
- Identify comparable benchmarks and/or thresholds and goals for monitoring of meaningful, industry-standard, performance indicators.
- Sustain quality of care and service when benchmarks and/or goals are achieved, or identify opportunities to improve when measurements fall outside thresholds.

- Evaluate barriers that are directly associated with continued improvement, and assess the potential for CenCal Health to mitigate each barrier and resolve identified problems.
- Based on identified barriers, design relevant, strong and timely interventions and take action to correct identified barriers.
- Systematically evaluate the effectiveness of those actions using relevant and reliable measurements.
- Communicate results to the appropriate committees and stakeholders, including but not limited to CenCal Health's Board of Directors.
- At appropriate intervals re-evaluate performance using comparable measurements; assess performance relative to benchmarks and goals; and identify remaining barriers, if any. Based on findings implement new and/or improved interventions as necessary.

The following organizational chart illustrates the structure of CenCal Health's Quality Improvement System, comprised of committees staffed by key contracted practitioners and CenCal Health employees:

To assure appropriate resource allocation to support the quality function, an organization-wide Quality Program Work Plan and Assessment are developed annually in congruence with CenCal Health's Quality Program and CenCal Health's Strategic Plan. An annual assessment is undertaken to systematically evaluate progress made toward the work plan of the prior year. The assessment assures CenCal Health systematically identifies areas of success and opportunities for improvement in the coming year. Those identified opportunities are used to plan new activities, or refine existing ones, and prospectively refine the Quality Improvement System. The Work Plan serves as a roadmap of specific quality improvement objectives and it establishes staff accountability for key activities in the coming year. To assure successful performance of the Quality Improvement System, with the annual development of CenCal Health's Quality Program Work Plan, CenCal Health's leadership sets appropriate goals and objectives for staff.

For additional information, please reference the CenCal Health Quality Program.

L2: Quality of Care (QOC) Review Process

CenCal Health is committed to ensuring our members receive appropriate medical care and services. CenCal Health has a process to identify and investigate potential quality of care issues (PQOC) and initiate corrective action when appropriate. This helps to continually improve the quality of care delivered to our members.

While PQOC sources include but are not limited to:

- Calls from members, which are the most significant source of complaints. Members can contact our toll free number (877) 814-1861 or can submit a complaint in person or in writing.
- CenCal Health's contracted providers, community agencies/liaisons (CCS, APS, hospital case managers) may submit potential quality of care concerns to populationhealth@cencalhealth.org.
- Any of CenCal Health's staff may identify PQOCs and submit them to populationhealth@cencalhealth.org.

Review Process: The assigned QOC review nurse or designee will determine whether the complaint includes any clinical component, and if so initiates a review as follows:

- Relevant medical records are obtained including provider chart notes, ED records, Pharmacy Profile, and a response from the provider when appropriate.
- Additional review or a focused site survey may be required if the medical records, pharmacy, or claims profiles are insufficient to answer all clinical issues or concerns.
- CenCal Health's Medical Director/Physician Designee determines if the clinical care met medical standards or was a deviation from standard of care, according to established evidence-based clinical guidelines or community standards. The Medical Director will consult with expert clinical specialists if applicable.
- If a deviation from standard of care is suspected, the Medical Director/Physician Designee will discuss the concern directly with the physician involved or request their written input. Formal provider interaction is undertaken to complete the investigation and assure due process.
- The Medical Director may forward quality of care issues to the Peer Review Committee for additional review and determination.
- Opportunities for improvement of care will be shared with the provider and may include a formal corrective action plan that is appropriately customized to the level of significance of the clinical concern.
- In some instances, ongoing monitoring of providers may be required to assure that clinical practices continue to meet standards of care.
- All medical record documentation, investigations, outcomes or allegations are held strictly confidential by CenCal Health. No portion of the information related to the investigation is shared with anyone not authorized to review the information.

L3: Quality Performance Reporting

Contracted Providers are required to participate in CenCal Health's quality improvement activities as appropriate. Such activities include but are not limited to those set forth in CenCal Health's Quality Program, including utilization management programs, Managed Care Accountability Set, Performance Improvement Projects (PIPs), or other quality improvement measures, policies, or processes.

Providers receive information relating to CenCal Health's quality of care through methods including but not limited to summaries and/or announcements in provider bulletins, site visit reports, and presentation of results to providers that participate on committees that comprise CenCal Health's quality committee structure.

Members receive information through methods including but not limited to summaries and/or announcements in member bulletins and on CenCal Health's website.

L4: Gaps in Care Program

CenCal Health's Gaps in Care Program serves to identify members who are due for clinically recommended aspects of care, to further assist PCPs in providing comprehensive high quality healthcare for members. This information is distributed through Provider Quality of Care Performance reports and Gaps in Care information.

Quality of Care categories and measures are systematically identified for inclusion in the program and are evaluated on an annual basis. As priorities regarding these criteria change, CenCal Health may update these categories and measures. Generally, measures remain in the Gaps in Care program for at least 2 years.

Provider Quality of Care Performance Reports & Gaps in Care Member Information

Quality of Care Performance Reports as well as Gaps in Care member information is available on the Coordination of Care section of the Provider Portal. Reports reflect data received for services rendered through the last day of the prior month.

The Provider Quality of Care Performance Reports show individualized quality scoring for each PCP.

Gaps in Care member information includes member level detail so PCPs may easily contact members to encourage them to receive important aspects of care.

For more information regarding the Gaps in Care Program, please reference the CenCal Health website at cencalhealth.org/providers/quality-of-care/gaps-in-care/.

L5: Performance Monitoring

To continually evaluate and improve the quality of care provided to CenCal Health's members, CenCal Health consistently monitors aspects of care prioritized by the Centers for Medicare & Medicaid Services (CMS). CenCal Health shares CMS' objective to collect, report, and use a standardized set of measures to drive improvement in Medicaid quality of care. The Healthcare Effectiveness Data & Information Set or "HEDIS" is one of the primary tools endorsed by the CMS and used by CenCal Health to measure the quality of healthcare provided to our members. Developed by the National Committee for Quality Assurance (NCQA), HEDIS provides a standardized methodology that is used nationally by health plans and regulators to evaluate important aspects of care.

