Section (Primary Department) **Quality Management**		**SUBJECT (Document Title)** **Initial Health Appointments for Children and Adults - CA**	
Effective Date 05/01/1996	**Date of Last Review** 11/17/2023	**Date of Last Revision** 11/17/2023	**Dept. Approval Date** 11/17/2023
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☒ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Blue Cross Medicaid (Plan) ensures the provision of an Initial Health Appointment (IHA) within 120 days of Plan enrollment for new members. The IHA policy is built on and complies with the requirements in the California Code of Regulations (CCR) Title 22, Section 53851, DHCS All Plan Letter 22-024 Population Health Management Policy Guide, the Plan's contract, and DHCS All Plan Letter 22-030 Initial Health Appointment. Engaging the new member with their Primary Care Provider (PCP) by providing a timely IHA is the foundation of Basic Population Health Management (BPHM) and:

- Leverages culturally and linguistically appropriate primary care in alignment with National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) in accord with policy CA CLLS 018 Cultural and Linguistic Program-CA
- Promotes establishment of a medical home and relevant adult and pediatric assessments
- Assists with navigating and coordination of referrals for health, health education, dental, social services, benefit programs and levels of care coordination
- Improves health care disparities

During the IHA, the Provider assesses and manages the acute, chronic, and preventative health needs of the member.

DEFINITIONS:

Dental screenings/oral health assessments for all members: As part of the IHA, PCPs provide an initial dental screening/oral health assessment for all members and refer to a dental provider to address any immediate dental needs and for comprehensive dental care. For Members under the age of 21, a dental screening/oral health assessment must be performed as part of every periodic assessment, with dental referrals made for Members no later than 12 months of age or when a referral is indicated based on assessment. Fluoride varnish, including

when provided by a PCP, and oral fluoride supplementation assessment and provision must be consistent with the AAP/Bright Futures periodicity schedule and anticipatory guidance. MCPs must also ensure that members are referred to appropriate Medi-Cal dental providers.

Dyadic Care Services: Per APL 22-029, Dyadic Care Services And Family Therapy Benefit, the Dyadic Care Services benefit is a family- and caregiver-focused model of care that addresses children's (member ages 21 or below) developmental and behavioral health conditions as soon as they are identified, and fosters access to preventive care, coordination of social-emotional health and safety, developmentally appropriate parenting, and maternal mental health. It is provided within pediatric primary care settings when possible and includes Dyadic Behavioral Health (DBH) well-child visits Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development. Refer to CA Dyadic Care Policy and Procedure.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, referred to by the CA Department of Health Care Services (DHCS) as Medi-Cal for Kids and Teens, provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

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

Health Information Form (HIF)/Member Evaluation Tool (MET): The Health Information Form (HIF)/Member Evaluation Tool (MET) is a screening tool that is required to be completed within 90 days of MCP enrollment for new members and the Health Risk Assessment (HRA) is required for Seniors and Persons with Disabilities. Members submit their completed assessments to Anthem Care Management, who reviews responses, outreaches to members to offer support and/or connection for follow-up, including following up with the PCP, as needed.

Individual Health Education Behavior Assessment (IHEBA) and Staying Healthy Assessment (SHA): The IHEBA/SHA were retired on January 1, 2023. As a result, all screenings and assessments addressed by completing a SHA are to be completed by the PCP using standardized assessment tools, in a culturally and linguistically appropriate manner that seek to define the member's risk factors and problems; determine a member's needs, preferences,

health goals and priorities; and aid in the development of treatment recommendations, referrals and follow-up as documented in the medical record. Tools include, but are not limited to, required age-specific screenings such as Adverse Childhood Experiences (ACEs); developmental progress and autism; vision and hearing; brief emotional/behavioral assessments and health behavior assessments and interventions; SABIRT, depression, substance use disorder (SUD) and postpartum mood disorder screening; Tobacco Cessation counseling and screening for referral to the Diabetic Prevention Program and cognitive assessment.

