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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.

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 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 in order to 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 cencalhealth.org/providers/quality-of-care/quality-program/

L2: Quality of Care 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 (PQIs) and initiate corrective action when appropriate. This helps to continually improve the quality of care delivered to our members.

PQI sources include:

- Member originated:
  - 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.
- External Referral (not member originated)
  - CenCal Health's contracted providers, community agencies, and liaisons (CCS, APS, hospital case managers) may email concerns to PQI@cencalhealth.org.
- Internal Referral
  - Any of CenCal Health's staff may identify PQIs and email them to PQI@cencalhealth.org.

Review Process
The assigned PQI 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 practitioner chart notes, Emergency Department records, pharmacy profile, and a response from the practitioner when appropriate.
- Additional review or a focused site review may be required if the medical records, pharmacy, or claims review are insufficient to answer all clinical concerns.
- CenCal Health's Chief Medical Officer (CMO) or 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 CMO or Physician Designee will consult with expert clinical specialists if applicable.
- If a deviation from standard of care is suspected, the CMO or Physician Designee will contact the practitioner involved to discuss the concern directly. Formal practitioner interaction may be undertaken to complete the investigation and assure due process as indicated.
- The CMO or Physician Designee 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 practitioner directly 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 practitioners 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. Such activities include but are not limited to those set forth in CenCal Health's Quality Program Description, including:

- Utilization and care management programs
- Managed Care Accountability Set (MCAS) data collection
- Plan-Do-Study-Act (PDSA)
- Other quality improvement and health equity activities, policies, or processes

These activities are in accordance with DHCS All Plan Letter (APL) 19-017 to identify improvements in quality of care for our membership to monitor, evaluate, and address accordingly.

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, presentation of results to providers that participate on committees that comprise CenCal Health's quality committee structure, and on CenCal Health's website.

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

Providers and members may also request a hardcopy of CenCal Health's quality performance results by calling the Quality Measurement team at 800-421-2560 extension 1609.

L4: Quality Care Incentive Program

The Quality Care Incentive Program (QCIP) serves to identify members who are due for clinically recommended aspects of care to further assist PCPs in providing comprehensive high quality health care for members. This innovative program encourages increased utilization of evidence-based treatment, screening, and preventive health services.

Performance & Payment Methodology

Performance measurement methodology is equally applied for all capitated PCPs, including but not limited to Federally Qualified Health Centers and Rural Health Centers. Incentive payments are not paid as an additional rate per service or visit. Performance is measured against pre-defined, industry-standard, clinical measures. Measurement results are calculated using NCQA-certified HEDIS® reporting software.

Measures:

Categories and measures are systematically identified for inclusion in the program based on the following criteria:

- Clinical importance for CenCal Health's members
- Areas of needed quality improvement for CenCal Health
- Feasibility of accurate measurement utilizing claim, lab, and registry data
- A balanced distribution of adult and pediatric measures
- A balanced distribution of disease management and preventive care measures
- Alignment with state-wide recommended quality focus areas

Categories and measures are evaluated annually to ensure that the above criteria are met. As priorities change, CenCal Health may update these categories and measures. Categories and measures will be changed no less than annually.

Payment:

Payment performance is calculated, expressed, and reported for each priority measure and all combined priority measures.

- Individual performance is calculated as a percentage, based on the numerator divided by the denominator, for each qualifying measure.
- Overall performance is based on the sum of all measure numerators divided by the sum of all measure denominators for the PCP.
- Performance is expressed using a 5-star performance scale (quintile).
- Star ratings (quintiles) are assigned for each measure, and for all measures in aggregate, by:
    - Ranking PCPs in descending order by their aggregate performance percentage
    - Stratifying the population by quintile, each containing an equal number of