CenCal Health begins its quality of care reviews every year in January, which includes several steps performed in strict accordance with HEDIS or other CMS quality measurement requirements. These steps include:

- Identification of members who qualify for inclusion in the measures. Members may be included based on their continuity of Medi-Cal eligibility, age, gender, medications, or diagnosis.
- Selection of a statistically significant sample of qualifying members for some measures. Sampling is not an option for many measures.
- Identification of members who have proof of evidence-based, clinically-recommended services, through claims and/or other data sources. These sources may include the California Immunization Registry (CAIR), and clinical results submitted by many of CenCal Health's largest laboratories.
- Any member who does not have proof of services rendered will require medical record review at one or more provider offices, if supplemental medical record review is an option. Annually, CenCal Health's medical record reviews take place from February through May. CenCal Health makes every effort to accomplish this task in the least intrusive manner possible.
- Reporting of quality of care findings for the Santa Barbara Medi-Cal and San Luis Obispo Medi-Cal programs is submitted in June of

each year to the California Department of Health Care Services, and the National Committee for Quality Assurance (NCQA).

Remote medical record review via secure connection to providers Electronic Medical Record (EMR) systems is CenCal Health's preferred method to collect information from medical record sources. Alternatively, CenCal Health may accept additional data sources that reduce the burden to providers to accommodate medical record review, including EMR data submissions. If you have questions about either of these options to provide medical documentation, please contact CenCal Health's Quality Measurement Department at (805) 562-1609.

Because of the excellent healthcare afforded to our members by CenCal Health's providers, and consistently exceptional quality of care results, CenCal Health has been recognized as a leading managed care organization in California.

L6: Performance Improvement Projects (PIPs)

PIPs are rapid cycle quality improvement projects used to improve healthcare outcomes and process improvements over an 18-month period. These projects are required by the Department of Healthcare Services and must be reported to their designated External Quality Review Organization (EQRO). Performance improvement projects must be designed to achieve significant improvement in clinical or non-clinical areas of care expected to have a favorable effect on health outcomes and member satisfaction.

L7: Initial Health Assessment Incentive Program

In order to encourage new members to become involved in their healthcare, CenCal Health informs new members that an Initial Health Assessment (IHA) is a covered benefit and instructs them to call their PCP for an appointment. The PCP's obligation is to attempt to schedule and provide an IHA within 120 calendar days from the date of program eligibility, unless the PCP determines that the member's medical record contains complete and current information to allow for assessment of the member's health status and health risk.

Program Components: An IHA visit should include the following components:

- A comprehensive physical and mental developmental health history
- A physical exam

- Oral health assessment and dental screening and referral for children
- Assessment of need for preventive screenings or services
- Identification of high-risk behaviors
- Health education and anticipatory guidance appropriate to age
- Diagnosis and plan for treatment of any disease
- "Staying Healthy Assessment" (SHA) questionnaire; SHA questionnaires and provider instructions can be found on the DHCS website

Data Sources: CenCal Health receives information regarding IHA's via claims data.

Reports: All provider notifications regarding members in need of an IHA is communicated through monthly reports that are updated on the Provider Portal.

Pay for Performance: Newly enrolled members must have completed an IHA within 120 calendar days of enrollment to the plan for the PCP to receive a $75 pay for performance incentive. CenCal Health conducts an annual focused medical record review of completed IHAs from our provider network, as required by DHCS on an annual basis.

Billing and Payment
PCPs should use the following CPT codes when billing for IHAs:

- Members less than 18 years of age:
  - New Patient: 99381-99384
  - Established Patient: 99391-99394

- Members 18 years and older:
  - New Patient: 99385-99387
  - Established Patient: 99395-99397

- Members who are Pregnant:
  - Z1032, 59400, 59510, 59610, 59618

Reference:
Staying Healthy Assessment (SHA) questionnaire
https://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

L8: Mandated Reporting of Provider Preventable Conditions (PPC)

Provider Preventable Conditions (PPCs) consist of health care-acquired conditions (HCAC) when they occur in acute inpatient hospital settings only and other provider-preventable conditions (OPPC) when they occur in any healthcare settings. HCACs are the same as hospital-acquired conditions (HAC) for Medicare, except that Medi-Cal does not require providers to report deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age.

Requirement Timelines

In March 2013, CenCal Health providers were notified that the Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services (CMS) to require providers to report Provider Preventable Conditions (PPCs). Federal legislation prohibits CenCal Health from paying for the treatment of PPCs, and payment adjustment may be applied. PPCs are divided into two categories: Other Provider Preventable Conditions (OPPCs) in all healthcare settings and health care-acquired conditions (HCACs) in inpatient acute care hospital settings only.

On March 30, 2016, CMS issued new PPC reporting requirements in rulemaking CMS-2390-F, in which CMS further defines OPPC's as conditions that 1) are identified by the State plan; 2) are reasonably preventable through the application of procedures supported by evidence-based guidelines; 3) have a negative consequence for the beneficiary; 4) are auditable, and 5) include, at a minimum, the procedures referenced below.

OPPCs are also known as "never events" and Serious Reportable Events under Medicare. For Medi-Cal, OPPCs are defined as follows: Providers must report the following three OPPCs when these occur in any healthcare setting. "Invasive procedure" refers to a surgical procedure.

- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Providers must report the occurrence of PPCs that are associated with claims for Medi-Cal payment or with courses of treatment prescribed to a CenCal Health beneficiary for which payment would otherwise be available. Providers do not need to report PPCs that existed prior to the initiation of treatment of the beneficiary by the provider. Reporting is required to evaluate whether the occurrence extended care and

determine whether CenCal Health can adjust any payment previously made. PPC reporting is mandated for Medi-Cal beneficiaries eligible through the State Medi-Cal Program under Fee-For-Service, as well as for members of CenCal Health..

Inpatient acute care hospitals and facilities are required to report OPPCs and HCACs for any CenCal Health member. To report a PPC, providers must:

- Login to the California Department of Health Care Services website to submit information for each provider-preventable condition, and;
- Send CenCal Health a copy of the PPC Report, via fax to (805) 681-3075. Generating this form is described within DHCS's Provider-Preventable Conditions page; the online portal allows providers to print their PPC Report after they submit the PPC Report to DHCS via the portal.

