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Director

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



EDMUND G. BROWN JR.
Governor

DATE: JUNE 24, 2013

DUALS PLAN LETTER 13-002

TO: ALL MEDI-CAL MANAGED CARE PLANS PARTICIPATING IN THE
DUALS DEMONSTRATION PROJECT

SUBJECT: HEALTH RISK ASSESSMENT AND RISK STRATIFICATION
REQUIREMENTS FOR DUAL DEMONSTRATION PLANS UNDER THE
COORDINATED CARE INITIATIVE

PURPOSE:

The purpose of this Duals Plan Letter (DPL) is to clarify and provide guidance on the risk stratification and health risk assessment (HRA) processes for Medi-Cal managed care health plans (MCPs) that are participating in the Duals Demonstration Project, now known as Cal MediConnect.

BACKGROUND:

In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities (SPDs) by shifting service delivery away from institutional care to home and community-based settings. Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).

A component of the CCI is a three-year Duals Demonstration, called "Cal MediConnect." Cal MediConnect will be implemented no sooner than January 1, 2014, in the following eight counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, Alameda, Santa Clara, and San Mateo and will serve enrollees who are both Medi-Cal and Medicare eligible (Duals). Cal MediConnect will combine the full continuum of acute, primary, institutional, and home and community-based Medicare and Medi-Cal services into a single benefit package delivered through an organized service delivery system administered by MCPs. Duals will be passively enrolled into Cal MediConnect plans, but may choose to opt out.

Overview of HRAs in the CCI Memorandum of Understanding (MOU)

The MOU between the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) requires MCPs to complete an HRA for

each enrollee, and provides that the HRA is the basis for developing the enrollee's individual care plan (ICP). This tool identifies further assessment needs that may include, but are not limited to: behavioral health, substance use, chronic conditions, disabilities, functional impairments, assistance in key activities of daily living, dementia, cognitive and mental status, and the capacity to make informed decisions. MCPs are required to use an HRA survey tool that has been approved by DHCS and CMS. The following are the requirements set forth in the MOU pertaining to the administration of the HRA:

- MCPs will provide enrollees with an assessment to identify primary, acute, long-term services and supports (LTSS), and behavioral health and functional needs. This assessment will incorporate standard assessment questions, such as VR-12, as specified by the State.
- MCPs shall assess the enrollee's needs and health or functional status, and the preference of the enrollee, when determining if the HRA will be completed in-person, by telephone, or by mail.
- MCPs will contact enrollees within the required assessment timeframes through a variety of communication methods that will include documented efforts to contact each enrollee, and at least include a letter followed by two phone calls or in-person visits.
 - i. For enrollees identified by the risk stratification mechanism or algorithm as higher risk, the HRA must be completed within 45 calendar days after coverage date or the documentation must demonstrate that the MCP was unsuccessful in its attempts to perform the assessment. Higher risk means enrollees who are at increased risk of having adverse health outcomes, or worsening of their health and functional status, or whose health conditions require careful monitoring and coordination of multiple medical, LTSS, or behavioral health services, if they do not receive their initial contact by the MCP within 45 calendar days after the coverage date.
 - ii. For enrollees in nursing facilities or those identified as lower risk for the purpose of developing ICPs, the assessment tool shall be used within 90 calendar days after coverage date.

For enrollees who are higher risk, the HRA leads to the assignment of the MCP's care managers or Interdisciplinary Care Teams (ICTs), more in depth and comprehensive care planning and coordination. It should be noted that the HRA is not a part of, but rather a step leading towards, the universal assessment tool being developed pursuant to Welfare and Institutions Code Section 14186.36. This process will be developed with stakeholder input and initially tested by a specified group of enrollees in a limited number of counties.

DISCUSSION:

The MOU requires MCPs to develop and submit to DHCS and CMS for review and approval, two tools or processes. The first, a risk stratification mechanism or algorithm will be applied by MCPs to enrollee specific historic Medi-Cal and Medicare fee-for-service utilization data and other data supplied by DHCS and CMS. It will be used to stratify newly enrolled members into higher and lower risk groupings, thus, allowing MCPs to identify those enrollees who have more complex health care needs.

