Policy:	GG.1613
Title:	**Initial Health Appointment**
Department:	Equity and Community Health
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 11/22/2024*
Effective Date:	10/01/1999
Revised Date:	11/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process through which CalOptima Health ensures that all Members receive an Initial Health Appointment (IHA), in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. Practitioners must complete the IHA within one hundred twenty (120) calendar days after enrollment in the CalOptima Health Program in accordance with applicable statutory, regulatory, and contractual requirements. The IHA must be provided in a way that is culturally and linguistically appropriate for the Member.

B. The IHA components may be completed over the course of multiple visits, so long as the Member receives all required screenings in a timely manner and consistent with the United States Preventive Services Taskforce (USPSTF) guidelines and immunizations based on the Advisory Committee on Immunization Practices (ACIP) recommendations for children and adults. Appropriate assessments from the IHA must be addressed during subsequent health visits.

C. Practitioners are required to complete all preventive screenings, including immunizations for adults and children as recommended by the USPSTF and ACIP as stated in Department of Health Care Services All Plan Letter (APL) 24-008: Immunization Requirements. Primary care visits will be used as a proxy for the IHA completion, leveraging Managed Care Accountability Sets (MCAS) measures specific to infant, child/adolescent well-being visits and adult preventive visits such as:

   a. Depression Screening and Follow-Up for Adolescents and Adults;

   b. Child and Adolescent Well – Care Visits;

   c. Childhood Immunization Status – Combination 10;

   d. Developmental Screening in the First Three (3) Years of Life;

   e. Immunizations for Adolescents – Combination 2;

   f. Lead Screening in Children;

g. Topical Fluoride for Children;

h. Well-Child Visits in the First thirty (30) Months of Life – zero (0) to fifteen (15) Months – Six (6) or More Well-Child Visits;

i. Well-Child Visits in the First thirty (30) Months of Life – fifteen (15) to thirty (30) Months – Two (2) or More Well-Child Visits;

j. Chlamydia Screening in Women;

k. Breast Cancer Screening;

l. Cervical Cancer Screening;

m. Adults' Access to Preventive/Ambulatory Health Services; or

n. Adult Immunization Status.

D. For Members under the age of twenty-one (21) years, the Member shall receive an IHA within one hundred twenty (120) calendar days following the date of enrollment or within the most recent periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures whichever is less.

E. CalOptima Health and its Health Networks shall inform its Practitioners of the need for timely IHA for all Members and shall track IHAs to ensure assessments are conducted within the time frames specified in applicable statutes and regulations.

F. CalOptima Health and its Health Networks shall identify Members with Special Health Care Needs and ensure that such Members receive age-appropriate and timely IHAs.

G. CalOptima Health and its Health Networks shall ensure Members receive follow-up services and plan of care that reflect the findings and risk factors determined during the IHA in accordance with Section III.I. of this Policy and CalOptima Health Policy GG.1608: Full Scope Site Reviews.

H. CalOptima Health and its Health Networks shall provide training to Practitioners regarding IHA provisions and exemptions.

1. The training shall include, but not be limited to, the timely and accurate reporting of IHA Encounters by Practitioners and proper documentation in the Medical Record.

I. CalOptima Health and its Health Networks shall educate Members regarding:

1. The availability of the IHA for all Members;

2. How to arrange for an appointment within the appropriate timelines;

3. The importance of keeping the IHA and other appointments; and

4. Member's rights regarding an IHA, including providing the Member the results of the IHA.

J. Health Networks shall establish policies and procedures to ensure all assigned Members receive an IHA that, at minimum, meet the requirements as outlined in this policy.