Providers must submit the form within five (5) days of discovering the event.

Please note: reporting PPC to CenCal Health, or DHCS, for any Medi-Cal beneficiary does not preclude the provider from reporting adverse events and healthcare associated infections (HAIs) to the California Department of Public Health for the same member.

Claims submitted for treatment of PPCs should also be identified on the claim form. For OPPCs, a modifier is required to be reported whereas HCACs must utilize diagnosis codes, and in some cases procedure codes, to indicate any Corresponding Complication (CC) or Major Complication or Co-morbidity (MCC) related to the PPC.

For any questions regarding this federally mandated DHCS reporting, please contact the Provider Services Department at (805) 562-1676, or Providers may email questions about PPCs to PPCHCAC@dhcs.ca.gov.

Provider Preventable Conditions

Other Provider Preventable Conditions *(OPPC)* – reportable in all healthcare settings; claims for OPPC must include the PPC modifiers as indicated in parentheses ().

Health Care-Acquired Conditions (HCAC) – reportable in inpatient acute care hospital settings only; claims for HCACs must include the Corresponding Complication (CC) or Co-Morbidity/Major Complication (MCC) ICD-10 diagnosis codes and/or procedure code; please refer to

the list of HCAC claim coding on our website in the Hospital Provider Obligations section of the Provider Manual under Section D, D3:

Providers need to report HCACs only when they occur in inpatient acute care hospitals.

HCACs:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Deep vein thrombosis/pulmonary embolism (excluding pregnant women and children under 21 years of age)
    - Total Knee Replacement
    - Hip Replacement
- Falls/trauma that result in the following:
    - Fracture
    - Dislocation
    - Intracranial injury
    - Crushing injury
    - Burn
      Other injuries
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
    - Diabetic ketoacidosis
    - Nonketotic hyperosmolar coma
    - Hypoglycemic coma
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity

- Stage III or IV pressure ulcers
- Surgical site infection
    - Mediastinitis following coronary artery bypass graft (CABG)
    - Surgical site infections following:
        - Bariatric surgery
            - Laparoscopic gastric bypass
            - Gastroenterostomy
            - Laparoscopic gastric restrictive surgery
        - Orthopedic procedures for spine, neck, shoulder, and elbow
    - Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection

Claim Reporting

HCAC must utilize diagnosis codes to indicate any Corresponding Complication (CC) or co-morbidity or major complication (MCC) related to the PPC. Federal legislation prohibits Medi- Cal payment for the treatment of PPC, and payment adjustment may be applied.

Please reference the CMS.gov website for a list of required diagnosis codes, and in some cases procedure codes that can be reported on a claim related to HCAC.

L9: Hospital Readmission Program

CenCal Health's Hospital Readmission Program is a PCP pay-for-performance program for members recently discharged from a hospital inpatient stay.

The primary goal of this program is to reduce 30-day inpatient hospital readmissions for CenCal Health members by ensuring timely completion of a post-discharge visit after an acute inpatient hospital stay.

Payment

A $100 incentive is paid to PCPs per qualified follow-up visit rendered within 5 business days after a hospital discharge.

Follow-Up Visits can be rendered and are payable to a PCP for his/her assigned members as well as for members that are not assigned to that PCP's practice. For those members that are not assigned, Referral Authorization Forms (RAFs) are not required for follow-up visits.

Appeal Process

CenCal Health acknowledges that the data received from acute care hospitals is not perfect. If any member is admitted as an inpatient and discharged from an acute hospital, but not reported to CenCal Health, providers may appeal to have completed Follow-Up Visit(s) considered for payment by contacting the Provider Services Department at (805) 562-1676. Provider appeals must be received for consideration within 180 days from the date of service of the Follow-Up Visit.

L10: PCP Incentive Program Protocols

Primary Care Provider (PCP) risk sharing has been an integral part of the Santa Barbara Health Initiative (SBHI) since inception of this managed Medi-Cal program. In 1997, CenCal Health (formerly the Santa Barbara Regional Health Authority) chose to adopt a methodology to compute financial incentives for utilization and quality management of its SBHI

program. The methodology changed from the long established risk-sharing concept, based upon PCP's prospects for shared surpluses generated through appropriate utilization management. Instead, the program utilizes a model in which the financial incentives are primarily based upon the PCP's utilization and quality performance relative to peers who share the same case mix, and incorporates criteria more indicative of quality of care. No specific payment is made directly or indirectly under CenCal Health's Incentive Programs to physicians or physician groups as an inducement to reduce or limit medically necessary covered services provided to an individual member. Beginning March 2008, all San Luis Obispo Health Initiative (SLOHI) program PCPs were incorporated into the existing PCP Incentive Program. Other characteristics of this methodology are that it:

- Includes timely incentive payments
- Allows for monthly status reporting
- Provides an adaptable framework to easily incorporate criteria
- Improves case mix risk adjustment techniques

Funding of the PCP Incentive Program

The total funds used for the PCP Incentive Program are based in part upon CenCal Health's historical payout under past trust account methodology. The funds are divided into two pools, one related to utilization and one related to quality. Each pool is based upon a percentage of the individual PCP's monthly guaranteed capitation rates for case managed SBHI and SLOHI members.

Funding for the program is obtained from the CenCal Health reserve funds and from the withhold contributed by all PCPs from the Guaranteed Payment. The Guaranteed Payment, as indicated in writing by the PCP ("selected percentage") is either eighty percent (80%) or sixty percent (60%) of the portion of the full Capitation rate allocated to primary care services and adjusted by eligibility category.

The Total Incentive Payments for all PCPs is approximately 57% of the total Guaranteed Payments paid to all PCPs during each calendar year. Of the approximately 57%, approximately 45% will fund the Utilization Pool and approximately 55% will fund the Quality Pool.

ALLOCATION OF POOLS

1. Utilization Pool The Utilization Pool is funded by 1) the twenty or forty percent (20 or 40%) of the capitation that is not paid monthly to the PCP (the PCP's withhold), and 2) contributions by CenCal Health.

