Government Business Division
Policies and Procedures

Section (Primary Department)		SUBJECT (Document Title)	
Quality Management		**Adult Preventive Care Services - CA**	
Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
06/14/2004	10/19/2023	10/19/2023	10/19/2023
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 screening, preventive and medically necessary diagnostic and treatment services for adult members. Adult preventive services are provided to adult members in accordance with the most recent recommendations from a variety of nationally recognized source organizations including the United States Preventive Services Task Force (USPSTF) Grade A and B recommendations, and regulatory requirements.

Engaging the member with their Primary Care Provider (PCP) for screening, preventive care, medically necessary diagnostic and treatment services, referrals and care coordination is the foundation of Basic Population Health Management (BPHM) and:

- Leverages culturally and linguistically appropriate primary care in alignment with National CLAS Standards,
- Promotes establishment of a medical home and relevant adult and pediatric assessments,
- Assists with navigating and coordination of referrals for health, social services, benefit programs and levels of care coordination, and
- Reduces health care disparities.

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. MCPs must also ensure that members are referred to appropriate Medi-Cal dental providers.

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, age-specific screenings such as Adverse Childhood Experiences (ACEs); 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 Anthem enrollment for new members, must be provided in a way that is culturally and linguistically appropriate for the member in alignment with National CLAS Standards, and must include a history of the member's physical and behavioral health, an identification of risks, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations. an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. An IHA must be 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. 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. IHA Provision of Services

The IHA is completed within 120 days of Anthem enrollment for new members, 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; evaluates the need for applicable preventive services in accordance with the United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations. 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. 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.

Anthem continues to hold network providers accountable for providing all preventive screenings for adults 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.

> 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 navigating and coordination of health, social services and benefit programs and levels of care coordination.
>
> 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.

Medical Record Documentation should include:

- A history of the member's physical and behavioral/mental health (H&P)
  - History of Present illness
  - Past Medical/Behavioral Health/Social History
- Review of Organ Systems (ROS), including dental screenings/oral health assessments (such as "inspection of the mouth" or "seeing a dentist" is acceptable)
- The diagnosis and plan for further evaluation and treatment of any diseases
- Referrals for any abnormal findings
- Notes relating to culturally and linguistically appropriate primary care in alignment with National CLAS Standards
- An identification of risks using standardized assessment tools
- An assessment of need for preventive screens or services, and corresponding referrals. An evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations.
- Health Education/Anticipatory Guidance, and supplemental documentation such as an assessment of developmental status or immunizations, labs, or other preventive screenings
- Referrals for navigating and coordination of health, social services and benefit programs and levels of care coordination
- PCP shall make reasonable attempts to contact a member and schedule an IHA. If an H&P is not found in the medical record, document all contact attempts to schedule and the reason (e.g. member's refusal, missed appointment)
- Documented attempts that demonstrate a PCPs unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement

II. Additional Adult Preventive Services

- **Preventive Services for Pregnant Women**
  For pregnant members, additional preventive screenings and services are offered in accordance with the American College of Obstetricians and Gynecologists (ACOG) Standards and the California Comprehensive Perinatal Services Program (CPSP) Guidelines.

  The results of these assessments shall be maintained as part of the obstetrical record, which shall include an Individualized Care Plan for each trimester and post-partum visit that includes documentation of specific obstetric, nutrition, psychosocial and health education risks/problems/conditions, interventions, and referrals. Each comprehensive obstetric visit will include the following assessments: medical/obstetrical history, physical exam, dental assessment, lab tests, nutrition, psychosocial, maternal mental

health, social needs, substance use/abuse, preeclampsia screening, intimate partner violence screening.

The substance use/abuse assessment will include questions about tobacco usage and exposure to second-hand smoke. Providers will offer all pregnant smokers at least one face-to-face counseling session per quit attempt. Face-to-face tobacco-cessation counseling services may be provided by or under supervision of a physician, legally authorized to furnish such services under state law. The Plan will encourage the PCP to ensure that pregnant women are referred to a tobacco cessation quit line. These counseling services must be covered for 60 days after delivery plus any additional days up to the end of the month.

Since smoking cessation medication is not recommended during pregnancy, the Plan will alert clinicians to refer to the tobacco cessation guidelines by the ACOG before considering offering tobacco cessation medication during pregnancy.

