



State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

DATE: May 5, 2008

MMCD Policy Letter No. 08-003

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: INITIAL COMPREHENSIVE HEALTH ASSESSMENT

BACKGROUND

This Policy Letter clarifies the Initial Comprehensive Health Assessment (IHA) contractual requirements. This letter delineates the purpose and components of the IHA, specifies who can perform them, gives timelines, indicates where they can be completed, and discusses exceptions from timeline requirements. Furthermore, it delineates plans' responsibilities in training providers, informing members, and creating written procedures.

For Two-Plan Model and Geographic Managed Care (GMC) plans, the contractual requirements for IHAs are based on the California Code of Regulations, Title 22, Sections 53851(b)(1), 53902(m), and 53910.5(a)(1). For County Organized Health System (COHS) plans, the requirements for the IHA are based on applicable sections of the COHS contract.

POLICY

I. What is the IHA?

The IHA is a comprehensive assessment that is completed during the member's initial encounter(s) with a selected or assigned primary care physician (PCP), appropriate medical specialist, or non-physician medical provider and must be documented in the member's medical record. The IHA enables the member's PCP to assess and manage the acute, chronic and preventive health needs of the member.

II. IHA Components

The IHA consists of the following:

A. Comprehensive History

The history must be sufficiently comprehensive to assess and diagnose acute and chronic conditions which includes, but is not limited to the following:

1. History of Present Illness
2. Past Medical History
 - a. Prior major illnesses and injuries
 - b. Prior operations
 - c. Prior hospitalizations
 - d. Current medications
 - e. Allergies
 - f. Age appropriate immunization status
 - g. Age appropriate feeding and dietary status
3. Social History
 - a. Marital status and living arrangements
 - b. Current employment
 - c. Occupational history
 - d. Use of alcohol, drugs, and tobacco
 - e. Level of education
 - f. Sexual history
 - g. Any other relevant social factors
4. Review of Organ Systems

B. Preventive Services

1. Asymptomatic Healthy Adults

Plans must adhere to the current edition of the *Guide to Clinical Preventive Services* of the U.S. Preventive Services Task Force (USPSTF), specifically USPSTF "A" and "B" recommendations for providing preventive screening, testing and counseling services. Status of current recommended services must be documented.

2. Members Under 21 Years of Age

Plans must provide preventive services for all members less than 21 years of age as specified by the most recent American Academy of Pediatrics (AAP) age specific guidelines and periodicity schedule. These preventive visits must include age specific assessments and services required by the Child Health and Disability Prevention Program (CHDP). When examinations occur more frequently using the AAP periodicity schedule rather than on the CHDP examination schedule, the IHA must follow the AAP periodicity schedule, and the scheduled assessments and services must include all content required by the CHDP for the lower age nearest to the current age of the child.

3. Perinatal Services

Plans must provide perinatal services for pregnant members according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG). Plans must implement a 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 per Title 22, CCR, Section 51348 that includes an individualized care plan. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up with appropriate interventions and documented in the medical record.

C. Comprehensive Physical and Mental Status Exam

The exam must be sufficient to assess and diagnose acute and chronic conditions.

D. Diagnoses and Plan of Care

The plan of care must include all follow-up activities.

E. Individual Health Education Behavioral Assessment (IHEBA)

1. IHEBA Requirement

An age-specific IHEBA must be administered as part of the IHA. Assessment tools used to complete the IHEBA must be approved by the Medi-Cal Managed Care Division (MMCD), prior to use. Since the "Staying Healthy" assessment tool was developed for MMCD health plans, it may be used without prior approval by MMCD. Please see MMCD Policy Letter 99-07 or the most current IHEBA Policy Letter for specific requirements and schedule for re-administering the behavioral assessment.

2. Exceptions for Transferring Members

The IHEBA requirement for members transferring from an outside group may be met if the medical record indicates that an IHEBA tool or a behavioral risk assessment has been completed within the last 12 months. The age specific and age appropriate behavior risk assessment should address the following areas:

- a. Diet and Weight Issues
- b. Dental Care
- c. Domestic Violence
- d. Drugs and Alcohol
- e. Exercise and Sun Exposure
- f. Medical Care from Other Sources
- g. Mental Health
- h. Pregnancy
- i. Birth Control
- j. STIs/STDs
- k. Sexuality
- l. Safety Prevention
- m. Tobacco Use and Exposure

III. Who Can Perform the IHA

A. Member's PCP of Record

When any person other than the member's PCP (see items III.B-III.D below) performs the IHA, the PCP must ensure that documentation of the IHA is contained in the member's primary medical record, and completed in an accurate and comprehensive manner.

B. Perinatal Care Providers

A plan provider who cares for the member during pregnancy may provide the IHA through the initial prenatal visit(s), and must document that the prenatal visit(s) met IHA content and timeline requirements.

C. Primary Care Providers

1. California licensed physicians qualified to serve as general practitioners;
or
2. Specific plan physicians who are board certified or board eligible in the following medical specialties:
 - a. Internal Medicine;
 - b. Pediatrics;
 - c. Obstetrics/Gynecology; or
 - d. Family Practice

D. Non-Physician Mid-Level Practitioners

Nurse practitioners, certified nurse midwives, physician assistants, and primary care providers in training may be designated as "providers of primary care services" to distinguish them from the member's PCP (see MMCD Policy Letter 98-12).

IV. Timelines for the Provision of the IHA

A. New Plan Members

All new plan members must have a complete IHA within 120 calendar days of enrollment.