Initial Health Appointment (IHA): Previously called Initial Health Assessment, the IHA is an appointment required to be completed within 120 days of enrollment for new members according to contractual and APL requirements [refer to below Provision of Services]. The IHA is provided in a way that is culturally and linguistically appropriate for the member in alignment with National CLAS Standards, and includes a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan of care for any needs, conditions and identified diseases.

An IHA is performed by a Primary Care Provider (PCP) within the primary care medical setting, which shall be designated as general practice, pediatrics, obstetrics, gynecology, or internal medicine, in alignment with the definition of PCPs and must be documented in the member's medical record. An IHA is not necessary if the member's PCP determines that the member's medical record contains complete information that was updated within the previous 12 months.

National CLAS Standards: The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care from the U.S. Department of Health and Human Services (as enhanced in 2013).

Perinatal services: Perinatal services may be part of an IHA, with services provided according to the most current standards of the American College of Obstetrics and Gynecology.

PROCEDURE:

I. Provision of Services

The IHA is completed within 120 days of enrollment for new members and provided in a way that is culturally and linguistically appropriate for the member in alignment with National CLAS Standards. An IHA is performed by a Primary Care Provider (PCP) within the primary care medical setting, who comprehensively assesses the member's physical and behavioral health

history and current acute or chronic conditions including diagnosis and plan for treatment of any disease; provides health education, identifies risks and assesses need for preventive screens or services and plans appropriate follow-up; and identifies those members whose health needs require coordinated services with appropriate community resources, including other agencies not covered by the Plan.

A Plan practitioner who cares for the member during pregnancy shall provide the IHA through the initial prenatal visit(s) and must document that the prenatal visit(s) met IHA content and timeline requirements.

Where appropriate, Providers who have implemented telehealth may provide appropriate elements of the IHA exam virtually, followed by a timely in-person visit. Providers are strongly encouraged to have an in-place process to monitor and ensure scheduling and completion of the in-person component of the IHA visit. The telehealth and secondary in-person visits are considered part of the same well-visit exam and may only be billed for once, at the completion of the telehealth component.

II. IHA Scheduling

Providers are required to offer an appointment for an IHA within 120 days for new members as described in policy *CA_PNXX_033 Access to Care Standards, the Medi-Cal Provider Manual* and other references listed below.

The Plan informs all eligible members about the importance of getting an IHA using clear and non-technical language and has a process to remind adult members and child members, if emancipated minors or of age of majority, or parent(s) or guardian of children about scheduling an appointment for an IHA. IHA information is included in the New Member Welcome Packet to inform members of the importance of completing their IHA within the below time frames.

IHAs for newly enrolled children less than 18 months of age must be completed within 120 calendar days of enrollment or within periodicity timelines established by the most recent American Academy of Pediatrics (AAP) “Recommendations for Preventive Pediatric Health Care” periodicity schedule for age 2 and younger, whichever is sooner. Likewise, for newly enrolled members up to 21 years of age, the IHA must be completed according to the most recent American Academy of Pediatrics (AAP) “Recommendations for Preventive Pediatric Health Care” periodicity schedule, but in no case no later than 120 days of enrollment.

For adults aged 21 and over, the IHA must be completed within 120 days of enrollment, and includes, but is not limited to, an evaluation of applicable preventive services provided in

accordance with the United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations. Specific time frames are included in the 2022 Medi-Cal Managed Care Contracts.

An IHA may be waived if a PCP determines that the enrollee's medical record contains complete and current information consistent with the health assessment requirements below within the last 12 months.