PCPs
    - Assigning stars to each quintile -- 5 stars to the highest performing quintile, 4 stars to the next lower quintile, etc.
- If multiple PCPs have the same aggregate clinical score after it is rounded up to 2 decimal places and PCPs are separated into different quintiles, PCPs with equal scores will be included in the higher quintile.
- PCPs earn incentives according to the number of stars earned:
    - Quintile 5 = 5 stars = 100% of total pool
    - Quintile 4 = 4 stars = 80% of total pool
    - Quintile 3 = 3 stars = 60% of total pool
    - Quintile 2 = 2 stars = 40% of total pool
    - Quintile 1 = 1 star = 20% of total pool
- Incentive payments will be completed quarterly reflecting performance through the end of the prior month, with each payment calculation period rolling forward by a quarter.
    - PCPs who have less than 30 members in all priority measures combined do not qualify for an incentive payment at the time of quarterly payment calculations. In lieu of an earned QCIP incentive, PCPs that do not qualify receive payment equal to the capitation withhold that they did not have opportunity to earn.

Quality Measures
Identified quality measures encompass aspects of care that PCPs can influence either through direct care or through referral to specialists or other ancillary practitioners. Identified priority measures are consistent with accepted clinical guidelines and are clinically significant to CenCal Health's membership.

Quality of care measures are comprised of six (6) clinical categories of care:

- Behavioral Health
- Women's Health
- Pediatric Care
- Diabetes Care
- Respiratory Care
- Cardiac Care

The quality measures included in each category may be found in the Quality Care Incentive Program Measures. All measure specifications reflect NCQA *HEDIS® Volume 2 Technical Specifications* and are updated as measure specifications change. Generally, measures remain within the Quality Care Incentive Program for at least two (2) years to reinforce improvement priorities and expectations, support program stability for PCPs, and increase the potential to achieve overall network performance that meets or exceeds external benchmarks of clinical excellence.

Performance Reporting
Performance reporting occurs monthly for all PCPs and made available via the Provider Portal on CenCal Health's website, www.cencalhealth.org, in the Quality Care Incentive Program module. Reporting is broken up into three (3) sections:

- QCIP Dashboard
- QCIP Performance Overview
- QCIP Financial Overview

For detailed instructions regarding navigation of the Provider Portal screens, please refer to cencalhealth.org/providers/provider-training-resources

Dashboard
The Quality Care Incentive Program Dashboard is a snapshot trended view of both a PCP's overall program performance and their overall financial performance. This page can be filtered by time frame.

Performance Overview
The Quality Care Incentive Program Performance Overview displays quality scoring for each PCP's membership. It includes:

- The PCP's trended performance which can be filtered by:
    - PCP location as applicable
    - CenCal Health identified quality measures for improvement
    - Priority quality measures (incentivized measure have an asterisk*)
    - County of service
    - Time frame
- The PCP's quality performance score by month is reflected on the trend line and performance rates can by displayed by hovering over the trend line marker.
    - Each trend line marker can be clicked on to display that month's performance detail on the QCIP Provider Summary Detail screen. It includes:
        - Number of members in each measure category
        - Number of members in each measure category that received the target services
            - By clicking on the number in this field you can drill into member detail
        - Number of members in each measure category that did not receive the target services
            - By clicking on the number in this field you can drill into member detail
        - Measure category rate
        - Number of members in each measure
        - Number of members in each measure that received targeted services
            - By clicking on the number in this field you can drill into member detail

        - Number of members in each measure that did not receive targeted services
            - By clicking on the number in this field you can drill into member detail
        - Measure rate
        - Number of overall members in the program
        - Number of overall members in the program that received targeted services
            - By clicking on the number in this field you can drill into member detail
        - Number of overall members in the program that did not receive targeted services
            - By clicking on the number in this field you can drill into member detail
        - Overall program rate
    - All member detail includes: member ID number, member name, member date of birth, member age, member gender, member phone number, measure category, and measure name
        - You can click on the member's ID number to view the Member 360 screen.

