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EDMUND G. BROWN JR.
Governor

DATE: July 11, 2017

ALL PLAN LETTER 17-012
SUPERSEDES ALL PLAN LETTER 14-010

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS OPERATING IN
COORDINATED CARE INITIATIVE COUNTIES

SUBJECT: CARE COORDINATION REQUIREMENTS FOR MANAGED LONG-
TERM SERVICES AND SUPPORTS

PURPOSE:

The purpose of this All Plan Letter (APL) is to clarify Medi-Cal managed care health plan (MCP) care coordination requirements for full benefit dual-eligible beneficiaries (Duals) who either opt-out of or are ineligible for the Duals Demonstration Project (herein referred to as Cal MediConnect), partial benefit Duals, and Medi-Cal only Seniors and Persons with Disabilities (SPDs) in Coordinated Care Initiative (CCI) counties. This APL does not apply to individuals enrolled in Cal MediConnect (see Duals Plan Letter 17-001¹) or members with a Share-of-Cost. For information on the Cal MediConnect program, see <http://www.calduals.org>. This APL supersedes APL 14-010².

BACKGROUND:

In January 2012, Governor Brown announced his intent to enhance health outcomes and member satisfaction for low-income Seniors and Persons with Disabilities (SPDs) and those dually eligible for both Medicare and Medi-Cal (Duals) by shifting service delivery away from institutional care to home and community-based settings. To implement that goal, the Legislature passed, and Governor Brown signed, Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012), and SB 94 (Chapter 37, Statutes of 2013), which authorized the implementation of the CCI.

¹ Duals Plan Letter 17-001 can be accessed at the following link:
<http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx>

² APL 14-010 can be accessed at the following link:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2014/APL14-010.pdf>

The three major components of the CCI are:

1. A three-year Duals Demonstration Project (Cal MediConnect) for Duals (individuals eligible for Medicare and Medicaid) that combines the full continuum of acute, primary, institutional, and home and community-based services into a single benefit package, delivered through an organized service delivery system;
2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of Long-Term Services and Supports (LTSS) as a Medi-Cal managed care benefit (Managed Long Term Services and Supports (MLTSS)) for SPD members who are eligible for Medi-Cal only, and for SPD Duals.

The seven CCI counties are Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

For the LTSS component of the CCI, all Medi-Cal members, including Duals, are required to join an MCP to receive Medi-Cal benefits, including LTSS and Medicare wrap-around benefits. MCPs are required to provide care coordination for these members. This includes risk-stratifying the population, conducting Health Risk Assessments (HRAs), when applicable or requested by the member, developing Individual Care Plans (ICPs) for high-risk members, and establishing Interdisciplinary Care Teams (ICTs), when appropriate, or requested by the member.

DISCUSSION:

This APL applies to the following three populations residing in the seven CCI counties:

1. Full benefit Duals who opt-out of Cal MediConnect. These members are eligible for Medicare Parts A, B, and D, and Full-Scope Medi-Cal;
2. Full benefit Duals who are ineligible for Cal MediConnect due to exclusion criteria and partial benefit Duals; and
3. Medi-Cal only members who, for purposes of this APL, are defined as Full-Scope Medi-Cal SPDs over age 21.

POLICY AND REQUIREMENTS:

Risk-Stratification

Cal MediConnect Opt-Outs AND Full Benefit Duals Excluded from Cal MediConnect AND Partial Duals

MCPs are required to establish a risk-stratification mechanism or algorithm for the following populations:

1. Full benefit Duals who opt-out of Cal MediConnect;
2. Full benefit Duals who are excluded from Cal MediConnect; and
3. Partial benefit Duals.

The risk-stratification mechanism should be designed to stratify newly enrolled members into high or low-risk groups. For purposes of this risk-stratification, an individual may be deemed high-risk if the individual has been authorized to receive In-Home Supportive Services (IHSS) greater than or equal to 195 hours per month, Community Based Adult Services (CBAS), and/or Multipurpose Senior Services Program (MSSP) Services.