III. Components of the IHA

Required elements of the IHA include:

- Culturally and linguistically appropriate primary care in alignment with National CLAS Standards
- A history of the member's physical and behavioral/mental health
    - History of past and current medical illness(es)
    - Behavioral Health/Social history
- Physical assessment, findings, preventive care, and screenings
    - For all members, Review of Organ Systems (ROS) with diagnosis and plan for further evaluation and treatment of any identified diseases or conditions. As indicated:
        - Perform routine intake assessments such as blood pressure readings
        - Perform prenatal visit and/or referral for prenatal care as indicated
        - Assess and manage new health conditions
        - Assess and manage chronic health conditions
        - Perform needed point of care lab work, such as A1c, or other diagnostic services and/or referral for same
        - Referrals for any abnormal findings
    - Dental screenings/oral health assessments for all members
        - Follow Plan's referral policy to ensure the member is seen by a dental provider following an initial dental health screening to address any immediate dental needs and for comprehensive dental care and oral exam.
    - Children's preventive care
        - IHAs for newly enrolled children less than 18 months of age must be completed within 120 calendar days of enrollment or within periodicity timelines established by the most recent American Academy of Pediatrics (AAP) "Recommendations for Preventive Pediatric Health Care" periodicity schedule for age 2 and younger, whichever is sooner, and services provided will conform to the AAP schedule
        - Likewise, for newly enrolled members up to 21 years of age, the IHA must be completed according to the most recent American Academy of

Pediatrics (AAP) "Recommendations for Preventive Pediatric Health Care" periodicity schedule, but in no case no later than 120 days of enrollment, and services provided will conform to the AAP schedule

- The initial IHA must include, or arrange for, provision of, all immunizations necessary to ensure that the child is up-to-date for their age
- Blood Lead Screening: For new members aged 6 to 72 months of age, parent(s)/guardian shall be given anticipatory guidance on the sources of lead exposure and health effects of lead poisoning
    - At the IHA, and then at every well child visit,
    - Obtain or order a blood lead level (BLL) test for children aged 12 months and 24 months. If a child has not had a BLL test at 24 months, a test shall be performed or ordered up to age 72 months
    - BLL Testing for refugees shall be completed according to the CDC guidelines
    - BLL test refusals shall be documented in the medical record by a signed voluntary refusal statement by the parent(s)/guardian or documentation that parent(s)/guardians refused to sign such a statement
- Identification of issues and risks using standardized assessment tools, for example
    - Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings
    - Assessment of developmental status
- Assessment of need for Dyadic Care, Family Therapy or other Behavioral Health Services and corresponding inclusion of Dyadic services within the context of the well-child visit and related referrals
- For all members, administering appropriate Health Education/Anticipatory Guidance

- Adult Preventive Care
    - Preventive screenings for adults are completed in accordance with the Plan's Preventive Health Care Guidelines based on the most current U.S. Preventive Services Task Force (USPSTF) "A" and "B" recommendations for providing preventive screening, testing, and counseling services, American College of Obstetricians and Gynecologists (ACOG) Standards and Guidelines and in conformance to Title 22, CCR, Section 53910.5(1)(1) for adults 21 years of age and older
    - The IHA provides the PCP with an opportunity to perform well- adult care, or at a minimum, perform an assessment of the need for preventive screens or services, and corresponding referrals

- Provide well-woman exams (including cervical cancer screening) and referral of members for related services, such as breast cancer screening
- For adults, the IHA includes an evaluation of and referral for applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations

- Identification of issues and risks using standardized assessment tools,
- Assessment and referral for behavioral health services
- For all members, administering appropriate Health Education/Anticipatory Guidance

The Plan continues to hold network providers accountable for providing all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the initial appointment, so long as members receive all required screenings in a timely manner consistent with USPSTF guidelines.

For all members, the IHA will include referrals for navigating and coordination of health, social services and benefit programs and levels of care coordination as appropriate. Anthem's Medi-Cal Provider Manual includes listings of many IHA-appropriate referral contacts, including, the Women's Infants and Children (WIC) Program; CA Children's Services (CCS); Regional Centers and more.