Financial Overview

The Quality Care Incentive Program Financial Overview displays each PCP's trended incentive payments and the trended incentive funding available to them. It includes:

- Trended financial payments performance which can be filtered by:
    - PCP Location as applicable
    - Time frame
- Financial payment performance by quarter is reflected on the trend line, and payment amounts can by displayed by hovering over the trend line marker. Projected monthly earnings and available funding is also displayed on a separate trend line.
    - Each trend line marker can be clicked on to display the quarterly or the monthly (projected) payment detail on the QCIP Payment Scoring Detail screen.
    - QCIP Payment Scoring Detail includes:
        - Incentive Date
        - Vendor ID
        - Provider NPI
            - By clicking on the number in this field you can drill into the payment detail which includes:
                - Incentive date
                - Vendor ID
                - Provider NPI

    - Total Incentive Payment
    - Member ID
    - Member Name
    - Member Date of Birth
    - Measure Name
    - If the member triggered an incentive payment
- Provider Name
- Performance Percentage Rate
- Quintile in which the provider fell (i.e., Stars Earned)
- Capitation Withhold Amount
- CenCal Contribution Amount
- Total Financial Pool Available Amount
- Percentage of Financial Pool Available Earned
- Total Incentive Payment Amount

Provider Ranking

The Quality Care Incentive Program Monthly Provider Ranking Report displays the providers star ranking in descending order by their performance score.

- The ranking report can be filtered by:
    - Time frame
- Quality Care Incentive Program Monthly Provider Ranking Report includes:
    - Provider Name
    - Star Ranking
    - Performance score
    - Earning %

Program Support

CenCal Health's Population Health and Provider Services Departments are available to provide orientation regarding quality measures, strategies to maximize data reporting, and sharing of best practices to help maximize service utilization consistent with prevailing evidence-based treatment and preventive health guidelines. Contact QCIP@cencalhealth.org for additional support.
More information can also be found here:

https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

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) and the Department of Health Care Services (DHCS). CenCal Health shares CMS' and DHCS' 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 (HEDIS[1]) is the primary tool used by CenCal Health to measure the quality of health care provided to our members. Developed by the National Committee for Quality Assurance (NCQA), HEDIS[1] provides a standardized methodology that is used nationally by health plans and regulators to evaluate important aspects of care.

Medi-Cal Managed Care Accountability Set (MCAS)

DHCS annually compiles a list of performance measures called the Medi-Cal Managed Care Accountability Set (MCAS) and requires all Medi-Cal plans to report on these priorities. The MCAS list for Measurement Year (MY) 2022/Reporting Year (RY) 2023 consists of 39 performance measures.

The NCQA 50th percentile is the minimum performance level (MPL) set for 15 of these performance measures. CenCal Health is subject to financial sanctions, quality improvement plans, and/or corrective action for performance that fails to meet or exceed any DHCS MPL.

Below is the complete MCAS list for MY2022/RY2023:

#	MEASURE	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY**	HELD TO MPL
1	Breast Cancer Screening	BCS	Administrative	Yes
2	Cervical Cancer Screening	CCS	Hybrid	Yes
3	Child and Adolescent Well-Care Visits*	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10	Hybrid	Yes
5	Chlamydia Screening in Women	CHL	Administrative	Yes
6	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes
7	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
8	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	HBD	Hybrid	Yes
9	Controlling High Blood Pressure*	CBP	Hybrid	Yes
10	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid	Yes
11	Lead Screening in Children	LSC	Hybrid	Yes
12	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid	Yes
13	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid	Yes
14	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits	W30-6+	Administrative	Yes
15	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits	W30-2+	Administrative	Yes
16	Ambulatory Care: Emergency	AMB-ED	Administrative	No

	Department (ED) Visits			
17	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No
18	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	No
19	Asthma Medication Ratio	AMR	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Colorectal Cancer Screening*	COL	Hybrid	No
22	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
23	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No
24	Topical Fluoride for Children	TFL-CH	Administrative	No
25	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No
26	Developmental Screening in the First Three Years of Life	DEV	Administrative	No
27	Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications	SSD	Administrative	No
28	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	No
29	Follow-Up After ED Visit for Substance Use – 7 days*	FUA	Administrative	No
30	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
31	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-Init	Administrative	No
32	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
33	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
34	Pharmacotherapy for Opioid Use Disorder	POD	Administrative	No
35	Plan All-Cause Readmissions	PCR	Administrative	No
36	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No
37	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No
38	Prenatal Immunization Status	PRS-E	ECDS	No