For each PCP, the Utilization Pool is allocated into the sub-categories by multiplying the total dollar amount in the Pool by the following percentages:

Physician /Outpatient Expenses **35%**
Inpatient Hospital Expenses **20%**
Pharmacy Expenses **20%**
Emergency Department Visits **25%**

2. Quality Pool The funding for the Quality Pool is only from CenCal Health. For each PCP, the Quality Pool is allocated into the "quality-based" sub-categories by multiplying the total dollar amount in the Pool by the following percentages:

After Hours PCP Visits: **30%**
Encounters: **25%**
Increased Access: **10%**
Preventive Health Services: **35**

DEFINITIONS

"After Hours PCP Visits" shall mean services that are within the PCP's medical expertise and scope of practice and which are rendered by the PCP during early morning, evening and weekend hours. Visits at any time during Saturday or Sunday, or before 8:00 AM and after 5:00 PM that take place Monday through Friday will be counted as After Hours PCP Visits for the After Hours PCP Visits measure. PCPs may not submit Claims for After Hours PCP Visits rendered after 8:00 AM or earlier than 5:00 PM on Monday through Friday. After Hours PCP Visits are for unscheduled appointments. Scheduled appointments that would not alternatively result in an emergency room visit occurring before 8:00 AM or after 5:00 PM on Monday through Friday are not considered After Hours PCP Visits.
"Emergency Department Visit" shall mean, for purposes of the PCP Incentive Program, a visit by a Member to any facility or subdivision of a facility that provides emergency treatment. Facility or professionals submit Claims to CenCal Health for emergency room services. A claim counts as "Emergency Department Visit" if reported with any of the following criteria:

- Emergency Department Location Code 23 and Procedure Codes 10040-69979
- Hospital Revenue Code *(x indicates wildcard)*: 45.x,or 981
- Physician Procedure Code: 99281, 99282, 99283, 99284, or 99285

"Encounters" shall mean those services (1) provided by a PCP to Capitated Members or (2) submission of Deferred Reimbursement Claims submitted under After Hours Claims. Capitated services are identified by select procedure codes included in Attachment A-1 of the Provider Agreement. One Encounter is counted for each Covered Service provided on a single day to a single Member. The PCP submits encounter information on a Claim form, indicating the service(s) provided by inserting the appropriate procedure code(s) for the rendered services. Encounters are for tracking of Covered Services, development of future Capitation rates for PCPs only, and for calculating Deferred Reimbursement Claims, and PCPs receive no fee-for-service reimbursement for these services.

"Increased Access" shall mean maintaining an average number of Members per month, or increasing the PCP's caseload each year, and meeting the minimum ages for Members as described in the "Quality Indicators" section below.

"Peer Pool" shall mean the particular pool to which PCP is assigned by CenCal Health in order to perform benchmark comparisons within the PCP Incentive Program. The assignment is based on the specialty designation of the PCP as well as the age ranges that he/she serves. The three Peer Pools are as follows:

- **Peer Pool F1**: CHDP certified Family Practice/General Practice/Clinic physician who accept Members, 3 years and older;
- **Peer Pool M2**: Internal Medicine, and non-CHDP certified Family Practice/General Practice/Clinic physicians who accept adult Members age 19 and older;
- **Peer Pool P4**: CHDP certified Pediatricians who accept Member children from newborn to, at a minimum, age 12.

"Preventive Health Services" shall mean those services that are provider-type specific and relate to preventing illnesses from occurring. The following preventive services are applicable to the following providers as indicated:

- **FP/GP/Community Clinics, Pediatricians, and Internists:** Annual Preventative Medicine Evaluations and Pediatric Well Care Visits. Such visits shall include: a comprehensive history & physical examination, counseling/anticipatory guidance/risk factor reduction interventions, and ordering of appropriate

laboratory/diagnostic procedures, as defined in the most recent American Medical Association CPT Manual.

The procedure codes that quantify the above Preventive Services are described in the Quality Indicators Section—Preventive Health Services Measure Criteria of this document. Additionally, a description of each of the required procedure codes is attached and incorporated by reference as Attachment 1 of this document.

"Special Case Members" shall mean the following Members (previously Special class Members in Santa Barbara County) that due to response of regulatory audits will now be assigned a "medical home" with a PCP to coordinate all aspects of care. Said Members are: (i) children who are currently designated as California Children's Services (CCS) eligible; (ii) Members eligible to receive organ transplants; and (iii) Members currently on renal dialysis. For the purpose of PCP Incentive Program calculations, CCS eligible members, Organ Transplant, and Dialysis Members will be classified in separate pools and their expenses and utilization will be compared only to each other within their established pool or pool subset, i.e. Members on dialysis against other Members on dialysis. All Special Case Members will be deemed to be Class I Members in the Agreement and Exhibits, unless specifically excepted. Higher capitation rates apply for the case management of CCS children set forth in Attachment A-2 of the Physician Services Agreement.

"Utilization Expenses" shall mean all expenditures for PCP's Class I Members which exclude Encounter Claims and as indicated below but include:

- **"Physician and Outpatient Hospital Expenses"** (including but not limited to expenditures for ancillary services performed in an outpatient facility, specialist physicians, and outpatient hospital services). Expenses associated with "After Hours PCP Visits" and "Emergency Department Visits" are excluded.
- **"Hospital Inpatient Expenses"** (including but not limited to an acute care or rehabilitative care setting)
- **"Pharmacy Expenses"** (including but not limited to prescription pharmaceuticals and prescribed over-the-counter pharmaceuticals)
- **"Emergency Department Visits"** (including one Emergency Department Visit per Member per facility per date of service).

QUALITY INDICATORS

After Hours PCP Visits

The intent of this measure is to encourage PCPs to increase their availability to CenCal Health's Members being seen on a walk-in or appointment basis after routine business hours. This quality incentive measure rewards PCPs for offering and rendering services to Members during early morning (before 8:00 AM) or evening (after 5:00 PM) and weekend hours (Saturday and/or Sunday). CenCal Health's goal is to keep Members out of the emergency departments and urgent care centers for care that can be appropriately managed by PCPs.