IV. Medical Record Documentation Requirements

Components of the IHA must be documented in the medical record and comply with the Plan's standards as described in policy *CA_QMXX_045 Medical Record Documentation and Confidentiality Standards.*

Medical Record Documentation should include:

- Notes relating to culturally and linguistically appropriate primary care in alignment with National CLAS Standards
- Documentation of the history of the member's physical and behavioral/mental health
  - Past and current medical illness(es)
  - Behavioral Health/Social History
- Documentation of physical assessment and findings, preventive care, and screenings
  - Review of Organ Systems (ROS) with diagnosis and plan for further evaluation and treatment of any identified diseases or conditions. As indicated:
    - Routine intake assessments such as blood pressure readings

- Prenatal visit findings and/or referral for prenatal care
- Assessment and management of new health conditions
- Assessment and management of chronic health conditions
- Point of care lab work, such as A1c, and results, or other diagnostic services and/or referral for same
- Referrals for any abnormal findings

- Dental screenings/oral health assessments for all members
  - Referral to ensure the member is seen by a dental provider to address any immediate dental needs and for comprehensive dental care and oral exam
- Children's preventive care
  - Services provided in conformance with AAP schedule
  - Immunizations
  - Blood Lead Screening: document anticipatory guidance on the sources of lead exposure and health effects of lead poisoning
    - Blood lead level (BLL) testing or referral, including results
    - BLL test refusals documented in the medical record by a signed voluntary refusal statement by the parent(s)/guardian or documentation that parent(s)/guardians refused to sign such a statement
  - Results of standardized assessment tools, for example
    - Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings
    - Assessment of developmental status
  - Assessment of need for Dyadic Care or other Behavioral Health Services and corresponding referral
  - Appropriate Health Education/Anticipatory Guidance
- Adult Preventive Care
  - Document preventive screenings completed and an assessment of the need for further preventive screens or services, and corresponding referrals in accordance with the United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations.
  - Identification of issues and risks using standardized assessment tools,
  - Assessment and referral for behavioral health services
  - Appropriate Health Education/Anticipatory Guidance

PCP shall make reasonable attempts to contact a member and schedule an IHA. If documentation of an IHA is not found in the medical record, document all contact attempts to schedule and the reason (e.g. member's refusal, missed appointment).

The Provider Manual instructs providers to document, in the medical record, unsuccessful attempts to contact a member, attempts to schedule an IHA, missed appointments or the member's refusal to schedule an IHA, as evidence that an IHA was attempted.

Documentation of attempts to schedule an IHA is considered evidence in meeting this requirement. For example: The member missed a scheduled PCP appointment and two additional documented attempts to reschedule have been unsuccessful.

V. Follow-up Services

The PCP is responsible for assuring that arrangements are made for follow-up services that reflect the findings, special needs or risk factors discovered during the IHA. This includes referrals for Dyadic Care Services, preventive care screenings, navigating and coordination of health, dental, social services and benefit programs and levels of care coordination and others that may have been identified.

Follow-up services are completed according to the General Appointment Schedule found in the policy *CA_PNXX_033 Access to Care Standards* and in the Provider Manual initiated 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.

Plan practitioners may refer members with chronic and/or complex medical needs to the Plan's Case Management area. The Case Manager will develop an individualized plan of care, in cooperation with the member/parent/guardian, PCP, licensed Clinical Social Workers, specialists and ancillary care providers, to ensure the delivery of coordinated treatment services to members with chronic and complex medical needs and to maximize benefits and control costs.

VI. Plan Monitoring of Adequate Provision of IHAs

Documentation of the IHA in the medical record is assessed by the DHCS Certified Site Reviewer (CSR) or DHCS Certified Master Trainer (CMT) Nurse during the full scope and focused site and medical record review survey (FSR/MRR) and Focused MRR review for providers. Practitioners not meeting the standards for documentation are required to complete a corrective action plan, which is verified and approved by the Plan. The site review process and corrective action plan process are described in policy *CA_QMXX_013 Facility Site and Medical Record Review Process*.