No sooner than 60 days prior to the beginning of new member coverage, the Department of Health Care Services (DHCS) will electronically transmit historical Medi-Cal fee-for-service (FFS) utilization data to MCPs for use in the stratification process. This data should be used to identify high and low-risk members. Utilization data may include, but is not limited to, Medi-Cal FFS (including CBAS and MSSP) and IHSS claims, for up to the most recent 12 months.

Medi-Cal Only Seniors and Persons with Disabilities

MCPs are required to follow risk-stratification requirements for newly enrolled Medi-Cal only SPD members. These requirements are set forth in APL 17-013³ titled, "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities."

³ APL 17-013 can be found at the following link: <http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

In addition to the requirements set forth in APL 17-013, MCPs must modify current risk-stratification mechanisms or algorithms to include the following services as indicators of high-risk members:

- IHSS authorized for greater than or equal to 195 hours per month;
- CBAS; and/or
- MSSP.

No sooner than 60 days prior to the beginning of new member coverage, DHCS will electronically transmit historical Medi-Cal FFS utilization data to MCPs for use in the stratification process. This data should be used to identify high and low-risk members. Utilization data may include, but is not limited to, Medi-Cal FFS (including CBAS and MSSP) and IHSS claims, for up to the most recent 12 months.

Health Risk Assessment

Cal MediConnect Opt-Outs AND Full Benefit Duals Excluded from Cal MediConnect AND Partial Duals

MCPs are not required to complete HRAs for Cal MediConnect opt-outs, full benefit Duals excluded from Cal MediConnect, or partial Duals since MCPs do not have responsibility for the full spectrum of health care services for these members. MCPs that choose to complete HRAs for these groups are required to follow HRA requirements for Medi-Cal only SPDs as set forth in APL 17-013 titled, "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities."

Medi-Cal Only Seniors and Persons with Disabilities

MCPs are required to follow HRA requirements for Medi-Cal only SPD members as set forth in APL 17-013 titled, "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities."

The HRA must include:

1. A process describing how the MCP will identify medical care needs, including primary care, specialty care, durable medical equipment (DME), medications, LTSS, and other needs, and for developing an individual care-management and care-coordination plan as needed;

2. A process to identify referrals needed to appropriate community resources and other agencies for services outside the scope of responsibility of the MCP, including but not limited to mental health and behavioral health, personal care, housing, home-delivered meals, energy assistance programs, LTSS and services for individuals with intellectual and developmental disabilities;
3. A process to identify the need for including appropriate involvement of caregivers;
4. A process to identify the need for facilitating timely access to primary care, specialty care, DME, medications, and other health services needed by the member, including the need for referrals to resolve any physical or cognitive barriers to access;
5. A process to identify the need for facilitating communication among the member's health care providers, including mental health and substance abuse providers when appropriate;
6. A process to identify the need for providing other activities or services needed to assist members in optimizing their health status, including assistance with self-management skills or techniques, health education and other modalities to improve health status;
7. A process to identify the need for coordination of care across all settings including those outside the provider network and to ensure that discharge planning is provided to members who are admitted to a hospital or institution;
8. A process for obtaining and compiling each assessment conducted on the member's behalf through IHSS, MSSP, CBAS, and/or the Skilled Nursing Facility (SNF), when applicable; and
9. A process for determining timeframes for re-contact or reassessment at least annually and, if necessary, the circumstances or conditions that require redetermination of risk-level. This includes Medi-Cal only SPDs upon reassessment.

Long-Term Services and Supports Assessment Review

Cal MediConnect Opt-Outs AND Full Benefit Duals Excluded from Cal MediConnect AND Partial Duals

MCPs are not required to develop a full HRA for high-risk members who opt-out of, or are excluded from Cal MediConnect (full benefit Duals), or for partial Duals. However, MCPs must retain and compile a copy of each assessment conducted on the member's behalf through IHSS, MSSP, CBAS, or the SNF. MCPs must review these assessments to determine if any further coordination of services for the member is appropriate.