39	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No

***** Measures that will be stratified by race/ethnicity to identify health disparities.

****** Methodology Explanation:

- **Administrative:** Measure compliance via Claims, Pharmacy, Immunization Registry, and Supplemental Data
- **Hybrid:** Measure compliance via Administrative, plus medical record review
- **ECDS (Electronic Clinical Data Systems):** Measure compliance via Administrative, plus data from an Electronic Medical Record, Health Information Exchange (HIE)/Clinical Registry, and Case Management System

Medical Record Review and Reporting Process

CenCal Health begins its quality of care reviews every year in January, which includes several steps performed in strict accordance with HEDIS[1] 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), information supplied by the California Department of Health Care Services (DHCS) and the California Department of Public Health, 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 data collection is an option. Annually, CenCal Health's medical record reviews are completed from February through May. Every effort is made 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 each year to DHCS and 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 record documentation, please contact CenCal Health's Quality Measurement Department at (805) 562-1609 or QMGRP@cencalhealth.org.

Because of the excellent health care 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

Performance Improvement Projects (PIPs) are rapid cycle quality improvement projects used to enhance quality and improve healthcare outcomes through process improvements over an 18-month period. The California Department of Healthcare Services (DHCS) requires Medi-Cal Managed Care Plans to participate in a minimum of two (2) PIPs per cycle and must be reported to DHCS' designated External Quality Review Organization (EQRO). PIP Topics are selected in consultation with DHCS and must align with demonstrated areas of poor performance, such as low HEDIS®[1] or CAHPS®[2] scores, and/or DHCS/EQRO recommendations. PIPs 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 Appointments

Primary Care Providers (PCPs) are required to perform an Initial Health Appointment (IHA) for each newly assigned member **within 120 days** of assignment. For members less than 18 months of age, PCPs must ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

IHA's enable PCPs to comprehensively assess and manage a member's current acute, chronic, and preventive health needs, and identify whose health needs require coordination with appropriate community resources and/or other agencies.

An IHA is not necessary if the member's medical record contains complete and current information updated within the previous 12 months to allow for assessment of the member's health status and health risk.

IHA Components: Documentation of the following components must be available in the medical record and provided in a way that is culturally and linguistically appropriate:

- Comprehensive history of physical and behavioral health status including past and social history as well as a review of organ systems
- Comprehensive physical and behavioral health examination
- Perinatal Services (when applicable)
- Oral health assessment and dental screening and referral for children
- Assessment for age/gender specific preventive screenings or services and health education
- Preventive screening as recommended by the United States Preventive Services Taskforce (USPSTF), Grade A & B recommendations
    - *Not all of the Grade A & B recommendations have to be completed during the IHA, so long as members receive all required screenings in a timely manner consistent with USPSTF guidelines.*
- Identification of risks (e.g., drug, alcohol, or tobacco use)

[1] **HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).**
[2] **CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).**

- Health education and anticipatory guidance appropriate for age
- Diagnosis and plan for treatment of any diseases

In addition to the components described above, IHAs must be completed in accordance with:

- Early and Periodic Screening, Diagnostic and Treatment American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule for *members under age 21, including but not limited to provision of all immunizations necessary to ensure that members are up-to-date for their age, Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings.*
- American College of Obstetricians and Gynecologists (ACOG) standards and guidelines for *pregnant or postpartum members*

For pregnant, breastfeeding, or postpartum members, or a parent/guardian of a child under the age of five (5), documentation of a referral to the Women, Infants, and Children Program (WIC) program is mandated by Title 42 CFR 431.635(c).

As soon as possible and no later than 60 calendar days following the IHA or other visit that identified a need for follow-up, PCPs must make arrangements for necessary follow-up, diagnostic, and/or treatment services for risk factors or disease conditions discovered. This includes the provision of immunizations in accordance with the recommendations published by the Advisory Committee on Immunization Practices (ACIP).

If any component of the IHA is refused, the member's, or parent's or guardian's, voluntary refusal must be documented in the member's medical record to indicate the services were advised.

Reports: All provider notifications regarding members in need of an IHA is communicated through monthly reports that are updated on CenCal Health's Provider Portal in the Coordination of Care Section – Assigned Members tab.