Immunizations shall be provided to pregnant women per the recommendations of the ACIP. Clinics providing OB care shall either administer the recommended immunizations or refer to the member's PCP or pharmacy to receive vaccines. Providers shall confirm immunizations have been given during the appropriate timeframe and document the administration per recommendations in the medical records. If the pregnant women refuse immunizations, education must be documented.

- **Screening for Sexually Transmitted Infections (STI) and, Human Papillomavirus (HPV) Vaccine**
  The Plan ensures that members have prompt access to STI prevention, screening, counseling, and diagnosis and treatment services. STI services do not require prior authorization, and the member can access out-of-network STI services through local health departments, family planning clinics or other community STI service providers. Out of network practitioners and local health departments will be reimbursed for STI services provided to members.

  Providers should offer expedited partner therapy (EPT) for sex partner(s) of members who are diagnosed with treatable STIs to reduce the risk of reinfection.

  The HPV vaccine is considered a medically necessary preventive service for males and females. Administration of HPV vaccine based on the most current Advisory Committee on Immunization Practice (ACIP) adult recommendation schedule shall be documented in the medical record.

- **Immunizations**

  The Plan informs PCPs of their responsibility to ensure adults receive necessary immunization at the time of any health care visit. PCPs will ensure the timely provision of vaccines in accordance with the most current ACIP Adult immunization schedule.

  In addition, the PCP shall provide age and risk appropriate immunizations in accordance with the findings of the IHA and/or other preventive screenings.

  The member is instructed to schedule a follow-up appointment with the PCP if the immunization cannot be given at the time of the current visit. PCP can also write a script for the required immunizations to be administered at a pharmacy. The PCP should follow-up to document in the medical records when the immunizations were administered.

  Members can access Local Health Department (LHD) clinics for immunizations regardless of whether the LHD is in-network or out-of-network, without prior authorization. The Plan is required to provide updated information on the status of the member's immunizations to the LHD clinic. The Plan shall reimburse local health departments for the administration fee for immunizations given to members after receipt of claims and supporting immunization records. However, the Plan is not required to reimburse the local health department for an immunization provided to a member who was already up to date.

  Following the passage of California AB 1797, all healthcare providers who administer vaccines and/or perform tuberculosis (TB) tests are required to enter the following for all ages:

  - Immunization information into the California Immunization Registry (CAIR) OR Healthy Futures/RIDE. Healthy Futures/RIDE is used in the following counties: Alpine, Amador, Calaveras, Mariposa, Merced, San Joaquin, Stanislaus, and Tuolumne,
  - Race and ethnicity information for each patient in the immunization registry to support assessment of health disparities,
  - TB test information including results.

  Immunizations shall also be documented in the medical record, either in the progress notes or an immunization record. Members are encouraged to bring copies of their previous immunization cards to their PCP in order to update the medical record and CAIR2. All attempts to provide immunizations, instructions on how to obtain necessary immunizations, dates of administered vaccines and provision of the Vaccine Information Statement (VIS) and VIS publication dates shall be documented in the medical record and CAIR2. Member's refusal of the vaccination must be documented

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in the medical record or in the form of a signed statement. If the member refuses, education must be documented.

The Plan monitors compliance with immunizations as described in policy *CA_QMXX_045 Medical Record Documentation and Confidentiality Standards*.

After Federal Food and Drug Administration Approval (FDA) and upon the recommendation of the ACIP and following the Medi-Cal fee-for-service guidelines, the Plan implements processes to ensure the PCPs can order the vaccine and be reimbursed for the cost of the vaccine and the injection fee.

- **Tobacco Cessation Services**
  The Plan requires providers to identify (initially and annually) all members (of any age) who use tobacco products and note this use in the member's medical record. In addition, provider must ask tobacco users about tobacco use at every visit.

  The Plan will:
    - Cover all seven FDA-approved tobacco cessation medications: bupropion SR, varenicline, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch for adults who smoke or use other tobacco products. At least one must be available without prior authorization.
    - Provide a 90-day treatment regimen of medications without other requirements, restrictions, or barriers and will cover any additional medications once approved by the FDA to treat tobacco use.
    - Cover a minimum of two separate quit attempts per year, with no mandatory break required between quit attempts. While counseling is encouraged, the Plan may not require members to attend classes or counseling sessions prior to receiving a prescription for an FDA-approved tobacco cessation medication.
    - Offer individual, group, and telephone counseling without cost to the members; and ensure that providers refer members to the California Smokers' Helpline (1-800-NO-BUTTS), a free statewide quit smoking service operated by the University of California San Diego or other comparable quit line services. MCPs should encourage providers to use the "5 A's" model or other validated behavior change model when counseling patients[1].

