Policy:	GG.1132
Title:	**Medi-Cal Annual Wellness Visit**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/ Michael Hunn 05/09/2024*
Effective Date:	04/01/2023
Revised Date:	04/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the program to promote, provide, and document Annual Wellness Visits (AWV) for adult Medi-Cal Members that are forty-five (45) years or older, excluding dual eligible Members..

II. POLICY

A. The Medi-Cal AWV program aims to ensure that Members complete a comprehensive AWV with their primary care provider. Members will receive an incentive for completion of an AWV. Qualified Providers will receive an incentive for providing a comprehensive AWV, reporting confirmed condition diagnosis codes, capturing Social Drivers of Health (SDOH) factors and properly documenting such information in Medical Records.

B. The Medi-Cal AWV program includes the following four (4) components:

1. A comprehensive AWV including:

   a. Patient and family health history;

   b. Physical exam;

   c. Assessment for cognitive, behavioral health, functional status, pain, risk factors, SDOH factors, and other health issues as appropriate;

   d. Preventive screening;

   e. Education and counseling services;

   f. Advance care planning; and

   g. Medication review.

2. Validated AWV provider payments:

   a. Qualified Providers will bill the Members' assigned Health Network for reimbursement per assigned Member, per Service Year for each completed, submitted, and verified AWV.

CalOptima Health will provide additional training to educate Provider, in accordance with CalOptima Health Policy EE.1103: Provider Network Training, on proper billing guidelines for AWVs using age-banded, preventive visit Initial Health Appointment (IHA) Current Procedural Terminology (CPT) codes.

3. Provider incentive for completion of the Primary Care Engagement and Clinical Documentation Integrity Program Attestation Form:

    a. Qualified Providers may earn a supplemental payment of one hundred and fifty dollars ($150) per Member, per Qualified Provider, per Service Year after completing an AWV and an attestation form for each assigned Member. The attestation form is used to document clinical conditions, preventive screens, and diagnosis codes to ensure accuracy and completeness.

4. Member incentive:

    a. Once per Service Year, CalOptima Health shall distribute a fifty-dollar ($50) gift card to Members who receive an AWV.

C. For dates of service on or after April 01, 2023, a Qualified Provider is eligible for incentives, if:

1. The assigned Member is eligible for Medi-Cal and forty-five (45) years or older as of December 31 of the Service Year;

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

3. The Qualified Provider addresses and documents all health conditions as noted on the attestation during the AWV as provided in Section II.B.1.; and

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

III. PROCEDURE

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

B. CalOptima Health shall provide each Qualified Provider an attestation form and Medical Records submission instruction documents for each of their assigned Members via the CalOptima Health Provider Portal.

C. The AWV must be completed in a face-to-face setting, in person and/or via telehealth utilizing a real-time synchronous audio-video platform.

D. The Qualified Provider shall complete all AWVs in the time period required and within the Service Year.

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

1. Member name;

2. Date of Service;

3. Clinical Assessment;

4. Preventive Health Screening section;

5. Year-Over-Year Chronic and Non-Chronic Conditions sections;

6. Acceptable Qualified Provider signature with credentials; and

7. Date of authentication.

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

F. The Qualified Provider shall submit the verified attestation form , completed SDOH questionnaire, and supporting Medical Records to the CalOptima Health via CalOptima Health Provider Portal, within the Submission Period, but no later than January 31 following the Service Year.

G. Within thirty (30) calendar days from the end of the Submission Period, the CalOptima Health Coding Initiatives Department shall review the Qualified Provider's attestation form and supporting Medical Records to ensure each condition diagnosis code submitted by the Qualified Provider has appropriate clinical documentation.

   1. Upon receipt of Medical Records, CalOptima Health shall retain the Medical Records as set forth in CalOptima Health Policy GG.1603: Medical Records Maintenance.

H. Upon CalOptima Health verification the Qualified Provider has met the conditions as specified in Sections III.E., III.F., and III.G. of this policy, CalOptima Health shall make a supplemental payment in accordance with Section II.B.3.a. of this policy:

   1. The CalOptima Health Finance Department shall process a check request and make a supplemental payment of one hundred dollars ($100) per Member, per Service Year, to the Qualified Provider for a completed and verified attestation form, with supporting Medical Records.

   2. CalOptima Health shall make supplemental payments to the Qualified Provider on a monthly basis.

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

I. If CalOptima Health determines that the attestation form or supporting Medical Record(s) is incomplete, lacking clinical justification, or the condition diagnosis codes/SDOH factors are not reported on a claim or encounter file that reflects the codes documented on the attestation form, 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.

   1. Upon receipt of CalOptima Health's notification of incomplete Medical Records, the Qualified Provider may correct or dispute the findings within thirty (30) calendar days and resubmit the completed attestation form, with supporting documentation and/or Medical Records.

J. CalOptima Health will remove and not submit any condition diagnosis codes to the Department of Health Care Services (DHCS) that are not supported in the Medical Records to ensure data reliability and program integrity.

K. CalOptima Health may provide additional provider education and technical assistance and/or make a referral to the Office of Compliance should CalOptima Health determine that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records supporting the attestation and/or reported condition diagnosis codes.

L. If CalOptima Health determines that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records supporting the attestation and/or reported condition diagnosis codes, and such issues negatively impact quality of care or service delivered to a Member, such matters may be referred as a Potential Quality Issue (PQI) 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)

Not Applicable

V. REFERENCE(S)

A. Primary Care Engagement and Clinical Documentation Integrity Program Attestation Form
B. Accountable Health Communities Health-Related Social Needs Screening Tool
C. CalOptima Health Policy EE.1103: Provider Network Training
D. CalOptima Health Policy GG.1603: Medical Records Maintenance
E. CalOptima Health Policy GG.1611: Potential Quality Issues Review Process
F. ICD-10-CM Official Guidelines for Coding and Reporting

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/06/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2023	GG.1132	Medi-Cal Annual Wellness Visit	Medi-Cal
Revised	04/01/2024	GG.1132	Medi-Cal Annual Wellness Visit	Medi-Cal

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 (PPP) to promote health and help prevent disease based on a Member's health risk factors.
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.
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.
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.
Qualified Provider	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.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.
Service Year	January 01 through December 31 (twelve (12) months).
Submission Month	The month within the submission period in which the attestation form is submitted to CalOptima Health.
Submission Period	January 1 of the Service Year through January 31 following the Service Year (thirteen (13) months).