III. PROCEDURE

A. An IHA shall include the following elements:

1. Comprehensive History: All elements of the comprehensive history shall provide a Practitioner the ability to assess and diagnose a Member's acute and chronic conditions. The comprehensive history shall include, but is not limited to:

   a. A history of the Member's physical and mental health;

   b. Assessing the member's needs for preventive screenings and services;

   c. A physical examination;

   d. Identification of health risks through health screenings including Managed Care Accountability Sets (MCAS) such as screenings for Adverse Childhood Experiences (ACEs), developmental, depression, autism, vision, hearing, lead, and substance use disorder (SUD);

   e. Health education; and

   f. A diagnosis and plan for treatment of any disease.

2. Preventive Services for asymptomatic Members:

   a. For Members twenty-one (21) years or older: The assessment shall include preventive screening, testing, and counseling services, in accordance with the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF).

   b. For Members under twenty-one (21) years of age:

      i. The assessment shall ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services in accordance with the American Academy of Pediatrics (AAP) /Bright Futures periodicity schedule. It shall also include age-specific assessments and services as required by the Child Health and Disability Prevention Program (CHDP) and as specified by the most recent American Academy of Pediatrics (AAP) age specific guidelines and periodicity schedule in accordance with CalOptima Health Policies GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and GG.1116: Pediatric Preventative Services.

      ii. Where 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.

      iii. Health screenings must include but are not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and substance use disorders (SUD).

      iv. The assessment must include, or arrange for the provision of, all immunizations necessary to ensure that the child is up-to-date for age.

v. If examinations occur more frequently as specified by the AAP periodicity schedule rather than on the CHDP examination schedule, the assessment shall follow the AAP periodicity schedule.

c. CalOptima Health and its Health Networks shall inform Members under twenty-one (21) years of age or their families/primary caregivers about EPSDT, including the benefits of preventive care, the services available under EPSDT, where and how to obtain these services and that necessary transportation and scheduling assistance is available.

d. Perinatal Services: The assessment shall include perinatal services in accordance with the most current guidelines of the American College of Obstetrics and Gynecology (ACOG). CalOptima Health and its Health Networks shall implement the Department of Health Care Services (DHCS)-approved comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and the Comprehensive Perinatal Services Program (CPSP) standards, including an individual care plan, in accordance with Title 22 California Code of Regulations, Section 51348, and CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services (PSS) Program.

3. Comprehensive Physical and Mental Status Exam;

4. Diagnoses and Plan of Care that include follow-up activities.

C. An IHA shall be performed, within a primary care medical setting, by the Member's Primary Care Provider (PCP), as described in the glossary section of this Policy.

D. A primary care setting is a site of usual delivery of primary care, as defined in the taxonomy code for service setting within the visit. Including only visits that have the following service settings:

a. Community Health;

b. Corporate Health;

c. Health Services;

d. Migrant Health;

e. Primary Care;

f. Public Health, State or Local;

g. Student Health;

h. Critical Access Hospital;

i. Medical Specialty;

j. Multi-Specialty;

k. Clinic/Center Not Otherwise Specified;

l. Federally Qualified Health Center;

m. Rural Health.

E. Timelines for the provision of an IHA shall begin on a Member's effective date of enrollment with CalOptima Health.

1. Effective date of enrollment shall be determined as follows:

   a. A Member's effective date of enrollment is the first (1st) month following notification from DHCS that the Member is eligible for CalOptima Health Medi-Cal and the Member is not on a hold status with DHCS.

   b. If an infant is born to a Member, the effective date of enrollment shall be the infant's date of birth.

   c. In the case of retroactive enrollment, the Member's effective date shall be the date that CalOptima Health receives notification of the Member's enrollment with CalOptima Health.

2. CalOptima Health shall provide a Member's effective date to the Member's assigned Health Network, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

3. All Members shall have completed the IHA within one hundred twenty (120) calendar days after the effective enrollment date, and Members under twenty-one (21) years of age shall receive an IHA in accordance with Section III.A.2.b. of this Policy.

4. If a Member requests a change in his or her PCP or CalOptima Health initiates a change in a Member's PCP assignment and the Member's IHA has not been completed, the newly assigned PCP must complete the Member's IHA within the remaining one hundred twenty (120) calendar days from the effective enrollment date.

