Section L: Quality Management

L1: Quality Improvement System

CenCal Health is firmly committed to high-quality equitable care delivered to our membership in a timely, appropriate, and compassionate manner. The way we ensure this happens is through our Quality Improvement and Health Equity Transformation Program (QIHETP). This program was designed to support CenCal Health's vision *to be a trusted leader in advancing health equity so that our communities thrive and achieve optimal health together*. The Quality Improvement System aligns with state regulations, (28 CCR 1300.70., Health Care Service Plan Quality Assurance Program). Additionally, the Quality Assurance for UM program oversight is consistent with DHCS guidelines (APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates) and the state regulations (H&S Code 1367.01).

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.

CenCal Health network providers and practitioners shall cooperate with CenCal Health's quality improvement activities to improve the quality of care and services, patient safety, and member experience. Cooperation includes collection and evaluation of data, including performance measurement data, and participation in CenCal Health's QIHETP. Network providers and practitioners agree that CenCal Health may use their performance data for quality improvement activities.

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 Improvement and Health Equity Transformation Program Work Plan and Evaluation of the prior year are developed annually in congruence with CenCal Health's Quality Improvement and Health Equity Transformation Program Description and CenCal Health's Strategic Plan.

- An annual Evaluation 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 to prospectively refine CenCal Health's Quality Improvement System.
- The annual Work Plan serves as a roadmap of specific quality improvement and health equity objectives and it establishes staff accountability for key activities in the coming year. To assure successful quality performance, with the annual development of CenCal Health's Work Plan, CenCal Health's leadership sets appropriate goals and objectives for staff.

For additional information, please contact CenCal Health's Population Health staff at populationhealth@cencalhealth.org.

Reference Link:
CenCal Health's Quality Improvement and Health Equity Transformation Program
www.cencalhealth.org/providers/quality-of-care/quality-program/

CenCal Health's Quality Improvement and Health Equity Committee Quarterly Reports to CenCal Health's Board of Directors
www.cencalhealth.org/providers/quality-of-care/quarterly-reports/

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 Improvement and Health Equity Transformation Program (QIHETP) Description, including:

- Utilization and care management programs
- Managed Care Accountability Set (MCAS) data collection - *refer to section L5 - Performance Monitoring for more details.*
- Plan-Do-Study-Act (PDSA)
- Performance Improvement Projects
- 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 Improvement and Health Equity Committee (QIHEC) 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 or QMGRP@cencalhealth.org

Reference Link:
Department of Health Care Services All Plan Letter (APL) 19-017
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-017.pdf

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 Relations 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.

Reference Link:

CenCal Heath Quality Care Incentive Program

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) 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.

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.

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) 2024/Reporting Year (RY) 2025 consists of 39 performance measures.

The NCQA Medicaid 50th percentile is the minimum performance level (MPL) set for 20 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.

Note: To find the current measurement year's performance measures, CenCal Health shares this information via CenCal Health's Website, Provider Bulletin, and Provider E-Mail Blast.
Please find the comprehensive list of the MY 2024/ RY 2025 draft MCAS measures that are currently available at the time of this publication:

#	MEASURE NAME	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY**	HELD TO MPL
Behavioral Health Domain				
1	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	YES
2	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	YES
3	Pharmacotherapy for Opioid Use Disorder*	POD	Administrative	YES
Cancer Prevention Domain				
4	Breast Cancer Screening*	BCS-E	ECDS	YES
5	Cervical Cancer Screening	CCS	Hybrid	YES
6	Colorectal Cancer Screening*	COL-E	ECDS	YES
Children's Health Domain				
7	Child and Adolescent Well-Care Visits*	WCV	Administrative	YES