This measure accounts for **30%** of the total Quality Pool. After Hours PCP Visits (reflected in the Schedule 1 report) are those services submitted via claims reported by using CPT Code 99051. The number of After Hours PCP Visits will be calculated by comparing each PCP to the average number of After Hour PCP Visits for the PCPs in the After Hours Peer Group. The After Hours Peer Group is comprised of all PCPs who submit Claims for After Hours PCP Visits. The average number of After Hours PCP Visits will then be calculated by factoring for case mix.

PCPs may also potentially receive additional monies due to lower emergency room utilization in the Emergency Department Visits measure of the PCP Incentive Program. PCPs who do not offer services beyond normal office hours will benefit by referring their assigned Members to PCPs who do provide the services as it will also lower their emergency room utilization and thus positively affect their Emergency Department Visits measure.

Referral Authorization Forms (RAFs) will be waived for After Hour PCP Visits, thus relieving both the referring PCP and the PCP who is providing the service of initiating or completing this authorization.

There are two payment options available under this measure: Fee-For-Service Reimbursement or Deferred Reimbursement to the Incentive Program.

Fee for Service Reimbursement (Option 1): In addition to their monthly capitation, PCPs who submit Claims for visits occurring outside of normal office hours will be reimbursed fee-for-service for these services.

1. After Hours PCP Visits to assigned or case managed Members will receive an additional $75.00 when billing with CPT code 99051.

PCPs must bill this After Hour Visit Code in addition to the visit procedure code, i.e. 99202, and this will be processed as an Encounter.

2. PCPs rendering After Hours PCP Visits to Members not assigned or case managed to them must bill the office visit code applicable to the level of service provided, i.e. 99202, and will be paid fee-for-service for the services. In addition, PCPs may bill CPT code 99051 to receive an additional $50.00 payment for providing after-hours coverage.

3. FQHC Providers rendering After Hours PCP Visits to assigned or case managed Members will receive an additional $50 when billing with CPT code 99051. PCPs must bill this After Hour Visit Code in addition to the visit procedure code, i.e. 99202, and this will be processed as an Encounter.

4. FQHC Providers rendering After Hours PCP Visits to Members not assigned or case managed to them must bill the office visit code applicable to the level of service provided, i.e. 99202, and will be paid fee-for-service for the services. In addition, PCPs may bill CPT code 99051 to receive an additional $25.00 payment for providing after-hours coverage.

Deferred Reimbursement to the PCP Incentive Program (Option 2): PCPs who select not to accept fee-for-service reimbursement for submitted Claims but instead decide to defer the reimbursement amounts stated in Option 1 above into the PCP Incentive Program, will receive EOBs that indicate the following:

After Hours PCP Visits to Case Management Members	Reimbursement for 99051 = $0.00
After Hours PCP Visits to Member **not** Case Managed by the PCP	Reimbursement for 99051 = $0.00 plus reimbursement for office visit fee-for-service at CenCal Health's rate

CenCal Health will track claims submitted under Option 2 as Encounters and include results in the monthly Schedule 1 report.

Encounter Data

As one of the PCP Incentive measures, comprehensive encounter data (derived from claims submitted by PCP for services included in the

capitation payment and for claims submitted if After Hours Option 2 is selected) is important to CenCal Health for a variety of reasons, including tracking utilization, complying with State, federal, and regulatory agency requirements, and adjusting capitated compensation. The incentive funding for Encounters accounts for **25%** of the PCP's total Quality Pool.

PCPs can find their specific number of encounters received year to date by CenCal Health on page 2 of the Schedule 1 report, under the column entitled "PCP's Total Actual Values." The next column ("Average Values Adjusted for PCP's Case Mix") indicates the average number of encounters received in this same timeframe by similar providers, adjusted for the PCP according to his or her particular case mix; thus assuring a fair comparison to the PCP's peers. These figures together are used to calculate the PCP's Performance in the form of a percentage.

PCPs are eligible to earn a percent of their pool amount for this category only if their performance is better than 90% of the average established by their particular peer group. If the PCP's performance in this category is below that of their peers, the PCP may either have fewer encounters with CenCal Health Members than their peers, or simply have not yet submitted this data.

Increased Access

CenCal Health's quality incentive measure, called "Increased Access", was added to encourage increased availability of PCPs to Members in order to allow for the most optimal physician-patient assignment. PCPs can find their total potential payout year to date for this measure by reviewing page 1 of their Schedule 1 report ("Allocation-Increased Access"). For this measure, the PCP is compared to fixed values that are not based on the performance of other PCPs in the PCP's Peer Pool. The increased access measure accounts for **10%** of the total Quality Pool. To be eligible to earn all "Increased Access" funds, the PCP must first satisfy the following requirements in 1 or in 2:

1. Maintain an average of *700* Members per month, per full-time physician throughout their contracted term in the year; **OR**

2. Increase actual caseload by a minimum of twenty-five (25) Members in comparison to the previous CY.

The PCP will receive 100% of the Increased Access Pool if either (1) is maintained, or if the increase in level (2) is met. PCPs will be eligible for a percentage of the Increased Access Pool for any

increase in caseload up to the minimum of twenty-five (25) Members. The PCP is compared to fixed values that are not based on the performance of other PCPs in the PCP's Peer Pool.

Preventive Health Services

The Preventive Services Measure Criteria is a set of quality criteria designed to be provider specific, to allow further comparison of services delivered by providers that serve comparable populations, and that are designed to prevent Member illness. In addition to counting these preventive medical services in the PCP Incentive Program, pursuant to the Agreement, CenCal Health pays PCP's claims described below (unless paid by the State for CHDP services). This measure accounts for **35%** of the total Quality Pool, and is structured as follows:

1. PCPs offering Initial and Periodic Preventive Medicine Evaluations must submit evidence of services rendered in the submission of claim forms for Well Infant, Well Child, Well Adolescent Visits, and Adult Preventive Medicine Evaluations.

