Policy:	MA.7025
Title:	**Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Health Community Network (CHCN) Contracted Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/ Michael Hunn 10/10/2024*
Effective Date:	12/31/2022
Revised Date:	10/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the Primary Care Engagement and Clinical Documentation Integrity Program for Qualified Providers contracted with the CalOptima Health Community Network (CHCN) for the OneCare (OC) Program.

II. POLICY

A. The Primary Care Engagement and Clinical Documentation Integrity Program is a Member-centered and Member-whole care approach which aims to improve Member engagement with their Qualified Provider and clinical documentation accuracy and completeness in Medical Records. CalOptima Health's contracted CHCN OC Qualified Providers will be incentivized for reporting confirmed chronic and/or acute severe condition diagnosis codes, evaluating and managing of each confirmed chronic and/or acute severe chronic condition, and reviewing preventive care needs for each CHCN OC Member based on a timely Annual Wellness Visit (AWV) and properly documenting such information in Medical Records as referenced in Title 42, Code of Federal Regulations (CFR) section 410.15.

B. Qualified Providers may earn supplemental payment after completing an AWV with their assigned Member, which shall be verified by CalOptima Health based on the Qualified Provider's attestation and supporting Medical Records to achieve the following quality goals:

1. Improve Member engagement with their Qualified Provider measured by the percentage of CHCN OC Members who have an AWV with their assigned Qualified Provider.

2. Promote health and early detection of health issues through a personalized prevention plan developed and maintained during the AWV.

3. Improve the accuracy and completeness of clinical documentation and the submission of chronic and/or acute severe condition codes measured by successful completion of the program's attestation form (Attachment A) by Qualified Providers.

C. For dates of service on and after January 1, 2023, a Qualified Provider is eligible for incentives, if:

1. The Member is eligible with OC and assigned to CHCN as of the date of service (DOS);

2. The Qualified Provider conducts an AWV with the Member within the Service Year;

3. The Qualified Provider addresses and documents all health chronic and/or acute severe conditions as noted on the attestation during the AWV and as provided in Section II.B.;

4. The Qualified Provider submits the completed attestation to CalOptima Health with supporting Medical Records by the required deadline; and

5. The CalOptima Health Quality Improvement Department verifies that the potential Healthcare Effectiveness Data and Information Set (HEDIS) preventive care measures in conjunction with CalOptima Health Financial Analysis, Audit and Coding Team audits Members chronic and/or acute severe health condition codes suggested in the attestation form (Attachment A) are documented in the supporting medical records. HEDIS specifications include both International Classification of Diseases, Tenth Edition (ICD-10) and Current Procedural Terminology (CPT) codes, which are used for hierarchical condition category (HCC) coding. HEDIS measures are quality measures designed to indicate how well preventive care is being carried out by a plan and its providers and assists CalOptima Health in ensuring that Members' preventive care needs are being addressed, along with their acute and chronic care needs. Accurate clinical documentation benefits both HEDIS and HCC coding. These HEDIS and health condition codes vary by Member.

D. The CalOptima Health Quality Improvement Department conducts oversight of the attestation accuracy and completeness of Medical Record documentation through random sample reviews in conjunction with CalOptima Health's Financial Analysis, Audit and Coding Team and identifies an opportunity to improve clinical documentation integrity. As demonstrated in journal articles, Members with access to AWV are likely to complete preventive services, which will lead to improved health outcomes.

III. PROCEDURE

A. CalOptima Health shall conduct provider education and provide technical assistance to improve provider accuracy and completeness of clinical documentation.

B. By March of each Service Year, subject to Board approval of the continuation of the Primary Care Engagement and Clinical Documentation Integrity Program and related funding, CalOptima Health shall provide to each Qualified Provider via facsimile, U.S. mail or CalOptima Health provider portal, an attestation and Medical Records submission instruction documents for each of their assigned Members.

C. Upon completion of an AWV with a Member, the Qualified Provider shall affirm, negate or provide additional information, as appropriate, regarding the individualized HEDIS preventive care measures and health conditions on the attestation document. All AWVs must be completed in the time period required by Service Year. The AWV must be completed in a face-to-face setting, including but not limited to in person and/or telehealth utilizing a real-time asynchronous audio-video platform.

D. The Qualified Provider shall submit the verified attestation form (Attachment A), as well as supporting Medical Records to the CalOptima Health Quality Improvement Department via facsimile, U.S. mail or CalOptima Health provider portal when available, within the Submission Period, but no later than January 31 following the Service Year.

E. The Qualified Provider must appropriately document all of the required elements in the attestation form (Attachment A),with supporting Medical Records, including, but not limited to:

1. Member name;

2. Date of service;

3. Preventive Medicine Screening section;

4. Year-Over-Year Chronic Conditions section;

5. Suspect Chronic Conditions, report the appropriate signs and symptoms when a related definitive diagnosis has not been established. (confirmed) by the Qualified Provider;

6. Report abnormal findings, e.g., based on laboratory, x-ray, pathologic, and other diagnostics results that have been interpreted by a provider(Pharmacy and/or Laboratory) section;

7. Additional Chronic and/or Acute Severe Conditions Present section;

8. Acceptable Qualified Provider signature with credentials; and

9. Date of authentication.

Note: For 4-6, chronic and/or acute severe condition diagnosis code(s) (existing and/or new) must be coded according to the *ICD-10 Clinical Modification Guidelines for Coding and Reporting*.