[1] Improving Chronic Illness Care, "5 A's Behavior Change Model, Adapted for Self-Management t Support Improvement," http://www.improvingchroniccare.org/downloads/3.5_5_as_behaviior_change_model.pdf; and Agency for Healthcare Research and Quality, "Five Major Steps to Intervention (The "5A's)," http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html

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- **Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT)**
  Effective June 2020, the Plan will cover and pay for an expanded alcohol and substance abuse screening for members 11 years of age and older who answer "yes" to any alcohol and drug use questions and/or any time the PCP identifies a potential alcohol misuse problem. Counseling interventions in the primary care setting can positively affect risky drinking and substance use behaviors in adults by reducing weekly alcohol consumption and substance use and increasing long-term adherence to recommended interventions. PCP must annually screen adult members for alcohol and drug misuse. Additional screenings must be provided when medically necessary. Medical necessity must be documented by the member's PCP or primary care team. DHCS recommended Alcohol Misuse Screening and Counseling (AMSC) tools may include the Alcohol Use Disorder Identification Test (AUDIT), or abridged version- Alcohol Use Disorder Identification Test-C (Audit-C) or a single question screening. Refer to policy: Alcohol and Drug Screening, Brief Interventions and Referral to Treatment. Other validated screening tools include: Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT); Tobacco Alcohol, Prescription medication and other Substances (TAPS); and Drug Abuse Screening Test (DAST-10). The PCP will refer any member identified with possible alcohol or substance use disorders to the alcohol and drug program in the county whether the member resides for evaluation and treatment.

  The Plan will also cover and pay for brief intervention(s) for members who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder. Behavioral counseling interventions must be authorized when medically necessary; however, medical necessity must be documented by the member's PCP. When a member transfers from one PCP to another, the receiving PCP must obtain the member's prior medical records including those pertaining to the provision of preventive services.

- **Cognitive Health Assessment**
  The Plan will cover and pay for an annual Medi-Cal cognitive health assessment for members 65 years of age or older who are otherwise ineligible for a similar assessment as part of an annual wellness visit through the Medicare program. The annual cognitive health assessment is intended to identify whether the patient has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare annual wellness visit and the recommendations by the American Academy of Neurology.

  The Plan will also provide guidance to Providers around training, medical record documentation, and billing requirements, as well as the use of validated cognitive assessment tools recommended by the Department of Health Care Services (DHCS.

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III. Preventive Care Guidelines

Adult preventive care and screening guidelines are reviewed and approved as described in policy *QIQM-02B Preventive Health Guideline Review, Approval and Distribution.*

IV. Member Outreach

The Plan educates/notifies members of the need for preventive services through:

- New Member Packet sent to each member at time of enrollment.
- IHA reminder messages (welcome outreach calls)
- Member Newsletters
- Member Website

V. Provider Education and Monitoring

The Plan performs ongoing monitoring of the provision of services to adult members through medical record reviews, collection of HEDIS® data, and data collection in support of DHCS' collaborative initiatives including All Cause Readmissions.

Plan practitioners can electronically access reports of members who have not received their IHA via the Plan's provider website or from the PCP's contracted IPA/PMG group.

A report is generated on an annual basis to evaluate IHA compliance based on the medical record reviews for the previous quarter. Results are presented to the Quality Management Committee (QMC) for review and discussion of improvement activities.

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 not limited through:

- Provider Newsletters, as needed
- Provider Manual
- Monthly eligibility reports
- Anthem Blue Cross Provider Website
- Provider Field Staff Visits

REFERENCES:

- AB 1797 Immunization Registry Eff. 1/1/23 (CDPH AB 1797 FAQs)
- Alcohol & Drug Misuse Screening and Behavioral Counseling Interventions in Primary Care – CA (Health Plan P&P)
- All Plan Letter 18-004 Immunization Requirements