8	Childhood Immunization Status: Combination 10*	CIS-10	Hybrid	YES
9	Developmental Screening in the First Three Years of Life	DEV	Administrative	YES
10	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid	YES
11	Lead Screening in Children	LSC	Hybrid	YES
12	Topical Fluoride for Children	TFL-CH	Administrative	YES
13	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	Administrative	YES
14	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	W30-2+	Administrative	YES
	Chronic Disease Management Domain			
15	Asthma Medication Ratio*	AMR	Administrative	YES
16	Controlling High Blood Pressure*	CBP	Hybrid	YES
17	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (> 9%) *	HBD	Hybrid	YES
	Reproductive Health Domain			
18	Chlamydia Screening in Women	CHL	Administrative	YES
19	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid	YES
20	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid	YES
	Report Only Measures to DHCS			
21	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	NO
22	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-Init	Administrative	NO
23	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	NO
24	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	NO
25	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	NO
26	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	NO
27	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	NO
28	Depression Screening and Follow-Up for Adolescents and Adults*	DSF-E	ECDS	NO

29	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	NO
30	Follow-Up After ED Visit for Substance Use – 7 days*	FUA	Administrative	NO
31	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	NO
32	Plan All-Cause Readmissions*	PCR	Administrative	NO
33	Postpartum Depression Screening and Follow Up	PDS-E	ECDS	NO
34	Prenatal Depression Screening and Follow Up	PND-E	ECDS	NO
35	Prenatal Immunization Status	PRS-E	ECDS	NO
36	Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications	SSD	Administrative	NO
	LTC Report Only Measures to DHCS			
37	Number of Outpatient ED Visits per 1,000 Long Stay Resident Days*	HFS	Administrative	NO

38	Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization*	SNF HAI	Administrative	NO
39	Potentially Preventable 30-Day Post Discharge Readmission*	PPR	Administrative	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

For questions regarding measurement specifications, please contact CenCal Health's Quality Measurement team at (805) 562-1609 or QMGRP@cencalhealth.org.

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 Electronic Medical Record (EMR) System Access

Remote medical record review via secure connection to providers 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 team at (805) 562-1609 or QMGRP@cencalhealth.org.

HIPAA

All providers are contractually obligated to provide CenCal Health with medical records upon request without the need for member consent. HEDIS data collection and release of information are permitted under HIPAA since the disclosure of records is part of quality assessment and improvement activities. Please be assured that when providing Quality staff EHR access, or medical records via a different means, that protected health information is maintained in accordance with federal and state laws.

Reference Links:
CenCal Health Performance Measures
https://www.cencalhealth.org/providers/quality-of-care/performance-measures/

Medi-Cal Managed Care Accountability Set
https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx#:~:text=The%20Managed%20Care%20Accountability%20Sets%20%28MCAS%29%2C%20previously%20known,reporting%20by%20Medi-Cal%20managed%20care%20health%20plans%20%28MCPs%29.

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 extended period. The California Department of Healthcare Services (DHCS) requires all Medi-Cal Managed Care Plans to participate in a minimum of two (2) PIPs per cycle. These PIPs 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 scores for measures within the Managed Care Accountability Set which includes National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS) measures. Topic selection can also be based on low CAHPS®[1] 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.

CenCal Health may ask providers in our contracted network to participate in these PIPs. Participation consideration is based on the requirements of the PIP as well as the providers scores as they relate to scores related to the topic selection.

CenCal Health's PIPs for 2023-2026:

- Improve the percentage of provider notifications for CenCal Health members diagnosed with substance use disorder (SUD) or serious mental illness (SMH) diagnoses within 7 days of an emergency department (ED) visit.
- Improve Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits (W30–6) measure rates for CenCal Health's Hispanic/ Latino population and decrease the disparity among other racial/ethnic counterparts.

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.

Initial Health Appointment'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.

Note: 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.

[1] **CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).**

Initial Health Appointment 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
- Current 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 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)
- 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.