E. PCP Documentation and Reporting of an IHA

1. The PCP shall document all elements of the IHA or any applicable IHA exemption in the Member's primary Medical Record.

2. The PCP shall submit all pertinent information in accordance with claims and encounter data capture and reporting process requirements to the Member's Health Network or to CalOptima Health, as appropriate.

3. If the PCP was unable to contact the Member, or the Member missed an IHA appointment, the PCP shall document in the Member's Medical Record at least two (2) outreach attempts to reschedule an IHA after a missed appointment.

F. Exemptions from IHA requirements: The timeline requirements for completion of a Member's IHA shall be exempt only if documented in the Member's Medical Record and in the following situations:

1. All elements of the IHA have been completed within less than twelve (12) months of current enrollment effective date and the current Member's PCP has reviewed, updated, and determined the Member's Medical Record contains complete information;

2. A Member is not continuously enrolled in CalOptima Health during the initial one hundred twenty (120) calendar day period;

3. A Member loses eligibility in less than one hundred twenty (120) days prior to an IHA being performed;

4. A Member declines an IHA, and refusal is documented in the Member's Medical Record; or

5. Three (3) documented outreach attempts to schedule a member for an IHA visit within the first one hundred twenty (120) days of enrollment; or

6. A Member misses a scheduled PCP appointment and two (2) additional documented attempts to reschedule have been unsuccessful. Documentation must include:

    a. The Health Network or PCP has made a good faith effort to update the Member's contact information, including updating information received from the Post Office for any change in address and from dialing Directory Assistance for any new telephone number, and; Attempts to perform the IHA at any subsequent Member's office visits even if the deadline for the IHA completion has elapsed.

G. Monitoring

1. CalOptima Health shall validate the PCP-reported IHA completion rates for new and existing Providers and Practitioners during site reviews, in accordance with CalOptima Health Policy GG.1608: Full Scope Site Reviews.

    a. During Facility Site Reviews (FSRs), Medical Records shall be reviewed to ensure all components of the IHA have been properly documented in accordance with CalOptima Health Policy GG.1608: Full Scope Site Reviews.

        i. The Medical Record Review shall include, but not be limited to, a review of the documentation for annual preventive screenings, Brief Interventions, and Referral to Treatment (SABIRT).

    b. FSRs shall be conducted in the frequency outlined in CalOptima Health Policy GG.1608: Full Scope Site Reviews.

2. CalOptima Health shall conduct a monthly review of the IHA Performance/Days Aged Report through CalOptima Health's Delegation Oversight Committee (DOC).

    a. CalOptima Health reserves the right to conduct random audits of Medical Records to validate the data contained in the IHA Performance/Days Aged Report.

    b. CalOptima Health shall maintain transparency of this data with the Health Networks through monthly forums and joint operations meetings with individual Health Networks.

3. CalOptima Health may issue a Corrective Action Plan to any Provider or Practitioner that fails to meet the IHA documentation metrics in accordance with CalOptima Health Policies GG.1608: Full Scope Site Reviews and HH.2005: Corrective Action Plan.

    a. A Provider or Practitioner may receive a CAP regardless of the overall Medical Record score.

    b. Providers or Practitioners unable to meet the IHA documentation standards shall receive continued monitoring until the reported completion rates are deemed accurate against the Medical Record.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Use
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health, Health Network Service Agreement
D. Contract for Health Care Services
E. Guide to Clinical Preventive Services, a Report of the U.S. Preventive Services Task Force
F. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
G. CalOptima Health Policy GG.1100: Alcohol and Substance Use Disorder Treatment Services
H. CalOptima Health Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider
I. CalOptima Health Policy GG.1116: Pediatric Preventative Services
J. CalOptima Health Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services CalOptima Health Policy GG.1608: Full Scope Site Reviews
K. CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services (PSS) Program
L. CalOptima Health Policy HH.2005: Corrective Action Plan
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-014: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (Supersedes APL 18-014)
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-030: Initial Health Appointment (Supersedes APL 13-017 and Policy Letters 13-001 and 08-003)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 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)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization Requirements
R. Department of Health Care Services CalAIM: Population Health Management (PHM) Policy Guide, May 2024
S. Population Health Management Strategy and Roadmap, July 2022
T. Title 17, California Code of Regulations, §§ 6842, 6843, and 6847
U. Title 22, California Code of Regulations, §§ 51348, 53851 and 53910.5