Well Infant, Well Child, and Well Adolescent Visits and Adult Initial and Periodic Preventive Medicine Evaluations:

Provider shall submit claim forms with CPT Codes: 99381-99387, 99391-99397, or 99432, and supply at least one of the following ICD-9 Codes: V20.2; V70.0; V70.3; V70.5; V70.6; V70.8; and V70.9

In Calculation of PCP's Performance, the PCP's Total Actual Values will be expressed as a number of Evaluations completed, and the Average Values Adjusted for PCP's Case Mix will be expressed as the expected number of Evaluations. The PCP is compared to similar Providers as to the average number of Preventive Medicine evaluations received in the same timeframe, but the figure is adjusted for the PCPs particular case mix to assure a fair comparison.

Providers submitting PM-160 forms to the State of California for CHDP services indicated above, for children up to age 21 are to render: (1) a history and physical examination, and (2) health education/anticipatory guidance, and including the date on which such services are rendered within CenCal Health's year. The State will forward CHDP information to CenCal Health, and CenCal Health will use said information in calculating this Measure. CenCal Health cannot guarantee the timeliness or completeness of the CHDP information as supplied monthly by the State,

but will work to ensure the data is as accurate as possible.

UTILIZATION INDICATORS

Physician and Outpatient Expenses

Physician and outpatient expenses are those services that are not covered under capitation and include costs incurred for referral to the following (included but not limited to) providers: specialist physicians, ancillary services performed in an outpatient facility and outpatient hospital services, the latter billed under the hospital's outpatient provider number. Emergency Department Visits expenses will also be included in this measure.

Inpatient Hospital Expenses

Inpatient hospital expenses are those services that are incurred when the Member is an inpatient at a contracted or non-contracted acute care hospital or a rehabilitation hospital or a rehabilitative care setting

Pharmacy Expenses

Pharmacy expenses are those expenses that include but are not limited to prescription drugs and over-the-counter drugs that have been prescribed by a prescribing provider.

Emergency Department Expenses

Emergency Department Visits are those services that are incurred when the Member is seen in the Emergency Department. Services include both those considered to be an emergency and those that are urgent but not emergent. The measure is intended to reward PCPs for controlling their Members' unnecessary and inappropriate use of emergency rooms, and whose members visit the emergency room at below average utilization rates.

The lower the number of Emergency Department Visits for a PCP's Members compared to the average number, the higher the PCP's incentive amount for the measure. To ensure fair comparisons, PCPs will only be compared to those PCPs within their Peer Pools (the three pools are: (i) pediatricians; (ii) internists, or (iii) family practitioners, general practitioners and clinics) and adjustments will be made for a PCP's case mix. A PCP's case-mix adjustment is determined by age, sex, Special Case Members grouping, and aid code groupings of assigned members. Only the number of Emergency Department Visits will be calculated in this measure; the actual costs for such visits are excluded from the program and are not included in any other utilization measure.

CenCal Health recognizes that there are those Members that no matter what a PCP does will continue to visit emergency rooms at excessive rates; however, these Members that are frequent users of the emergency room are proportionately distributed across both large and small PCP providers, and for this measure PCPs are compared against their Peer Pool. CenCal Health reserves the right, when requests meet criteria for Member reassignment as set forth in the CenCal Health "Request for Member Reassignment" policy, to reassign emergency department abusing Members to a different PCP.

PCP Incentive Reports

PCPs are sent a monthly report (Schedule 1), which explains the calculation of funding year to date for both the utilization and quality pools. This report expresses the PCP's individual values and performance scores, some which are compared to PCPs who share a common membership assignment, termed Peer Pool.
How the PCP fared based on year-to-date claims data in both the utilization and quality criteria categories results in the "Total Incentive Payment for the Year" reflected in the Schedule 1 reports. This figure represents an approximation of what the PCP will earn for the year to date.

The following additional reports are available by contacting the Provider Services Department:

- **Schedule 4** reflects the year-to-date Member totals by category of claim expense, i.e. physician/outpatient, inpatient, and pharmacy;
- **Schedule 5** reflects the year-to-date Member claim expense detail, claim by claim - including claim control number, date of service, date of payment, claim explanation code, amount paid, description or procedure, and diagnosis on claim.

Schedules 4 and 5 afford PCPs a more detailed representation of how they are faring in important utilization categories.

Caution Regarding Annualizing Reports

For a number of reasons, we recommend that PCPs use caution when assessing "Potential Incentive Payment for Year" reflected on page 2 of the Schedule 1 report early in the year. Claims received by CenCal Health, necessary adjustments to comply with contractual allocation of funds, and unforeseeable future changes in the PCP's practice could dramatically change final figures used to determine interim and final PCP Incentive Program payments. Also, at the beginning of CenCal Health's

year, there is relatively little claims data to analyze, including physician/outpatient, inpatient, and pharmacy expenses, reported encounter and after hours visits, and preventive services. Therefore, there may be fluctuations of current data for the other physicians in the provider peer group to whom the PCP may be compared. Therefore the averages shown are only an approximation of annual utilization expenses and performances and should be recognized as an average that will increase in significance over the course of the year.

Monitoring Your Case Management List

Due to the need for monthly Medi-Cal eligibility verification, it is recommended that all additions to each PCP's case management list be monitored closely, as Members may be in need of immunizations and/or well care. The PCP has 120 days after receiving the monthly capitation list to notify CenCal Health's Provider Services Department of any Members assigned to her/him that should not have been assigned. If the PCP does not notify CenCal Health within this timeframe, any expenses incurred by the Member(s) will be included in the calculation of the PCP's Incentive Payment.

Special Case Members

Effective January 1, 2007, some Members who were previously Special Class Members were assigned instead to PCPs and became case managed Class 1 Members. This change addressed concerns brought forth by regulatory agencies and additionally allow for more oversight of all care for Members that include, but are not limited to those who: (i) received an organ transplant; (ii) are diagnosed with end stage renal disease ("ESRD") and are currently receiving renal dialysis treatment; and (iii) are children who are currently designated as California Children's Services (CCS) eligible.

In order to reimburse PCPs for additional services that may be associated with the assignment of these above Members, effective January 1, 2007, CenCal Health: (i) established higher capitation rates for PCP case management of Santa Barbara County CCS children; and (ii) placed a limit on the expenses incurred for utilization expense calculation for Special Case Members.