For additional training on the portal, please contact CenCal Health's Webmaster via email at webmaster@cencalhealth.org.

Pay for Performance: CenCal Health's new Quality Care Incentive Program encourages IHA visits through measures like Well Child Visits in the First Thirty Months of Life, Child and Adolescent Well-Care Visits, HbA1c Testing, Breast Cancer Screening, and Cervical Cancer Screening. For more information, please go to: https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

Monitoring: To assure the completion and documentation of required components addressed during an IHA visit, CenCal Health performs an annual medical record review audit. Findings are shared via IHA Provider Performance Reports and discussed with audited PCPs. The completion of IHA documentation including the use of the SHA is also monitored through the Facility Site Review process.

Member Outreach: CenCal Health performs 3 documented attempts (telephone and mail notification) to informs new members that an IHA is a covered benefit. Members are

instructed to call their PCP for an appointment to assure their health care risks and needs are assessed and met timely.

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

Member Population	CPT Billing Codes	ICD-10 Codes
Preventive visit, new patient	99381 - 99387	No restriction
Preventive visit, established patient	99391 - 99397	No restriction
Office visit	CPT and appropriate diagnosis codes: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2	
Prenatal care	Z1032, Z1034, Z1038, Z6500, 59400, 59510, 59610, 59618	Pregnancy related diagnosis

Reference Link:
USPSTF Grade A & B Recommendations:
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

Bright Futures/AAP Periodicity Schedule
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.40438369.2145994991.1677151637-1437524156.1677151636

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.

Reference Link:
California Department of Health Care Services
https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx

DHCS's Provider-Preventable Conditions
https://www.dhcs.ca.gov/individuals/Pages/PPC_Reporting.aspx

L9: Adverse Childhood Experiences Screening
An Adverse Childhood Experiences (ACEs) screening evaluates children and adults for trauma that occurred during the first 18 years of life.

Training and Certification

The California Department of Health Care Services (DHCS), in partnership with the California Office of the Surgeon General, created a first-in-the-nation statewide effort to screen patients for ACEs that lead to trauma and the increased likelihood of ACEs-Associated-Health Conditions due to toxic stress.

Detecting ACEs early and connecting patients to interventions, resources, and other supports can improve the health and well-being of individuals and families. By screening, providers can better determine the likelihood a patient is at increased health risk due to a toxic stress response, which can inform patient treatment and encourage the use of trauma-informed care.

The two-hour online curriculum will provide Continuing Medical Education (CME) and Maintenance of Certification (MOC) credits. To sign up, go to:
https://www.acesaware.org/

Billing and Payment
To be eligible for reimbursement, the network provider performing the screening must meet all the following criteria:

1. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate.
2. Be on DHCS' list of providers that have completed the state-sponsored trauma-informed care training and provided a *self-attestation*.
3. Bill using one of the HCPCS codes in the table below.

Patients under age 21 may receive periodic rescreening as determined appropriate and medically necessary, not more than once per year, per provider. Patients age 21 and older may be screened once in their adult lifetime up to age 65, per provider.

Coding of the screening is dependent on the resulting score.

HCPCS Code	Description	ACEs Score
G9919	Screening performed – results *positive* and provisions of recommendations provided	4 and greater (high risk)
G9920	Screening performed – results *negative*	0 to 3 (low risk)

Screening Tools
The ACEs questionnaire for adults (ages 18 years and older) and Pediatric ACEs and Related Life-events Screener (PEARLS) tools for children (ages 0 to 19 years) are both forms of ACEs screening. Both tools are acceptable for Members aged 18 or 19 years. The ACEs screening portion (Part 1) of the PEARLS tool is also valid for use to conduct ACEs screenings among adults ages 20 years and older. If an alternative version of the ACEs questionnaire for adults is used, it must contain questions on the 10 original categories of ACEs to qualify.