The Plan's Government Business Division (GBD) Quality Analytics will generate a report at least quarterly for internal evaluation and monitoring of IHA compliance based on claims and

encounter data. Annual results are presented to the Quality Management Committee (QMC) for the prior measurement year for review and discussion of improvement activities.

The Plan's Government Business Division (GBD) Provider Performance Management (PPM) team will perform oversight of Initial Health Appointment (IHA) for its Medicaid delegated network. PPM will identify noncompliant Participating Medical Groups (PMGs)/ Independent Physician Associations (IPAs) for outreach and escalation.

Enforcement recommendations are informed by the CA Medicaid IHA Completion Rate dashboard in Tableau that is maintained by Quality Management (QM) at least quarterly. PPM may bring enforcement action recommendations to the Provider Performance Advisory Committee (PPAC) for further escalation discussion and approval. For groups with IHA completion rates below 70%, PPM will promptly initiate enforcement procedures. All escalation beyond a CAP will be communicated by Contracting.

VII. PCP Notification/Education/Outreach

PCPs must review their monthly new member IHA list and proactively contact their assigned membership to make an appointment for the member's IHA within required timeframes but no later than within 120 days of enrollment. Providers can electronically access reports of members who have not received their IHA through the Plan's Availity portal, or through their PMG/IPA.

The PCP's office is responsible for making and documenting all attempts to contact assigned members. Records must reflect the reason for delays in completing the IHA, such as a member not showing up for a scheduled appointment, or refusals by the member to schedule an IHA.

The Plan provides education and training to practitioners on Anthem Blue Cross' Preventive Health Care Guidelines and the need for new members to receive an IHA through the following:

- New provider orientation and training
- Provider Newsletters/Bulletins
- Provider Manual
- On-going Provider Training on monthly eligibility and IHA reports
- Anthem Blue Cross Provider Website/Availity Portal
- Provider Outreach Visits

The Plan's IHA reports notify provider offices of member(s) who have not had an IHA within the 120-day time frame.

VIII. Member/Parent Education/Outreach

The Plan educates/notifies all members, including emancipated minors and members of age of majority, or the parent or guardian of child members of the need for an IHA through:

- New Member Packet given to each member at time of enrollment.
- The Plan's vendor provides IHA welcome and outreach calls to new members at 30, 60 and 90 days after enrollment with reminders for scheduling an appointment for an IHA and associated recommended screening or age-appropriate immunizations. This automated call system informs new members to see their provider within 120 days of enrollment and of the benefits of getting an IHA.
- Upon request, the vendor can transfer the member's call to their PCP to schedule an appointment. Members have an option to transfer to Anthem Blue Cross member services so any questions or concerns they have can be addressed.
- Member Newsletters
- Member Portal/Website

Member education and notification outreach includes, at a minimum:

- The IHA is an Anthem Blue Cross benefit for all members.
- The importance of getting an IHA, using clear and non-technical language
- Instructions on how to arrange an IHA appointment within the appropriate timelines and access transportation services through ModivCare (formerly known as LogistiCare), if needed.
- The importance of keeping the IHA and other appointments.

REFERENCES:

- American Academy of Pediatrics (AAP) "Recommendations for Preventive Pediatric Health Care"
- American College of Obstetrics and Gynecology Practice Standards
- CA CLLS 018 Cultural and Linguistic Program-CA
- CA Medicaid P&P – Quality Improvement and Health Equity Transformation Program
- CA_PCXX_009 Services for Members Under 21 Years of Age-CA
- CA_PNXX_033 Access to Care Standards
- CA_QMXX_013 Facility Site and Medical Record Review Process
- CA_QMXX_045 Medical Record Documentation and Confidentiality Standards
- DHCS All Plan Letter 20-016 Blood Lead Screening of Young Children (revised)
- DHCS All Plan Letter 22-024 Population Health Management Policy Guide (supersedes APLs 17-012 and 17-013)
- DHCS All Plan Letter 22-029 Dyadic Care Services and Family Therapy Benefit