PAYMENT THRESHOLDS AND FORMULAS

Utilization Expenses and Capitation

CenCal Health calculates the PCPs' total utilization expenses based on the actual dollars paid by CenCal Health for covered services for capitated members rendered during the specified time period. Covered

services not included in the said calculation include: (i) all of the PCPs capitated services and "after hours" services; (ii) any service not reported on an EOB before the final PCP Incentive Program calculations are completed; and (iii) Utilization Expenses (total of Physician/Outpatient, Inpatient, and Pharmacy) which, when prorated monthly, total more than $15,000 rendered per Member, per PCP, per CY. After the $15,000 threshold is reached, any services then rendered per Member, per PCP, per CY are not counted in the total utilization expenses calculation.

For Special Case Members, Covered Services exceeding $30,000 per Member per PCP per CY year will not be included in the calculation of Total Actual Values and Average Values Adjusted for PCP's Case Mix, as described below. The $30,000 maximum for a Special Case Member is also subject to monthly proration as described above.

Establishment of PCP's Total Actual Values

The total actual utilization expenses, the number of After Hours Visits, Emergency Department Visits, Encounters, and Preventive Health Services are called the PCP's Actual Values and are used as a basis to establish the PCP's Performance Score for: (i) Utilization criteria subcategories; and (ii) the Quality criteria sub-categories of: (a) After Hours Visits, (b) Encounters, and (c) Preventive Health Services.

Establishing Average Values Adjusted for PCP's Case Mix

For all PCPs in the PCP's Peer Pool, the total Actual Values per Member per month are calculated for each aid category or aid sub-category and by the Member's age category and gender (when applicable). This calculation produces a set of numbers that are the average per Member per month grouped by aid category and by the Member's age category and gender (when appropriate) for all PCPs within that Peer Pool. Next, the individual PCP's number of actual Member months is calculated for these same categories and then multiplied by the corresponding, just calculated, average per Member per month values. Lastly, these separate values for each category are all totaled together to produce a single "Average Value Adjusted for PCP's Case Mix". The above steps are completed for: (i) Physician/Outpatient Expenses; (ii) Hospital Inpatient Expenses; (iii) Pharmacy Expenses; (iv) Emergency Department Visits; and (v) Encounters.

The After Hours PCP Visits are calculated in the same manner except that there are no PCP Peer Pools. PCP Peer Pools are not used in the calculation because there are fewer numbers of After Hours PCP Visits

resulting in all of the PCPs being grouped together, (in the After Hours Peer Group) regardless of type.

The groupings of all individual values above make up the Average Values Adjusted for PCP's Case Mix.

Calculation for Group And Clinic PCPs

All PCP Incentive Payments are calculated on a grouped basis for PCP groups or clinics. Any separate office site of the group or clinic to which Members are assigned will have the Utilization and Quality pools (as well as the corresponding pool sub-categories, the PCP's Total Actual Values, and the Average Values Adjusted for PCP's Case Mix) calculated separately by site. FQHCs and RHCs are offered same terms and conditions relating to reimbursement rates as other contracted providers providing similar scope of services to members.
Individual PCPs who join or separate from a PCP group or clinic during the year receive one PCP Incentive report (and payment if warranted), and a second PCP Incentive Payment and report for the group.

Calculation of Performance Scores

The performance scores are expressed as a percentage and are calculated by dividing the PCP's Total Actual Values by the Average Values Adjusted for PCP's Case Mix. For example, if Dr. John Doe's actual Physician/Outpatient Hospital Expenses total $32,946.41 (Actual Value) and the Average Values Adjusted for PCPs Case Mix total $24,432.26 for the same time period, then Dr. Doe's Performance Score for this Criteria would be 134.85%. Performance Scores for all Utilization and Quality Categories (not including the Increased Access Measure) will be calculated using the same methodology. The Actual Values used to compute this performance score for the Physician/Outpatient, Inpatient, and Pharmacy Measures are expressed by Total Plan Expenditures. The Actual Values used to compute the performance score for the After Hours, Emergency Department, Encounter, and Preventive Health Service Measures are expressed in Number of Visits. The Actual Value for the Increased Access Measure used to compute this performance score is a fixed number dependent upon the PCP's caseload.

Variables Used In Calculating PCP's Earned Percent Of Pool

	% Performance Start Pay	Pool Earned Minimum %	% Performance End Pay	Pool Earned Maximum %
Utilization Pool				
Physician/Outpatient	110%	20%	75%	120%
Hospital Inpatient	110%	20%	50%	120%
Pharmacy	110%	20%	75%	120%
Emergency Room Visits	110%	20%	75%	120%
Quality Pool				
Encounters	90%	20%	125%	100%
After Hours Visits	50%	20%	110%	100%
Preventive Health	90%	20%	125%	100%

Calculations for PCP Incentive Program

$$\frac{(\text{PCP's Performance Score} - \text{Start Pay}) \times (\text{Max\%} - \text{Min\%})}{(\text{Max Pay} - \text{Start Pay})} + \text{Min\%}$$

As in the above example, if the PCP's Performance Score for the Encounters is **115%**, the calculations are:

$$\frac{(\mathbf{115\%} - 90\%) \times (100\% - 20\%)}{(125\% - 90\%)} + 20\% = \frac{(.25) \times (.80)}{(.35)} + 0.2 = 0.6 \text{ or } \mathbf{60\%}$$

Earned Percent Of Pool Formula

CenCal Health establishes the Maximum percent and Minimum percent of the Percent of Pool Earned and the Maximum Pay percent or hours of PCP.

Establishment of PCP's Earned Percent of Pool

PCP's Earned Percent of Pool will be calculated for each Utilization Pool and Quality Pool sub-category by the mathematical formulas that reference the corresponding subcategories in the above chart.

For Physician/Outpatient, Inpatient Hospital, and Pharmacy Expenses:
If any of the PCP's Performance scores (a percentage) is greater than the Start Pay percentage (established by CenCal Health and shown above) the PCP's Earned Percent of that sub-category of the Pool is 0%.

Otherwise, the percent is computed according to the formula shown above.

For After Hours, Emergency Department Visits, Encounters, and Preventive Health Services: If any of the PCP's Performance scores is less than the Start Pay percentage or hours, the PCP's Earned Percent of that sub-category of the Pool is 0%. Otherwise, the percent is computed according to the formula shown above.