The second tool or process, an HRA, will be used by MCPs to assess an enrollee's current health status and establish a platform to begin building care management and coordination, when appropriate, and developing an ICP. HRAs will be administered within 45 days after coverage date for those identified as higher risk and 90 days for those identified as lower risk.

The HRA includes minimum assessment components to enable comparability and standardization of elements among all MCPs. In addition, MCPs are required to monitor and report on activities and performance measures related to the HRA.

This DPL serves to provide the details necessary to implement and comply with the requirements set forth pertaining to the HRA in the MOU and other guidance later issued by CMS and/or DHCS.

POLICY AND REQUIREMENTS:

In accordance with the three way contract, MCPs are required to develop and submit policies and procedures during the readiness review process which demonstrate compliance with the requirements set forth in this document. DHCS and CMS will review these documents.

A. *Risk Stratification*

No sooner than 60 days prior to new enrollee coverage, DHCS and/or CMS will electronically transmit historical Medicare and Medi-Cal FFS utilization and other data to the MCPs for use in their stratification process. These data may include, but are not limited to, Medicare Parts A, B, and D, Medi-Cal FFS, Medi-Cal In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Skilled Nursing Facility (SNF), behavioral health pharmacy, and outpatient, inpatient, emergency department, pharmacy, and ancillary services, for up to the most recent 12 months.

MCPs are required to establish a **risk stratification** mechanism or algorithm designed for the purpose of identifying newly enrolled members who are considered higher or

lower risk. Higher risk for risk stratification purposes means enrollees who are at increased risk of having an adverse health outcome or worsening of their health status if they do not receive their initial contact by the MCP within 45 calendar days of coverage date.

By analyzing the historical data provided, each MCP will identify higher risk as an enrollee who, at a minimum meets any one of the following criteria:

- Has been on oxygen within the past 90 days.
- Has been hospitalized within the last 90 days, or has had three or more voluntary and/or involuntary hospitalizations within the past year.
- Has had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases).
- Has IHSS greater than or equal to 195 hours/month.
- Is enrolled in MSSP.
- Is receiving Community Based Adult Services (CBAS).
- Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant.
- Has cancer, currently being treated.
- Has been prescribed anti-psychotic medication within the past 90 days.
- Has been prescribed 15 or more prescriptions in the past 90 days.
- Has other conditions as determined by the MCP, based on local resources.

B. Health Risk Assessment

MCPs are required to develop a health **risk assessment survey tool** that will be used to assess an enrollee's current health risk within 45 calendar days of coverage for those identified by the risk stratification mechanism or algorithm as higher risk, and within 90 calendar days of coverage for those identified as lower risk for the purpose of developing individualized care management plans.

In-Person HRAs

Upon initial contact, MCPs are required to offer an in-person HRA to all enrollees at an agreed upon location. This in-person HRA is particularly important for enrollees who are stratified as higher risk. Furthermore, enrollees always have the option to request to complete the HRA in-person. MCPs are required to document and report their outreach efforts to enrollees related to HRAs including: telephone attempts, mailing dates of the HRA survey, enrollee refusals to participate in the HRA process, requests for in-person HRAs, and other outreach efforts, as determined by DHCS. However, the provision of medically necessary services is not contingent on the completion of the HRA.

If an enrollee is determined to have a cognitive impairment, MCPs should work with an authorized observer, when available, to confirm enrollee responses to HRA questions. MCPs shall also develop policies and procedures to determine when it is appropriate to use a proxy respondent, and who that person may be.

MCPs are required to have policies and procedures to address an enrollee's housing status, specifically those who are homeless.

The following MCP procedures and timeframes must be followed to conduct the HRA:

Higher Risk Enrollees

The following process applies to enrollees who are categorized as higher risk and must be completed by the MCP within 45 days of the enrollee coverage date.