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/02/2019	Department of Health Care Services (DHCS)	Approved as Submitted
01/25/2021	Department of Health Care Services (DHCS)	Approved as Submitted
02/17/2022	Department of Health Care Services (DHCS)	Approved as Submitted
08/18/2023	Department of Health Care Services (DHCS)	Approved as Submitted
12/22/2023	Department of Health Care Services (DHCS)	File and Use
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1999	GG.1613	Initial Health Assessment	Medi-Cal
Revised	05/01/2007	GG.1613	Initial Health Assessment	Medi-Cal
Revised	09/01/2008	GG.1613	Initial Health Assessment	Medi-Cal
Revised	01/01/2014	GG.1613	Initial Health Assessment	Medi-Cal
Revised	11/01/2015	GG.1613	Initial Health Assessment	Medi-Cal
Revised	12/01/2016	GG.1613	Initial Health Assessment	Medi-Cal
Revised	08/01/2017	GG.1613	Initial Health Assessment	Medi-Cal
Revised	03/01/2018	GG.1613	Initial Health Assessment	Medi-Cal
Revised	09/01/2018	GG.1613	Initial Health Assessment	Medi-Cal
Revised	09/01/2019	GG.1613	Initial Health Assessment	Medi-Cal
Revised	12/01/2020	GG.1613	Initial Health Assessment	Medi-Cal
Revised	08/01/2021	GG.1613	Initial Health Assessment	Medi-Cal
Revised	12/01/2021	GG.1613	Initial Health Assessment	Medi-Cal
Revised	11/01/2022	GG.1613	Initial Health Appointment	Medi-Cal
Revised	03/01/2023	GG.1613	Initial Health Appointment	Medi-Cal
Revised	12/01/2023	GG.1613	Initial Health Appointment	Medi-Cal
Revised	06/01/2024	GG.1613	Initial Health Appointment	Medi-Cal
Revised	11/01/2024	GG.1613	Initial Health Appointment	Medi-Cal

IX. GLOSSARY

Term	Definition
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Health Members, the CHDP Program is incorporated into CalOptima Health's Pediatric Preventive Services Program.
Comprehensive Perinatal Services Program (CPSP)	Services as defined in Welfare and Institutions Code, Section 14134.5, and Title 22, California Code of Regulations, Sections 51179 and 51348. For CalOptima Health Members, CPSP is incorporated into CalOptima Health's Perinatal Support Services.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than twenty-one (21) years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or Provider, including out-of-network services and sub-capitated and delegated Covered Services.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume Specialty Care Provider offices.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by

Term	Definition
	W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Medical Record	The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP Medical Records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Mid-Level Practitioner	A non-physician Practitioner who has a professional license and certification. They include but are not limited to Certified Nurse Midwives, Certified Nurse Practitioners, and Physician Assistants.
Practitioner	A licensed independent Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Primary Care Practitioner/Physician (PCP)	A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Screening, Brief Intervention, Referral and Treatment (SBIRT)	Comprehensive, integrated delivery of early intervention and treatment services for Members with Substance Use Disorders (SUDs), as well as those who are at risk of developing SUDs.
Special Health Care Needs	A Member who meets at least one of the following criteria: 1. Medicare eligible; 2. Diagnosed with an emotional or physical disability; 3. Placed in the foster care system; 4. Regional Center of Orange County (RCOC) program eligible; or 5. CCS program eligible.