- DHCS All Plan Letter 22-030 Initial Health Appointment (supersedes DHCS APL 13-017 and DHCS Policy Letters 13-001 and 08-003)
- DHCS All Plan Letter 23-005 Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)
- DHCS Contract, Exhibit A
- Medi-Cal Managed Care Provider Manual https://providers.anthem.com/docs/gpp/california-provider/CA_CAID_ProviderManual.pdf
- Provider Bulletin CABC-CD-003921-22 July 2022 Initial health assessment
- Provider Bulletin CABC-CD-009862-22 October 2022 IHA requirements
- Provider Bulletin CABC-CD-016093-22 January 2023 Retirement of the Individual Health Education Behavior Assessment/ Staying Healthy Assessment
- Telehealth: Provider Bulletin ACAPE2639-20 IHA via telehealth_Final.pdf
- Title 17, CCR, Division 1, Chapter 9, commencing with Section 37000
- Title 22, CCR, Division 3; Subdivision 1; Section 53910.5(a) (1), 53851 (b) (1) and 51348
- United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations

RESPONSIBLE DEPARTMENTS:

Primary Department:
Quality Management

Secondary Department(s):
Case Management
Clinical Program Management
Cultural and Linguistic
Health Education
Medicaid Compliance
Medicaid Marketing and Member Communications
Provider Performance Management
State Clinical Compliance

EXCEPTIONS:

None

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **Initial Health Appointments for Children and Adults - CA**

REVISION HISTORY:

Review Date	Changes
11/17/23	• Annual Review • Updated Policy, Definitions, Procedure, and References sections
06/23/23	• Off-Cycle Review • Updated Policy, Definitions, Procedure, and References sections • Added revisions in accord with DHCS APL 22-030 Initial Health Appointment (supersedes APL 13-017 and Plan Letters 13-001 and 08-003) • Updated Provision of Services, IHA Scheduling, Components of the IHA, Medical Record Documentation Requirements and Follow up Services sections to align with APL 22-030 Initial Health Appointment (supersedes APL 13-017 and Plan Letters 13-001 and 08-003); • Added revisions in accord with DHCS All Plan Letter 22-024 Population Health Management Policy Guide (supersedes APLs 17-012 and 17-013) • Added revisions in accord with DHCS All Plan Letter 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under The Age of 21 (supersedes APL 19-010) to the reference section. • Added revisions in accord with DHCS APL 22-029 Dyadic Care Services and Family Therapy Benefit • Added Cultural and Linguistic as a secondary department • Added policy number to footer to match GBD Template
06/06/23	• Off-cycle Review • Updated policy name from "Initial Health Assessments for Children and Adults - CA" to "Initial Health Appointments for Children and Adults - CA" • Removed "MMP/Duals" from applicable products • Updated Policy, Definitions, and Procedure, and References sections • Updated Policy, Definitions, Procedure, and References sections to align with APL 22-030 requirements • Updated the definition of Initial Health Appointment to align with APL 22-030 definition • Revised Provision of Services section to align with new APL • Revised Components of the IHA section to align with new APL • Revised Medical Record Documentation Requirements section • Added reference to DHCS All Plan Letter 22-024 Population Health