Time Frame	Activity
Day 1	Enrollee begins coverage in the MCP.
Day 1 to Day 30	MCP attempts at least five phone calls (two within ten business days of the enrollee's coverage date) and first offers the enrollee the option of an in-person HRA, or if the enrollee agrees, the MCP may complete the HRA by telephone at that time. MCP <i>may</i> send a mailing any time after a good faith effort to contact the enrollee during the first ten days has occurred.
Day 31 to Day 40	If the MCP is unable to complete the HRA by day 30, it must mail the HRA to the enrollee by the next business day.
Day 41 to Day 45	If the enrollee has not completed an HRA, the MCP must attempt another phone call.
6 Months after enrollment	If the MCP is unable to complete the HRA due to a lack of response from the enrollee, it must mail an HRA survey to the enrollee.

Step One. Complete HRA In-Person

Each enrollee will first be offered the opportunity to complete the HRA in-person. For higher risk enrollees, an in-person HRA, conducted by trained or licensed MCP care managers (e.g. registered nurse, licensed social workers), is preferable, with the HRA leading to comprehensive, in-depth assessment and care planning. The MCP must attempt to contact the enrollee by phone, or in a manner consistent with the physical or cognitive needs of the enrollee, at least two times within ten business days of the enrollee's coverage date.

All communications, whether by phone or mail, will inform enrollees how the MCP will arrange for an in-person HRA and it shall be provided in a linguistically and culturally appropriate manner.

Step Two. Complete HRA by Telephone

The MCP attempts to contact the enrollee by telephone, making at least five calls within a 30 day period following the enrollee's coverage date. The first two phone calls must be made within ten business days of the enrollee's coverage date.

- When the MCP reaches an enrollee, it should first offer the enrollee an in-person HRA, and, if the enrollee refuses, offer the opportunity to complete it by phone or mail.

If the MCP has completed the HRA, the HRA process is complete.

If the MCP has not completed the HRA by the 30th day following the enrollee's coverage date, the MCP should complete the process as outlined under Step Three below.

Step Three. Complete HRA by Mail

If the MCP has been unable to complete the HRA by the 30th day after the enrollee's coverage date, it must then mail the HRA by the next business day.

- The MCP may send a mailing any time after the first two phone calls have been completed but no later than the next business day after the 30th day following the enrollee's coverage date.
- The MCP must provide information in the mailing as to how the enrollee can contact the MCP and obtain assistance when completing the HRA by mail.

If the MCP has completed the HRA, the HRA process is complete.

If the MCP has not completed the HRA by the 40th day following the enrollee's coverage date, the MCP should complete the process as outlined under Step Four below.

Step Four. Complete HRA by Follow-Up Telephone Call

If the MCP had not received a response from the enrollee by day 40 after the enrollee's coverage date, it must again attempt to contact the enrollee by telephone prior to the 44th day. The HRA process must be completed by the 45th day.

Step Five. HRA Six Month Follow-Up

If the MCP is unable to complete the HRA due to a lack of response from the enrollee, it must mail an HRA survey to the enrollee six months following the enrollee's coverage date.

Lower Risk Enrollees

The following process applies to enrollees who are categorized as lower risk, and must be completed by the MCP within 90 days after the enrollee's coverage date.

Time Frame	Activity
Day 1	Enrollee is enrolled into the MCP.
Day 1 to Day 30	MCP attempts at least two phone calls within 30 days of the enrollee's coverage date to first offer the enrollee the option of an in-person HRA or, if the enrollee agrees, the MCP may complete the HRA by telephone at that time. MCP <i>may</i> send a mailing any time after a good faith effort to contact the enrollee.
Day 31 to Day 60	If the MCP is unable to complete the HRA by day 30, it must mail the HRA to the enrollee by the next business day.
Day 61 to Day 85	If the MCP is unable to complete the HRA by day 60, it must send a second mailing to the enrollee by the next business day.
Day 86 to Day 90	If the enrollee has not completed an HRA, the MCP must attempt another phone call.
6 Months after enrollment	If the MCP is unable to complete the HRA due to a lack of response from the enrollee, it must mail an HRA survey to the enrollee.