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

Member Outreach: CenCal Health performs 3 documented attempts (telephone and mail notification) to inform 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: 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	Any CPT and appropriate diagnosis code: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2	
Obstetrical Care	Z1032, Z1034, Z1038, Z6500, 59400, 59510, 59610, 59618	Prenatal/Postpartum related diagnosis

Reference Links:

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

American College of Obstetricians and Gynecologists (ACOG) standards and guidelines
https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline

Advisory Committee on Immunization Practices (ACIP)
https://www.cdc.gov/vaccines/acip/recommendations.html

Department of Health Care Services All Plan Letter (APL) 22 – 030:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf

CenCal Health's Quality Care Incentive Program
https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

L8: 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/

Please make a copy of your email confirmation, and email a copy of your training certificate to CenCal Health Provider Relations Department at psrgroup@cencalhealth.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

Information, materials, screening tools, and training opportunities can be found at ACEsAware.org, or by emailing info@ACEsAware.org. For more information on this service, or for help improving your clinical care, please email CenCal Health's Quality team at qualityimprovement@cencalhealth.org.

L9: 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 Links:

Department of Health Care Services All Plan Letter (APL) 21-009
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf

CenCal Health Social Determinants of Health
https://www.cencalhealth.org/providers/social-determinants-of-health/

L10: Basic Population Health Management

Basic Population Health Management (BPHM), is a primary component of CenCal Health's Population Health Management (PHM) Strategy and Program Description as required by the Department of Health Care Service (DHCS) which is a cornerstone of CalAIM. The BPHM is an approach to care that ensures needed programs and services are made available to each member, regardless of the member's risk and Social Determinants of Health (SDOH), at the right time and in the right setting. CenCal Health maintains a BPHM system and ensures it promotes health equity and provides all members services delivered in a culturally and linguistically competent manner that are responsive to member needs, beliefs, and preferences. All Basic PHM services are aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). .

CenCal Health and the provider network should note the following components of the PHM Strategy and Program Description:

- Gathering member Information: through providers' initial screenings and reporting in claims, encounters, and other data;
- Understanding Risk: where CenCal Health analyzes member medical utilization and personal characteristics through available data to quantify member risk; and,
- Providing Services and Supports: through Basic Population Health Management (BPHM), Care Management, and, as-needed, Transitional Care Services.

Gathering Member Information

Providers are required to report accurate and timely claim and encounter data to CenCal Health. This facilitates CenCal Health's ongoing efforts to gather complete member information and to be able to analyze our members' risks and population needs. Providers should ensure they are also reporting all available (SDOH) diagnosis codes in their claim, encounter, and other report data provided to CenCal Health to ensure proper capture of these factors contributing to the health outcomes of members. More information about SDOH and coding can be found in Section L10: "Social Determinants of Health" of this Provider Manual.

Understanding Risk

CenCal Health aims to help members with their health before they require intensive treatment and care. Therefore, understanding member risk is important as it helps to identify potential interventions that are at the earliest possible point of intervention based on member risk level. CenCal Health utilizes Risk Stratification and Segmentation (RSS) and Risk Tiering to understand members' risk.

Providing Services and Supports

In addition to providing accurate and timely member data, providers have a role in ensuring the delivery of services under this framework and ensuring coordination of services.

BPHM is provided to all members, regardless of their level of need; in contrast to Care Management, which is focused on populations with significant or emerging needs.

The BPHM system includes:

1. Access, Utilization, and Engagement with Primary Care
2. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports
3. Information Sharing and Referral Support Infrastructure
4. Integration of Community Health Workers (CHWs) in PHM
5. Wellness and Prevention Programs
6. Programs Addressing Chronic Disease
7. Programs to Address Maternal Health Outcomes
8. PHM for Children

Primary Care Providers (PCPs) and Enhanced Care Management (ECM) providers have a unique role in managing care coordination efforts for their assigned members; however, all providers should ensure care coordination and referral support throughout the continuum of care, including coordination with those lead care management providers in the network (PCPs and ECM providers) to facilitate member access to services.