B. Members Changing their PCP

If the member requests or the plan initiates a change in their PCP within the first 120 days of enrollment and the IHA has not yet been completed, the IHA must be completed by the newly assigned PCP within the established timeline for new members.

C. Subcontract Requirements

Plan must ensure that subcontracted provider organizations selected or assigned to a member receive timely notification of member's effective date of enrollment to allow scheduling and completion of the IHA within the required time frame. Plans may assist providers in contacting new members for scheduling the IHA appointment.

D. Effective Date of Enrollment

The effective date of enrollment is defined as follows:

1. The first of the month following notification from the DHCS that:
 - a. The member is eligible to receive services from the plan, and capitation will be paid; and
 - b. The member is not on "hold" status.
2. For infants born to plan members, the effective date of enrollment is the date of birth. Such infants are the responsibility of the plan under the mother's enrollment and are covered for all medically appropriate plan services from date of birth through the last day of the following month. Thereafter, the infant is identified by his/her own member number.
3. In the case of retroactive enrollment, the effective date, for purposes of determining the time-frame for performing the IHA, is the date the plan receives notification of the member's enrollment, as described in IV. D. 1 above.

V. IHA Visit Settings

An IHA may be performed in settings other than ambulatory care for members who are continuously enrolled for 120 days as follows:

A. Nursing Facility

For members admitted to a nursing facility, or residing in a nursing facility when they become a plan member, the nursing facility PCP assessment may provide information for the IHA. However, the plan PCP must either complete the IHA or ensure completion of all components of the IHA.

B. Home Visits

The PCP may begin or perform part of the IHA at a home visit; however, all components of the IHA (including components that cannot be performed during home visits) must be completed within 120 days of the effective date of plan enrollment.

C. Hospitalized Members

If members are hospitalized at any time during the initial 120 day period, the PCP may complete the IHA within the hospital during the 120 day period. The PCP may include the hospital admission history and physical with the post-discharge office visit for completion of the IHA requirements. Any physical findings from the hospitalization that would be expected to be resolved must be rechecked and documented in the post-hospital discharge outpatient visit.

VI. Exceptions from IHA Requirements

Exceptions from the timeline requirements described above can occur only in the following situations, and only if documented in the medical record:

A. Completed 12 Months Prior to Enrollment

All elements of the IHA were completed within 12 months prior to the member's effective date of enrollment. If the member's plan PCP did not perform the IHA, the plan PCP must document in the member's medical record that the findings have been reviewed and updated accordingly.

B. New Plan Members Who Choose Their Current PCP

For new plan members who choose their current PCP as their new plan PCP provider, an IHA still needs to be completed within 120 days of enrollment. The current established PCP may incorporate relevant patient historical information from the member's old chart. However, the PCP must conduct an updated physical exam if the patient has not had a physical exam within 12 months of enrollment.

C. Member Not Continuously Enrolled

The member was not continuously enrolled in the plan for the required number of days.

D. Disenrolled Members

The member was disenrolled from the plan before an IHA could be performed.

E. Members Refusing an IHA

The member, including emancipated minors or a member's parents or guardian, refusing an IHA. The plan may wish to offer members who refuse an IHA, referral or reassignment to another PCP.

F. Missed Scheduled Appointment

The member missed a scheduled PCP appointment and **two additional** documented attempts to reschedule have been unsuccessful. The documentation must include at least the following:

1. One attempt to contact the member by telephone with the telephone number provided by the plan; and
2. One attempt to contact the member by letter or postcard sent to the address provided by the plan; and
3. The plan 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
4. Attempts to perform the IHA at any subsequent member office visit(s), even if the deadline for IHA completion has elapsed, until the IHA is completed or the member is disenrolled from the plan.

VII. Provider Training

Plans are responsible for training network providers and their staff regarding:

1. Adequate documentation of IHAs or the reasons IHAs were not completed.
2. Timelines for performing IHAs.

3. Procedures to assure that visit(s) for the IHA are scheduled and that members are contacted about missed IHA appointments.

VIII. Informing Members

A. Member Service Guide

The Plan Member Services Guide must contain information in a language and literacy level that is understandable to the member (see MMCD Policy Letter 99-04) on the following:

1. The availability of the IHA for all members.
2. Instructions on how to arrange for an IHA appointment, within the appropriate timelines.
3. The importance of keeping the IHA and other appointments.
4. Member rights, including providing the member the results of the IHA.

B. Alternative Communication Methods

The plan may provide the same information on IHAs to members via any other communication methods used, such as web site or telephone call center.

IX. Required Written Procedures

A. Required Documentation

All plans must have written procedures for requiring health care providers to document all components of the IHA, or any applicable IHA exemption, in the member's medical record in a timely manner.

B. Monitoring

Procedures for monitoring IHA completion within the required timeframes.

C. Scheduling Appointments

Encouraging the scheduling of IHAs and following up on missed appointments for IHAs as part of the plan's general policies and procedures for scheduling appointments.

D. Promotion of IHA Completion

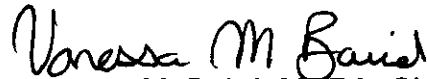
Promoting the IHA completion rate via mechanisms such as quality improvement strategies and training of providers.

E. Informing Members About IHAs

Procedures for informing members about the importance of the IHA, timelines and process for scheduling and conducting an IHA.

If plans have any questions or require additional information regarding the content of this policy letter, please contact Dr. Michael Farber at (916) 449-5000.

Sincerely,

A handwritten signature in black ink that reads "Vanessa M. Baird". The signature is written in a cursive, flowing style.

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division