Step One. Complete HRA In-Person

Each enrollee will first be offered the opportunity to complete the HRA in-person. The MCP must attempt to contact the enrollee by phone, or in a manner consistent with the physical or cognitive needs of the enrollee, at least two times within 30 business days of the enrollee's coverage date.

All communications, whether by phone or mail, will inform enrollees how the MCP will arrange for an in-person HRA and it shall be provided in a linguistically and culturally appropriate manner.

Step Two. Complete HRA by Telephone

The MCP attempts to contact the enrollee by telephone, making at least two calls within a 30 day period following the enrollee's coverage date.

- When the MCP reaches an enrollee it should first offer the enrollee an in-person HRA, and if the enrollee refuses, then offer the opportunity to complete it by phone or mail.

If the MCP has completed the HRA, the HRA process is complete.

If the MCP has not completed the HRA by the 30th day following the enrollee's coverage date, the MCP should complete the process as outlined under Step Three below.

Step Three. Complete HRA by Mail

If the MCP has been unable to complete the HRA by the 30th day after the enrollee's coverage date, it must then mail the HRA by the next business day.

- The MCP may send a mailing any time after the first two phone calls have been completed but no later than the next business day after the 30th day after the enrollee's coverage date.
- The MCP must provide information in the mailing as to how the enrollee can contact the MCP and obtain assistance when completing the HRA by mail.

If the MCP has completed the HRA, the HRA process is complete.

If the MCP has not completed the HRA within 60 calendar of the enrollee's coverage date, it must mail a second HRA survey by the next business day.

If the MCP has not completed the HRA by the 85th day following the enrollee's coverage date, the MCP should complete the process as outlined under Step Four below.

Step Four. Complete HRA by Follow-Up Telephone Call

If the MCP has not received a response from the enrollee by day 85 after the enrollee's coverage date, it must again attempt to contact the enrollee by telephone prior to the 89th day. The HRA process must be completed by the 90th day.

Step Five. HRA Six Month Follow-Up

If the MCP is unable to complete the HRA due to a lack of response from the enrollee, it must mail an HRA survey to the enrollee six months following the enrollee's coverage date.

C. Plan Policies and Procedures

MCPs will submit to CMS and DHCS during the readiness review process policies and procedures for the following:

- a. A process for stratifying enrollees into at least two groups: higher risk, and lower risk for the purposes of completion of ICPs.
- b. Conducting the HRA within 45 calendar days of enrollment for those identified as higher risk by the risk-stratification mechanism or algorithm, and 90 calendar days of enrollment for lower risk.
- c. How the HRA will be conducted by:
 - Personnel trained in the use of the assessment instrument.
 - Professionally knowledgeable, licensed and/or certified personnel to review, analyze, identify and stratify health care needs for higher risk enrollees, such as physicians, physician assistants, nurse practitioners, registered nurses, licensed social workers, or behavioral health specialists.
 - Personnel must also be trained for cultural and linguistic competency, needs of individuals with functional impairment, and LTSS needs.
- d. Making assessment materials available upon request in the enrollee's preferred written or spoken language and/or alternate formats that effectively communicate the information.
- e. Including appropriate involvement of caregivers or authorized representatives, and obtaining enrollee consent when the need for such involvement is identified.
- f. Sharing assessment results with enrollees, caregivers and/or authorized representative with enrollee consent, the ICT, the primary care physician, as appropriate, the MSSP care manager, county IHSS and behavioral health partners, or any other LTSS providers within ten days of completion of the HRA.

These processes for sharing assessment results will be developed jointly between the MCP and appropriate county agency or provider.