Providers must ensure coordination of care with all entities, including those agencies that provide services not directly managed by CenCal Health. Those entities include but are not limited to:

- Dental services
- Specialty Mental Health Services
- County Substance Use Services
- California Children's Services (CCS)

- Tri-Counties Regional Center (TCRC)
- Local Education Agency (LEA)
- Medi-Cal's Pharmacy Benefit via Medi-Cal Rx

CenCal Health provides the following resources to providers to assist in this process:

- Systems to electronically track and monitor referrals, including those for care management and the outcomes of those referrals via the Provider Portal.
- A community resource directory available on the CenCal Health website at www.cencalhealth.org.
- A toll-free number to obtain assistance with making referrals. More information on referrals can be found within this Manual on Section H: "Referrals and Authorizations," and Section I "Care Management Programs and Community Support Services."
- Other training and provider supports for working with CenCal Health, as further described in Section B3: "Provider Education and Training Resources" of this Manual.

References:

Policies

- Basic Population Health Management: Identifying & Addressing Member's Needs due to Social Drivers of Health
- Basic Population Health Management: Identifying Members Needing Preventive Services & Increasing Appropriate Preventive Service Utilization

L11: Vaccines for Children (VFC) & Declinations Process

Vaccines for Children (VFC) is a federally funded program that provides free vaccines for eligible children aged 18 or younger (including all Medi-Cal Eligible children age 18 or younger) and distributes immunization updates and relation information to participating providers. CenCal Health encourages all providers who see members aged 18 or younger to enroll as a VFC participating provider to improve access to immunizations.

Providers that are enrolled in the VFC program have access to all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Providers that would like to enroll in the VFC program may do so through eziz.org. CenCal Health providers may also contact the Provider Relations department for support in enrolling in the VFC program.

When providing vaccines to children, appropriate medical documentation protocol must be followed. If any vaccines are refused, documentation must be entered in the member's Medical Record which indicates the services were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of those services.

L12: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

CenCal Health PCPs are required to ensure the provision of all screening, preventive and medically necessary diagnostic and treatment services for members under 21 years of age required under the Early and Periodic Screen, Diagnosis and Treatment (EPSDT) benefit described in Title 42 of the United States Code section 1396d(r) and W&I Code section 14132(v).

The benefits covered under EPSDT are key to ensuring children and youth receive appropriate preventive medical, dental, vision, hearing, mental health, substance use disorder, developmental and specialty services, as well as all medically necessary services to address any defects, illnesses or conditions identified.

The following chart defines the separate components of the EPSDT benefit:

Early	Assessing and identifying problems early
Periodic	Checking member's health at periodic, age-appropriate intervals
Screening	Providing physical, dental, vision, hearing, mental health, developmental and other comprehensive screening exams and tests to detect potential problems
Diagnostic	Performing diagnostic tests to follow up when a risk is identified
Treatment	Control, correct or reduce health problems found

EPSDT services, including preventive health visit anticipatory guidance, must be provided as recommended by the American Academy of Pediatrics (AAP) Bright Futures Guidelines and age-specific assessments and services within the Periodicity Schedule (https://www.aap.org/periodicityschedule) for all members under 21 years of age. The AAP regularly publishes updated tools and resources for use by clinicians and state agencies.

- At each non-emergency primary care visit with a member under 21 years of age, the member (if an emancipated minor), or the parent(s) or guardian of the member, is advised of the children's preventive services due and available from CenCal Health.

- When a request is made for children's preventive services by the member, the member's parent(s) or guardian, or through a referral from the local Child Health and Disability Prevention (CHDP) program, *an appointment must be made for the member to have a visit within ten (10) Working Days of the request*, unless member declines a visit within ten (10) Working Days of the request and another appointment date is chosen by the member.

- Documentation must be entered in the member's medical record indicating receipt of preventive services in accordance with the AAP Bright Futures standards.

- All refusals of children's preventive services must be documented in the member's medical record indicating the services were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of those services.

Medical Necessity

- EPSDT services are medically necessary or a medical necessity if they correct or ameliorate defects and physical or behavioral health conditions discovered through screening as set forth in Title XIX of the Social Security Act, Section 1905(r)(5) and in Welfare and Institutions Code (W&I Code), Section 14059.5(b)(1).