Minimum Percent For PCP's Earned Percent Of Pool
The smallest percent for PCP's Earned Percent of Pool for all sub-categories is 20%. Any calculations that would result in a percent lower than the minimum percent will be set to zero (0%).

Maximum Percent For PCP's Earned Percent Of Pool: The maximum percent for PCP's Earned Percent of Pool is 120% for Physician/Outpatient Hospital, Inpatient Hospital, Pharmacy Expenses, and Emergency Department Visits subcategories. The maximum percent is 100% for all Quality Pool Criteria sub-categories. Any calculations that would result in a percent higher than the maximum percent will be reduced to the maximum value.

PCP's Incentive Payments
The PCP's Incentive Payment for each Utilization Pool and Quality Pool sub-category is determined by multiplying the sub-category Pool Amount by the corresponding PCP's Earned Percent of Pool values.

Federally Qualified Health Centers
Federally Qualified Health Centers (FQHCs) are not excluded from participation in CenCal Health's PCP Incentive Program. Due to federal guidelines related to their expenses, FQHCs generally receive reimbursement higher than the Medi-Cal allowable. Locally, five (5) Santa Barbara County Health Care Centers, four (4) Santa Barbara Neighborhood Clinics, Santa Ynez Tribal Health Clinic, American Indian Health and Services, Marian Community Clinics – Santa Maria and fifteen (15) Community Health Centers of the Central Coast are Federally Qualified Health Centers. They may provide virtually any medical service available under the Medi-Cal program, and referral to their services will influence PCP incentive reports the same as referrals to other providers.

Rural Health Clinics

Rural Health Clinics (RHCs) are not excluded from participation in CenCal Health's PCP Incentive Program. Due to federal and state guidelines related to their expenses, RHCs also generally receive higher reimbursement than Medi-Cal allowable rates. Marian Community Clinics – Guadalupe is the only RHC in Santa Barbara County. They may provide virtually any medical service available under the Medi-Cal program, and referral to their services will influence PCP incentive reports the same as referrals to other providers.

Mental Health Services

In April 1998, the State mandated that certain Medi-Cal fee-for-service mental health moneys be "carved-out" or removed from the SBHI's program. This carve out also extends to FQHCs and RHCs as well. These moneys were instead redirected by the State to the Santa Barbara County Department of Alcohol, Drug, and Mental Health Services (ADMHS), the San Luis County Mental Health Services Department, and to the State Department of Mental Health. Payments by either County or State agency will not be counted in the Physician/Outpatient Services Utilization Pool. Psychotropic Drugs not routinely provided by a PCP will also be excluded. However, those services not carved out by the State, such as lab and other non-Psychotropic Drugs, which are related to mental health services continue to be reimbursed through the SBHI and SLOHI programs and will affect the utilization portion of incentive reports.

Incentive Payments

The Total Incentive Payment for each PCP for the CY is equal to the sum of the Utilization Pool and Quality Pool sub-category incentive payments. In addition to the guaranteed monthly capitation, which is received by all PCPs, eligible PCPs will be paid Incentive Payments in two installments within six (6) months of the close of that CY. The initial payout of 25% of the estimated Total Incentive Payment will be made in December of the current CY, with the remaining incentive payment to be paid in June of the next CY.

Changes in Practice Ownership and Group Membership

Incentive payments represent additional payment for performance during each year. When a PCP practice is sold or transferred or the PCP commences or terminates membership in a group, CenCal Health should be informed as to how this change may affect potential PCP Incentive Program payments. It is important that CenCal Health be made aware of, in writing, the date of the transfer and any relevant terms related to accounts receivable, as soon as possible. If changes are not made to the PCP's records in advance or soon after the transaction, there is a strong likelihood that the wrong PCP may profit from past performance—or suffer because of it. For instance, selling a practice

to another wherein accounts receivable are *included* in the terms of the sale will mean that the new owner will receive any PCP incentive payment for performance during the year and paid after the close of the year, or that poor performance during the first period will affect the PCP incentive calculation negatively resulting in the owner during the second period receiving a smaller incentive payment or no incentive payment at all. Similarly, selling a practice wherein accounts receivable are *not included* in the terms will mean that CenCal Health will keep separate the performance prior to the transaction and calculate any related incentive monies separately for the two PCPs before and after the sale. If applicable, separate checks would be paid to the two PCPs under the two different tax ID numbers.

Future Improvements to the PCP Incentive Program

An important milestone for the Program occurred in the second year (July 1999), when the quality-based portion of the incentive payment first exceeded the utilization-based portion. Since this time, annual assessments are completed and improvements and readjustments are made. As we strive to make sound and important improvements to the Program, CenCal Health welcomes input from its primary care physicians. An internal committee meets continually to review the goals and progress of the Program, the effectiveness of the measures, and to consider new measures or improvements to existing measures.

Attachment 1: Preventive Services Measure Procedure Code

Family Practice/General Practice/Clinic, Pediatricians and Internists:
Well Infant, Well Child, Well Adolescent and Adult Preventive Medicine Evaluations; Initial and Periodic

NOTE: These code numbers are subject to change.

CPT CODE	DESCRIPTION OF SERVICE
99381	Initial preventive medicine evaluation: under 1 year
99382	Initial preventive medicine evaluation: 1 through 4 years
99383	Initial preventive medicine evaluation: 5 through 11 years
99384	Initial preventive medicine evaluation: 12 through 17 years
99385	Initial preventive medicine evaluation: 18 through 39 years
99386	Initial preventive medicine evaluation: 40 through 64 years
99387	Initial preventive medicine evaluation: 65+ years
99391	Periodic preventive medicine evaluation: under 1 year
99392	Periodic preventive medicine evaluation: 1 through 4 years

99393	Periodic preventive medicine evaluation: 5 through 11 years
99394	Periodic preventive medicine evaluation: 12 through 17 years
99395	Periodic preventive medicine evaluation: 18 through 39 years
99396	Periodic preventive medicine evaluation: 40 through 64 years
99397	Periodic preventive medicine evaluation: 65+ years