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- All Plan Letter 22-025 Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older
- CA_PCXX_003 Initial Health Appointments for Children and Adults
- CA_PCXX_108 Tobacco Cessation Services-CA
- CA_QMXX_045 Medical Record Documentation and Confidentiality Standards
- DHCS All Plan Letter 16-009 Adult Immunizations as a Pharmacy Benefit
- DHCS APL 16-014 Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries (supersedes DHCS Policy Letter 14-006)
- DHCS APL 22-030 Initial Health Appointment (supersedes DHCS APL 13-017 and DHCS Policy Letters 13-001 and 08-003)
- DHCS Contracts, Exhibit A, Attachment 9 – 11 and 18
- DHCS MMCD All Plan Letter 21-014 Alcohol and Drug Screening, Brief Interventions and Referral to Treatment
- DHCS MMCD Policy Letter 07-015 Human Papillomavirus Vaccine
- DHCS MMCD Policy Letter 96-09 STI Services in Medical Managed Care
- QIQM-02B Preventive Health Guideline Review, Approval and Distribution

RESPONSIBLE DEPARTMENTS:

Primary Department:
Quality Management

Secondary Department(s):
Health Education
Medicaid Compliance
Provider Communications

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
10/29/23	• Annual Review • Updated Procedure section • Added Cognitive Health Assessment to Section II Additional Adult Preventive Services • Revised Section C Immunization to reflect new AB 1797 requirements • Removed State Clinical Compliance as a secondary department

Review Date	Changes
06/30/23	• Off-cycle Review • Removed MMP/Duals as an applicable product • Updated Policy, Definitions, Procedure, and References sections • Added language to "Policy Section" linking screening, preventive care, etc. with Basic Population Health Management • Added various items to Definition Section: Dental Screening/oral health assessments; HIF/MET; IHEBA/SHA retirement guidelines; National CLAS Standards; and Perinatal Services • Revised IHA in Definition Section and in IHA Provisions of Services Sections to comply with new DHCS APL 22-030 Initial Health Appointment • Added language to Immunizations section to comply with DHCS 2024 Contract, Attachment III, 5.2.8.E (Network and Access to Care): Members access to LHD clinics for immunizations, whether in-network or out-of-network without prior authorization. Plan must provide updated information on member's immunization status. Plan will reimburse LHD clinics after receipt of claims and supporting immunization records • Updated primary department from Preventive Care to Quality Management • Added Health Education as Secondary Department; removed Regional Health Plan as a secondary department • Removed all references to IHEBA and SHA as those assessment tools are retired effective 1/1/23 • Removed reference to CA_QMXX_003 Individual Health Education Behavioral Assessment/Staying Health Assessment because this P&P was retired/archived
11/16/22	• Annual Review • Revised Anthem references to either Anthem Blue Cross or Plan to comply with branding requirements throughout Policy, Procedure, and Responsible Department(s) sections • Minor formatting corrections to Definitions section • Updated Procedure section • Updated and alphabetized Secondary Department(s)
12/14/21	• Annual review • Updated STI Expedited Partner Therapy • Updated procedure • Updated references • Added MMP as an applicable product

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Review Date	Changes
	• Updated secondary department name for Provider Communications
12/04/20	• Annual review • Update to the definition: Individual Health Assessment (IHA) • Procedure updated
12/23/19	• Annual Review • Edit to definition: Individual Health Assessment (IHA)
01/25/19	• Annual review • Updates/changes to Definitions and References sections
02/27/18	• Off-cycle edits - Added verbiage to be compliant with APL 18-004
12/22/17	• Annual review. • Updated APL References
01/25/17	• Annual review • Added welcome calls to member outreach • Removed language around practitioner report of members not receiving IHA; added language for practitioner report access • Removed mandatory education and training for practitioners; added provider outreach to education and training • Updated PL/APL References • Updated SBIRT with AMSC
12/21/15	• Replaced IHEBA with SHA per MMCD PL 13-001 (revised). Added SBIRT screening instrument references (AUDIT and AUDIT-C) from DHCS.
12/30/14	• Added language from PL 14-006 • Removed language about meeting on regular basis with local health departments • Added verbiage about Tobacco Cessation services • Added verbiage about SBIRT
11/22/13	• Changed CA_HEHP_003 to CA_QMXX_003
11/26/12	• Added policy history • Changed SSB to Medicaid • Removed reference to the supplemental IHA report which was mailed twice a year to PCPs. • Changed DHCS collaborative initiative from Chlamydia to All Cause Readmissions.

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.

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