10 original ACE categories:

- Abuse
    1. Physical
    2. Emotional
    3. Sexual
- Neglect
    4. Physical
    5. Emotional
- Household Dysfunction
    6. Parental incarceration
    7. Mental illness
    8. Substance dependence
    9. Separation or divorce
    10. Intimate partner violence

The ACEs questionnaire and the PEARLS tool are available at the following link: https://www.acesaware.org/screen/screening-for-adverse-childhood-experiences/

Documentation Requirements
Medical record documentation of the ACEs screening must remain in the patient's medical record and be available upon request. It must include:

- Use of appropriate screening tool
- Review of completed screening
- Results
- Interpretation of results
- Discussion with the patient and/or family
- Any appropriate actions taken

L10: Social Determinants of Health (SDOH)
Social Determinants of Health (SDOH) are conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Consistent and reliable collection of SDOH data is vital to

identify ways to support our members. There are several health-related social factors that can be improved through the analysis of the member characteristics, health, social, and risk needs. Our providers are the key to identify the health disparities, and their root causes, that are negatively impacting our members' health.

Coding for SDOH

All network providers should include SDOH codes in their billing so that CenCal Health can better identify members needs and find solutions to help them thrive and achieve optimal health. The categories include:

- **Z55** – Problems related to education and literacy
- **Z56** – Problems related to employment and unemployment
- **Z57** – Occupational exposure to risk factors
- **Z58/Z59** – Problems related to housing and economic circumstances
- **Z60** – Problems related to social environment
- **Z62** – Problems related to upbringing
- **Z63** – Other problems related to primary support group, including family circumstances
- **Z64** – Problems related to certain psychosocial circumstances
- **Z65** – Problems related to other psychosocial circumstances

Code	Problems related to education and literacy (8)
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable and unattainable
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.5	Less than a high school diploma
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified

Code	Problems related to employment and unemployment (*11*)
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work

Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment

Code	Occupational exposure to risk factors (11)
Z57.0	Occupational exposure to noise
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor

Code	Problems related to housing and economic circumstances (17)
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.2	Discord with neighbors, lodgers, and landlord
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified

Code	Problems related to social environment (7)
Z60.0	Problems of adjustment to life transitions (life phase, retirement)
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty (migration, social transplantation)
Z60.4	Social exclusion and rejection (physical appearance, illness, behavior)
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problem related to social environment, unspecified

Code	Problems related to upbringing (19)
Z62.0	Inadequate parental supervision and control
Z62.1	Parental overprotection
Z62.21	Child in welfare custody (non-parental family member, foster care)
Z62.22	Institutional upbringing (orphanage or group home)
Z62.29	Other upbringing away from parents
Z62.3	Hostility towards and scapegoating of child
Z62.6	Inappropriate (excessive) parental pressure
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.812	Personal history of neglect in childhood
Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z62.819	Personal history of unspecified abuse in childhood
Z62.820	Parent-biological child conflict
Z62.821	Parent-adopted child conflict
Z62.822	Parent-foster child conflict
Z62.890	Parent-child estrangement NEC
Z62.891	Sibling rivalry
Z62.898	Other specified problems related to upbringing
Z62.9	Problem related to upbringing, unspecified

Code	Other problems related to primary support group, including family circumstances (12)
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.31	Absence of family member due to military deployment
Z63.32	Other absence of family member
Z63.4	Disappearance/death of family member (assumed death, bereavement)

Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.71	Stress on family due to return of family from military deployment
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful events affecting family/household (ill/disturbed member)
Z63.8	Other specified problems related to primary support group (discord or estrangement, inadequate support)
Z63.9	Problem related to primary support group, unspecified

Code	Problems related to psychosocial circumstances (3)
Z64.0	Problems related to unwanted pregnancy
Z64.1	Problems related to multiparity
Z64.4	Discord with counselors

Code	Problems related to other psychosocial circumstances (8)
Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.3	Problems related to other legal circumstances (arrest, custody, litigation)
Z65.4	Victim of crime and terrorism
Z65.5	Exposure to disaster, war, and other hostilities
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
Z65.9	Problem related to unspecified psychosocial circumstances

The list is subject to revisions and additions to improve alignment with SDOH data elements.

Reference Link:
https://www.cencalhealth.org/providers/social-determinants-of-health/