F. Within sixty (60) calendar days from the end of the submission period, the CalOptima Health Quality Improvement Department in conjunction with Financial Analysis, Audit and Coding team shall review the program's attestation form (Attachment A) and supporting medical records to ensure each chronic and/or acute severe condition diagnosis code submitted by the Qualified Provider has appropriate clinical documentation. Upon receipt of Medical Records, CalOptima Health shall retain the Medical Records as set forth in CalOptima Health Policy GG.1603: Medical Records Maintenance.

G. In the event the CalOptima Health's Quality Improvement Department, in conjunction with CalOptima Health's Financial Analysis, Audit and Coding Team, determines that the attestation form (Attachment A) or supporting medical record(s) is incomplete or lacking clinical justification, CalOptima Health staff will deny payment and provide written notification within thirty (30) calendar days to the Qualified Provider of the determination and rationale for the rejection.

H. CalOptima Health will remove and not submit any chronic and/or acute severe condition diagnosis codes to Centers for Medicare & Medicaid Services (CMS) that are not supported in the Medical Records to protect the integrity of the process.

I. Upon receipt of CalOptima Health's notification of incomplete Medical Records, the Qualified Provider may dispute the findings within thirty (30) calendar days and resubmit the completed attestation form (Attachment A), with corrected medical records.

J. In the event that the CalOptima Health Quality Improvement Department, in conjunction with CalOptima Health's Financial Analysis, Audit and Coding Team, verifies the Qualified Provider has met the chronic and/or acute severe conditions as specified in Sections III.D and III.E. of this Policy, CalOptima Health shall make a supplemental payment of one hundred fifty dollars ($150) per completed and verified attestation form (Attachment A), with supporting Medical Records per Member per Qualified Provider per year.

1. CalOptima Health shall ensure per Member per Qualified Provider once a year payments are distributed to the Qualified Provider on a monthly basis.

2. CalOptima Health shall make supplemental payments within forty-five (45) calendar days from the end of the Submission Month.

K. In the event CalOptima Health determines that a Qualified Provider has not accurately reported chronic and/or acute severe condition diagnosis codes and/or does not have Medical Records supporting the attestation and/or reported chronic and/or acute severe condition diagnosis codes, CalOptima Health may provide additional provider education and technical assistance and/or make a referral to the Office of Compliance, as appropriate.

L. In the event CalOptima Health determines that a Qualified Provider has not accurately reported chronic and/or acute severe condition diagnosis codes and/or does not have Medical Records, and such issues negatively impact quality of care or service delivered to a Member, such matters may be referred as a Potential Quality Issue in accordance with CalOptima Health Policy GG.1611: Potential Quality Issues Review Process or referred to the Office of Compliance for further review and investigation depending on the nature and scope of the inaccurate reporting.

IV. ATTACHMENT(S)

A. Attestation Form: Primary Care Engagement and Clinical Documentation Integrity Program

V. REFERENCE(S)

A. American Journal of Managed Care, "Medicare Annual Wellness Visit Association with Healthcare Quality and Costs", March 8, 2019, https://www.ajmc.com/journals/issue/2019/2019-vol25-n3/medicare-annual-wellness-visit-association-with-healthcare-quality-and-costs
B. CalOptima Health Policy GG.1603: Medical Records Maintenance
C. CalOptima Health Policy GG.1611: Potential Quality Issues Review Process
D. Centers for Medicare & Medicaid Services (CMS) Health and Human Services (HHS) Proposes Physician Payment Rule to Drive Whole-Person Care and Improve Health Quality for All Individuals with Medicare: https://www.cms.gov/newsroom/press-releases/hhs-proposes-physician-payment-rule-drive-whole-person-care-and-improve-health-quality-all
E. Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual, IOM, Chapter 7
F. Journal of Primary Care & Community Health, "The Effectiveness of Medicare Wellness Visits in Accessing Preventive Screening", October 08, 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5932741
G. Orange County Aging Services Collaborative Annual Wellness Visit (AWV) Toolkit: https://www.ocagingservicescollaborative.org/awvtoolkit/
H. Title 42, Code of Federal Regulations (CFR), §§410.15 and 422.310

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/31/2022	MA.7025	Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Health Community Network (CCN) Contracted Providers	OneCare
Revised	10/01/2023	MA.7025	Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Health Community Network (CCN) Contracted Providers	OneCare
Revised	10/01/2024	MA.7025	Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Health Community Network (CHCN) Contracted Providers	OneCare

IX. GLOSSARY

Term	Definition
Annual Wellness Visit (AWV)	An Annual Wellness Visit (AWV) is a yearly visit to develop or update a personalized prevention plan to promote health and help prevent disease based on a Member's health risk factors.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Medical Record	A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Potential Quality Issue (PQI)	Any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Primary Care Engagement and Clinical Documentation Integrity Program	A program to improve member engagement with their primary care provider (PCP) and clinical documentation accuracy and completeness in Qualifying Medical Records. CalOptima Health shall provide PCP's an attestation form (Attachment A) listing quality measures and chronic and/or acute severe condition diagnosis codes for each of their assigned members for clinical validation during an Annual Wellness Visit (AWV). The provider shall be responsible for completing the attestation form (Attachment A)and returning the form along with supporting clinical documentation to CalOptima Health.
Qualified Provider(s)	For purposes of this policy, contracted Primary Care Provider (PCP), or, when applicable, other affiliated PCP, nurse practitioner or physician assistant operating within the provider group.
Service Year	January 1 through December 31 (12 months).
Submission Month	The month within the submission period in which the attestation is submitted to CalOptima Health.
Submission Period	January 1 of the Service Year through January 31 following the Service Year (13 months).