The LTSS assessment review must include:

1. A process to identify referrals to appropriate community resources and other agencies for services outside the scope of responsibility of the MCP that meet member's social, and transportation needs and preferences, including but not limited to mental health and behavioral health, personal care, housing, home-delivered meals, energy assistance programs, and services for individuals with intellectual and developmental disabilities;
2. A process to identify the need for including appropriate involvement of caregivers, which includes identifying participant and caregiver preferences and having back-up plans in place for situations when caregivers are unavailable;
3. A process to identify member's current health status and treatment needs and the need for facilitating communication among the member's LTSS and other providers, including mental health and substance abuse providers when appropriate;
4. A process to identify the need for providing other activities or services needed to assist members in optimizing their health status, including assistance with self-management skills or techniques, health education, and other modalities to improve health status and meet personal goals; and
5. A process for determining timeframes for re-contact or reassessment and, if necessary, the circumstances or conditions that require redetermination of risk-level through risk-stratification.

Individual Care Plan

Cal MediConnect Opt-Outs AND Full Benefit Duals Excluded from Cal MediConnect AND Partial Duals

MCPs are not required to develop a full ICP for high-risk members who opt-out of, or are excluded from Cal MediConnect (full benefit Duals) or who are partial Duals. However, MCPs must retain and compile a copy of each ICP created on the member's behalf through the IHSS, MSSP, CBAS, or the SNF. MCPs must review these ICPs to determine if any further coordination or delivery of services for the member is appropriate.

Medi-Cal Only Seniors and Persons with Disabilities

MCPs are required to establish an ICP for newly enrolled and reassessed Medi-Cal only SPD members meeting high-risk criteria pursuant to this APL, when appropriate. ICPs must be established per the following requirements:

1. If a member demonstrates the need or asks for an ICP, the MCP must develop a plan and engage the member and/or his or her representative(s) in its design. The ICP is the responsibility of the MCP and is separate and distinct from the medical care plan that is created, established, and maintained by the member's primary care provider (PCP).

MCPs may identify the need for an ICP through interactions with the member (e.g. when conducting the HRA) and stratify members into lower and higher-risk categories (e.g. through the HRA risk-stratification process) and take any other appropriate interactions as necessary.

2. The member must have the opportunity to be involved in the development, review, and approval of the ICP and any amendments to the ICP, as appropriate. The member must be offered and provided, upon request, a copy of the ICP and any amendments to the ICP. The ICP must be made available in alternative formats and in the member's preferred written or spoken language upon request.
3. The ICP shall include:
 - Member goals and preferences;
 - Measurable objectives and timetables to meet physical health and LTSS needs as determined through the assessment process, IHSS assessment

results, MSSP and CBAS records, and input from members of the ICT, as appropriate; and

- Coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies, when appropriate.
4. Re-evaluation of the ICP must be conducted at least annually or upon a significant change in condition.

Interdisciplinary Care Teams

For Medi-Cal only SPD members, MCPs are required to offer an ICT to all high-risk members, or those who request one, when a need is demonstrated and in accordance with the member's functional status, assessed need, and the ICP. The ICT must be built around the needs of the member and ensure integration and coordination of the member's medical care and LTSS. A member or his/her provider may contact an MCP to request that the MCP review the member's need for an ICT and ICP. MCPs must include information about the availability of the ICT and ICP to high-risk members in new member welcome packets.

1. ICT Functions

The ICT must facilitate care-management, including assessment, care-planning, authorization of services, and transitional care issues. The ICT must work closely with members to stabilize medical conditions, increase compliance with ICPs, maintain functional status and meet individual member ICP goals. ICT functions must include, at a minimum:

- Develop and implement an ICP with member and/or caregiver participation;
- Conduct ICT meetings periodically, including at the member's request;
- Manage communication and information flow regarding referrals, transitions and care delivered outside the primary care site;
- Maintain a call line or other mechanism for member inquiries and input and a process for referring to other agencies, as appropriate; and
- Conduct conference calls with the MCP, providers, and the member, as appropriate.

Secured email, facsimile, web portals, or written correspondence must be used when communicating with members. The ICT must take the member's individual needs (e.g. communication, cognitive, or other barriers) into account when communicating with the member.