Review Date	Changes
	Management Policy Guide (supersedes APLs 17-012 and 17-013) • Added reference to new DHCS APL 22-029 Dyadic Care Services and Family Therapy Benefit • Added reference to new DHCS APL 22-030 Initial Health Appointment (supersedes APL 13-017 and Plan Letters 13-001 and 08-003) • Removed references to SHA (Staying Health Assessment) as this is no longer a required component of the IHA beginning 1/1/2023. • Revised all Initial Health Assessment references to Initial Health Appointment as per DHCS APL 22-030 • Removed Regional Health Plan as a secondary department; added Case Management as a secondary department
12/08/22	• Annual Review • Revised all "Anthem" references to Anthem Blue Cross and/or Plan to comply with branding guidance throughout policy • Updated Procedure section • Updated Primary Department from Preventive Care to Quality Management • Removed Health Care Management – Utilization Management & Case Management as a secondary department and replaced with Health Education
09/06/22	• Off-Cycle Review • Updated Policy, Definitions, and Procedure sections • Added Provider Performance Management as Secondary Department for oversight and monitoring process for delegated groups
07/07/22	• Off-Cycle Review • Revised Diagnosis to Diagnostic throughout the P&P • Added blood lead level test to Screening services • Added additional pediatric member AAP guidance to IHA Provision of Services • Added anticipatory guidance, CDC guidelines, and BLL test refusal guidance to PCP opportunity section • Revised QMC reporting timeline – removed requirement to report at the first quarterly QMC meeting to allow for flexibility pending data availability. • Added CA_PCXX_009 Services for Members Under 21 Years of Age-CA to References section • Added DHCS All-Plan Letter 20-016 (revised) to References section • Placed references in alphabetical order

Section (Primary Department)	**SUBJECT (Document Title)**
Quality Management	**Initial Health Appointments for Children and Adults - CA**

Review Date	Changes
12/22/21	• Annual review • Added definition of EPSDT • Updated Procedure Sections I, II, III, VI, VII, VIII • Updated references to add link to Provider Manual
01/28/21	• Annual review • Updates to language in procedure • Edits in Procedure Sections II, III, V through VIII • Updated and deleted part of Section VI due to change in process approved by Compliance • Added MMP/Duals as an applicable product • Added Telehealth to Provision of Services section 1. • References updated • National Provider Communication removed as secondary department
02/17/20	• Annual review • Minor edits within policy and definition sections • Edits within the procedure sections • Changes to Procedure sections to include further elaboration on documentation requirements and information on Provider and Member education. • Secondary department name update from Medicaid Marketing to Medicaid Marketing and Member Communications
01/14/19	• Annual Review • Updates/changes made to Definitions, Procedure and References sections
12/07/18	• Annual review • Changes to Definitions and Procedure sections
12/22/17	• Annual review. No revisions.
01/25/17	• Annual review • Revisions to IHA completion time frames • Removed language around provider report of members not receiving IHA • Removed mandatory education and training for practitioners; added provider outreach to education and training • Removed Healthy Families contract reference; All Plan letter
12/21/15	• Replaced IHEBA with SHA per MMCD PL 13-001 (revised). Added reference to PL 13-001 (revised). • Added LA Care timeline for SHA
12/22/14	• Added verbiage on new IHA monitoring process by requesting medical

Review Date	Changes
	records from PCPs
01/22/14	• Added reference to California Medi-Cal Managed Care Division (MMCD) Policy Letter 08-003 • Combined previous sections on IHAs for Children and IHAs for Adults • Removed reference to CA_CAXX_107 Case Management: Coordination of Care Services for Seniors and Persons with Disabilities • Removed reference to availability of immunization reports for providers
01/23/13	• Removed language about sending a report to PCPs twice a year of patients who need an IHA • Added statement that providers must document attempts to schedule an IHA • Changed reference from CA_CAXX_119 to CA_CAXX_107 • Added references to policies: QIQM-02B Preventive Health Guideline Review, Approval and Distribution; CA_PNXX_033 Access to Care Standards; CA_QMXX_045 Medical Record Documentation and Confidentiality Standards; CA_CAXX_107 Case Management: Coordination of Care Services for Seniors and Persons with Disabilities
08/29/12	• Added policy history • Changed SSB to Medicaid

Compliance is everyone's responsibility, including the reporting of known or suspected compliance issues. You can report issues to the Staff VP of Clinical Compliance or confidentially/anonymously to the Ethics and Compliance Helpline at 877-725-2702. In addition, retaliation against anyone who reports a compliance issue in good faith is strictly prohibited. If you see retaliation or believe it has occurred, you must report it to the Ethics and Compliance Helpline at 877-725-2702.