- PCPs must arrange for all medically necessary services identified at a preventive screening or other visit identifying the need for treatment, either directly or through referral to appropriate agencies, organizations, or individuals.

- All medically necessary services must be initiated in a timely manner, as soon as possible, *but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up*.

- If members less than 21 years of age are not eligible or accepted for medically necessary targeted case management services by a Regional Center or local government health program, CenCal Health will arrange for comparable services for the member.

- CenCal Health provides appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from

medical appointments for medically necessary services, including all services available through the Medi-Cal program, whether or not they are covered services.

Specialty Mental Health Services

- Covered services do not include Specialty Mental Health Services (SMHS). For these non-covered services, CenCal Health ensures that:
    - The case management for medically necessary services authorized by county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System Plans is equivalent to that provided by CenCal Health for covered services for members under 21 years of age.
    - If indicated or upon the member's request, CenCal Health provides additional Care Coordination and case management services as necessary to meet the member's medical and behavioral health needs.

"Medi-Cal for Kids and Teens"

The Department of Health Care Services (DHCS) refers to EPSDT as "Medi-Cal for Kids and Teens" in outreach and education materials. DHCS has developed child-focused and teen-focused brochures that provide an overview of EPSDT, including Covered Services, how to access those services, and the importance of preventive care. Additionally, DHCS provides guidance that illustrates what to do if Medi-Cal care is denied, delayed, reduced, or stopped, including who to contact, how to file grievances and appeals, and how to access other enrollee assistance resources.

Member Outreach

CenCal Health supports its PCPs by identifying Members who have not utilized EPSDT screening services or AAP Bright Futures preventive services by:

- Making gaps in care reports available via the Provider Portal. Please refer to **Section L4: Quality Care Incentive Program** and **L7: Initial Health Appointment** for details. For additional information, please contact the Population Health team at populationhealth@cencalhealth.org.
- Ensuring outreach to these Members in a culturally and linguistically appropriate manner to increase utilization of clinically recommended services in accordance with established guidelines. For additional information, please contact the Health Promotion team at: healtheducation@cencalhealth.org

Reference Links:

DHCS APL 23-005 Requirements For Coverage Of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the age of 21
APL 23-005 (ca.gov)

American Academy of Pediatrics Bright Futures
https://www.aap.org/en/practice-management/bright-futures/

DHCS Medi-Cal for Kids and Teens Provider Information
https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Provider-Information.aspx

Medi-Cal for Kids & Teens Provider Training
https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/DHCS-EPSDT-Provider-Training.pdf

Medicaid.gov: Early and Periodic Screening, Diagnostic, and Treatment
https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

L13: Autism Spectrum Disorder (ASD) Screening

ASD Screenings must be performed at 18 months and 24 months of age based on AAP periodicity "Bright Futures."

If the patient is positive for risk factors, providers should offer and document the follow-up interventions:

- Ages and Stages Questionnaires (ASQ)
- Communication and Symbolic Behavior Scales (CSBS)
- Parents' Evaluation of Developmental Status (PEDS)
- Modified Checklist for Autism in Toddlers (MCHAT)
- Screening Tool for Autism in Toddlers and Young Children (STAT)
- Survey of Well-being of Young Children (SWYC) screening tools (assess three domains of child functioning: developmental domain, emotional/behavioral domain, and family context)

Screening should occur per "identification, Evaluation, and Management of Children With Autism Spectrum Disorder."

Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449.

See the AAP publication regarding Identification, Evaluation, and Management of Children with ASD, available at: https://pediatrics.aappublications.org/content/145/1/e20193447.

See the Tufts Children's Hospital Survey of Well-being of Young Children, available at: https://www.tuftschildrenshospital.org/The-Survey-of-Wellbeing-of-YoungChildren/Overview.