2. Composition of the ICT

The ICT must be person-centered and developed around the member's specific preferences and needs, including language and culture, which will ensure integration of the member's medical and LTSS care. The member has the primary decision-making role in identifying his/her needs, preferences, and strengths and has a shared decision-making role in determining the services and supports that are most effective and helpful for his/her care.

The ICT must be led by professionally knowledgeable and credentialed personnel, and at a minimum must be comprised of the following core individuals:

- Member – The member and/or his/her authorized representative if the IHSS recipient chooses to participate, and consents to the participation of the authorized representative;
- Family and/or caregiver, if approved by the member. For IHSS, the recipient must consent;
- Care coordinator – A person employed or contracted by the MCP who is a licensed medical professional or is overseen by a licensed medical professional. The care coordinator is accountable for providing care coordination services that includes assessing appropriate referrals and timely two-way transmission of useful member information, obtaining reliable and timely information about services other than those provided by the PCP, assisting in the development and maintenance of the ICP, and participating in the initial assessment and supporting safe transitions in care for members moving between settings;
- PCP – A physician or non-physician medical practitioner under the supervision of a physician, who is responsible for supervising, coordinating, and providing initial and primary care to patients, initiating referrals, and maintaining the continuity of patient care;
- Specialist – If a specialist is serving as the member's PCP, he/she must be part of the ICT; and

- If receiving IHSS, the county social worker.

If a member's PCP or specialist is unwilling or unable to participate in the ICT, the other individuals listed above are sufficient.

The ICT must include the aforementioned individuals to the extent possible. The ICT must also include individuals or providers who are actively involved in the care of the member, if approved by the member and the individuals or providers are willing to participate in the ICT, when appropriate:

- Hospital discharge planner;
- Nurse;
- Social worker;
- Nursing facility representative;
- Specialized providers, such as physician specialists, pharmacists, physical therapists, and occupational therapists;
- If receiving IHSS, the IHSS provider if authorized by the member;
- If participating in CBAS, the CBAS provider;
- If enrolled in the MSSP waiver program, the MSSP coordinator; and
- Other professionals, as appropriate.

For purposes of the ICT, the MCP is not required to compensate any individuals who are not directly employed by, or contracted with, the MCP for participation in the ICT.

MCP Policies and Procedures

1. Pursuant to APL 17-013, MCPs must submit to DHCS the applicable policies and procedures for risk-stratification for Cal MediConnect opt-outs, full benefit Duals excluded from Cal MediConnect and partial Duals;

2. MCPs must submit to DHCS the policy and procedure that describes their process for coordinating the care plans for their members who are enrolled in LTSS programs; and
3. MCPs must submit to DHCS the policy and procedure that describes the applicable policies and procedures for the HRA process for Medi-Cal only SPDs, incorporating the requirements of APL 17-013 and this APL.

Plan Reporting Requirements

Beginning with the implementation of MLTSS (date will vary depending on county), and quarterly thereafter, MCPs must report to the Managed Care Quality and Monitoring Division 135 days after the end of each quarter, at a minimum:

1. The number of newly-enrolled MLTSS members during the quarter who have been determined to be at higher-risk and lower-risk by means of the risk-stratification mechanism or algorithm;
2. The number of newly-enrolled Medi-Cal only SPD members during the quarter in each risk category who were successfully contacted (MCP received phone or mailed response) during the quarter and by what method;
3. The number of newly-enrolled Medi-Cal only SPD members during the quarter who were successfully contacted and who completed the HRA (answered all the questions) and the number who declined to participate in the HRA survey;
4. The number of newly-enrolled Medi-Cal only SPD members during the quarter who completed the HRA survey and who were then determined to be in a different risk category (higher or lower) than was established for those members by the MCP during the risk-stratification process;
5. The number of newly-enrolled Medi-Cal only SPD members during the quarter who had an ICP completed; and
6. The number of newly-enrolled Medi-Cal only SPD members during the quarter who had an ICT created.

The aforementioned data must be submitted according to the instructions tab of the current MLTSS reporting template. For questions about MLTSS reporting or the reporting template, please send an email to your contract manager with MLTSS data reporting in the subject line.

If you have any questions regarding the requirements of this APL, please contact your Medi-Cal Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division