- g. A process describing how the MCP will identify care needs in order to develop an individual care management and care coordination plan, including:
 - Need for primary care.
 - Need for specialty care including, but not limited to behavioral health.
 - Need for durable medical equipment.
 - Need for medications.
 - Need for LTSS such as, IHSS, CBAS, MSSP, and Nursing Facility/Acute Hospital Waiver.
 - Need for chronic disease management.
 - Need for cognitive and depression screening.
 - Need for fall risk prevention/management.
 - Need for caregiver support and respite.
 - Need for mental and behavioral health treatment.
 - Need for alcohol and/or substance use treatment and counseling.
 - Any other needs.
- h. A process for identification of referrals needed to appropriate community resources and other agencies for services outside the scope of responsibility of the MCP, including but not limited to:
 - Need for mental health, services and substance use disorder services.
 - Need for personal care.
 - Need for housing.
 - Need for home-delivered meals.
 - Need for energy assistance programs.
 - Need for services for individuals with intellectual and developmental disabilities.
- i. A process to identify:
 - Need for facilitating timely access to primary care.
 - Need for facilitating timely access to specialty care, including but not limited to behavioral health.
 - Need for facilitating timely access to LTSS.
 - Need for facilitating timely access to durable medical equipment.
 - Need for facilitating timely access to medications.
 - Need for facilitating timely access to other health services needed by the enrollee, including:
 - Need for referrals to resolve any physical barriers to access.
 - Need for referrals to resolve any cognitive barriers to access.
- j. A process to identify the need for facilitating communication among the enrollee's health care providers, including:

- Primary care and specialty providers.
 - LTSS providers (CBAS, IHSS, MSSP, NF).
 - Mental health and substance use disorder providers when appropriate.
- k. A process to identify the need for providing other activities or services needed to assist enrollees in optimizing their health status, including:
- Assisting with self-management skills or techniques.
 - Health education.
 - Home modification.
 - Home care services and support above and beyond IHSS.
 - Back up emergency caregiver when a personal care services provider, such as IHSS, is absent.
 - Other modalities to improve health status.
- l. A process to identify the need for coordination of care across all settings including post transition care coordination and follow up planning to ensure care coordination is effective and appropriate outside the provider network.
- m. A process to ensure that care coordination and discharge planning is provided to enrollees who are admitted to a hospital or institutional care facility.
- n. A process for determining timeframes for re-contact or reassessment at least annually and, as necessary, the circumstances or conditions that require redetermination of risk level.
- o. A process for identifying circumstances or conditions that require reassessment and redetermination of risk level.
- p. A process for obtaining enrollee approval to share HRA results with another plan if the individual leaves the plan that conducted the HRA. It should be noted that if the individual disenrolls from one plan and joins another, a new HRA must be conducted.
- q. A process for use of enrollee-specific information including their historical Medi-Cal and Medicare FFS utilization data provided by DHCS and CMS electronically prior to coverage beginning.
- r. A process that tests the stratification mechanism or algorithm by using MCP utilization data which ensures that enrollees are stratified into the appropriate higher or lower risk group.

D. Plan Reporting Requirements under Cal MediConnect

No later than 45 days after the end of the first quarter of coverage, and quarterly thereafter and in a manner specified by DHCS and CMS, MCPs shall report:

1. The number of newly enrolled Duals during the previous quarter who have been determined to be at higher risk and lower risk by means of the risk stratification mechanism or algorithm.

- The number of newly enrolled members during the previous quarter, who have been determined, specifically related to their mental health and/or substance use disorder rating, to be determined at higher risk and lower risk by means of the risk stratification mechanism or algorithm.
2. The number of newly enrolled members during the previous quarter in each risk category who were successfully contacted (in-person, phone, or by mail) and by what method.
 3. The number of newly enrolled members during the previous quarter who were successfully contacted and who completed the risk assessment survey (both partially and in total) including how (e.g. in-person, phone or by mail) and the number who declined the risk assessment survey.
 4. The number of newly enrolled members during the previous quarter who completed the risk assessment survey and who were then determined to be in a different risk category (higher or lower) than was established for those enrollees by the MCP during the risk stratification process.
 5. Any other data related to HRAs, as specified by DHCS and CMS in MCP reporting templates.

We look forward to supporting MCPs in the implementation of the risk stratification and health risk assessment processes for the newly enrolled members under the CCI.

If you have any questions regarding this DPL, please contact Sarah Brooks at sarah.brooks@dhcs.ca.gov or (916) 552-9373.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar, Chief
Medi-Cal Managed Care Division