See the AAP Screening Tools, available at: https://www.aap.org/en/patientcare/screening-technical-assistance-and-resource-center/screening-toolfinder/?page=1

Referral for BHT Services

Physicians, Psychologists, and Surgeons who recommend Behavioral Health Treatment (BHT) as Medically Necessary should submit an ABA Recommendation Form directly to the Behavioral Health Department at (805) 681-3070 or via secure link at https://gateway.cencalhealth.org/form/bh

An ASD diagnosis is not necessary to start Behavioral Health Treatment, only a recommendation from a physician, psychologist, or surgeon. The member may be eligible if they are medically stable, not in an need of 24 hour nursing or monitoring, and not in an Intermediate Care Facility.

Providers should complete the ABA Recommendation form entirely. Providers mut work with the member to identify an available contracted BHT provider.

Referral for Psychological Testing

Psychological testing utilizes tests and other assessment tools to measure and observe a patient's behavioral to assess diagnosis and guided treatment.

Providers who believe that a member may need psychological testing after completing screening and evaluative methods should refer the member to a contracted psychologist for a psychological evaluation to determine if psychological testing is medically necessary. A referral is not required, providers may contact any contracted provider to arrange an appointment on behalf of the member or refer the member to the provider for scheduling.

Providers should ensure to provide the psychologist with all relevant evaluative and developmental history and the clinical question that testing would answer.

Billing

Developmental Screening

- CPT Code: 96110 with modifier KX

Developmental Testing

- CPT Code: 96112
- CPT Code: 96113

L14: Depression Screenings

AAP recommends screening for major depressive disorder in adolescents aged 12 to 20 years.

Screenings should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up if screening is positive and a follow up plan is documented.

Depression screening may be completed using a validated screening tool. Commonly used validated screening tools include:

- Patient Health Questionnaire-9 (PHQ-9)
- Patient Health Questionnaire-2 (PHQ-2)

Per AAP, screen using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit, and available at: https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf and https://www.aap.org/en/patient-care/screening-technical-assistance-and-resourcecenter/screening-tool-finder/?page=1

Maternal Depression Screening

Maternal mental health conditions is defined as a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

Providers who provide prenatal or postpartum care for a patient are required to screen or appropriately screen a mother for maternal mental health conditions. Screenings should also occur if the member has experienced a stillbirth or miscarriage (Health and Safety Code, section 123640).

Maternal depression screenings must occur at 1-month, 2-month, 4-month and 6-month visits.

Maternal depression screening must be done using a validated screening tool.

Perinatal Depression Screening

- A Safe Environment for Every Kid (SEEK) Questionnaire-R (PQ-R)
- Edinburgh Postpartum Depression Scale (EPDS)
- Patient Health Questionnaire-9 (PHQ-9)

Per AAP, "screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice', available at: https://pediatrics.aappublications.org/content/143/1/e20183259

See the ACOG Frequently Asked Questions on Postpartum Depression, available at: https://www.acog.org/Patients/FAQs/Postpartum-Depression. See the USPSTF recommendation on Screening

Depression in Adults, available at:
https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1

See the U.S. Department of Health and Human Services guidance on Postpartum Depression, available at: https://www.womenshealth.gov/mental-health/mental-healthconditions/postpartum-depression.

Referrals

Members may be referred, with appropriate consent, for mental health services using the Behavioral Health Care Coordination form to the Behavioral Health Department at (805) 681-3070.

Members do not require a referral or authorization to access mental health services. Members may also contact the Behavioral Health Call Center at (800) 421-2560 to obtain names and numbers of available providers.

Please refer to **E7 Mental Health Services**, **E8 Substance Use Services** and **F2 Specialty Mental Health Services**.

Members may also be referred to Case Management Services, please refer to I3 Care management.

Documentation

Providers should offer and document appropriate follow up interventions(s) for patient whose screening is positive for depression.

Providers should also ensure to document appropriate follow up for referrals.

Billing

- **G8431:** Screening for Depression, Positive Result and Provision of Recommendations Provided.
- **G8510:** Screening for Depression, Negative Result