



TOBY DOUGLAS
Director

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



EDMUND G. BROWN JR.
Governor

DATE: FEB 25 2011

MMCD Policy Letter 11-007

TO: ALL TWO-PLAN AND GEOGRAPHIC MANAGED CARE MODEL MEDI-CAL
MANAGED CARE PLANS

SUBJECT: REVISION TO POLICY LETTER 11-001 REGARDING REQUIREMENTS
FOR HEALTH RISK ASSESSMENT OF MEDI-CAL SENIORS AND
PERSONS WITH DISABILITIES

PURPOSE:

This Policy Letter (PL) 11-007 revises and replaces PL 11-001 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities (SPDs). PL 11-007 provides a definition for "higher risk" beneficiaries, which for purposes of the risk stratification process, means Medi-Cal beneficiaries 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 plan within 45 calendar days of enrollment.

PL 11-001 provided Medi-Cal managed care plans (Plans) with the requirements to implement the health risk assessment of Medi-Cal-only Seniors and Persons with Disabilities (SPDs) and to develop the risk stratification and risk assessment survey tools that must be submitted to the Department of Health Care Services (DHCS) for approval as required by Welfare and Institutions Code section 14182 (added by Senate Bill 208 Chapter 714, Statutes of 2010).

BACKGROUND:

Welfare and Institutions Code (W&I) section 14182 which became law on October 19, 2010 permits DHCS to enroll SPDs in Plans on a mandatory basis and implement the requirements of the statute through a policy letter. The Centers for Medicare and Medicaid Services (CMS) approved the California Section 1115 Medicaid Demonstration Waiver entitled "Bridge to Reform" (1115 Waiver) effective November 1, 2010 which included the federal approval to enroll SPD beneficiaries on a mandatory basis into Plans. DHCS will, as of June 1, 2011, implement mandatory enrollment of

the Medi-Cal-only SPD population into Plans in counties where their enrollment is now voluntary. Mandatory enrollment of this population will be phased in over a twelve-month period. Upon mandatory enrollment of each Medi-Cal-only SPD into a Plan (whether by member choice of a Plan or default assignment to a Plan), Plans must apply a health risk stratification mechanism or algorithm and perform a health risk assessment survey within statutorily required timeframes.

DISCUSSION:

W&I section 14182 requires Plans to develop and submit for DHCS review and approval, two tools or processes. The first, a risk stratification mechanism or algorithm will be applied by Plans at the time of member enrollment into the Plan using the member-specific historic Medi-Cal fee-for-service utilization data supplied by DHCS to identify those members with higher risk and more complex healthcare needs. The second tool or process, a risk assessment survey, shall be used to assess a SPD member's current health risk within 45 days of enrollment for those identified by the risk stratification method or algorithm as higher risk and within 105 days of enrollment for those identified at lower risk for the purpose of developing individualized care management plans for the higher risk SPDs.

The 1115 Waiver Special Terms and Conditions require DHCS to provide the CMS with detailed information about the health risk assessment process and ensure minimum assessment components be included in a Plan's assessment to enable comparability and standardization of elements among all Plans. Additionally, DHCS is required to monitor and report Plan activities and to develop Plan performance measures specific to the SPD population. Plans are required to report specific information and statistics related to the health risk assessments for these purposes.

Plan contract language will be added to include these new Plan requirements. This Policy Letter will be referenced in the Plan contracts and serves to provide the detail necessary to implement and comply with these new requirements.

POLICY:

In accordance with W&I section 14182, Plans shall develop and submit the following by March 1, 2011, and DHCS will review within one month of submission:

- A. A **risk stratification** mechanism or algorithm designed for the purpose of identifying newly enrolled SPD members who have higher risk and more complex health needs, and those who are at lower risk, within 44 calendar days of enrollment. "Higher risk" for risk stratification purposes means Medi-Cal

beneficiaries 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 plan within 45 calendar days of enrollment. The higher risk individuals who should be identified from the fee for service utilization data and the self assessment questionnaires include but are not limited to beneficiaries who:

- Have been on oxygen within the past 90 days.
- Are residing in an acute hospital setting.
- Have been hospitalized within the last 90 days, or have had 3 or more hospitalizations within the past year,
- Have had 3 or more ER 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),
- Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern e.g. homelessness,
- Have ESRD, AIDS, and/or a recent organ transplant,
- Have cancer, currently being treated,
- Are pregnant,
- Have been prescribed anti-psychotic medication within the past 90 days,
- Have been prescribed 15 or more prescriptions in the past 90 days,
- Have a self-report of a deteriorating condition,
- Have other conditions as determined by the plan, based on local resources.

The submission must include:

1. A process for incorporating stakeholder and consumer input into development of the mechanism or algorithm.
2. A process for use of member-specific information including their historical Medi-Cal fee-for-service utilization data provided by DHCS electronically at the time of enrollment. This data may include, but is not limited to, outpatient, inpatient, emergency department, pharmacy, and ancillary services data for up to the most recent 12 months.
3. A process for use of the information obtained from the completed MET, a member self-assessment of health that will be provided to Plans by DHCS electronically at the time of enrollment.
4. A process that tests the stratification mechanism or algorithm by using Plan utilization data to stratify current voluntarily enrolled SPD members into higher and lower risk groups.

B. A **risk assessment survey tool** that shall be used to comprehensively assess a member's current health risk within 45 calendar days of enrollment for those identified by the risk stratification mechanism or algorithm as higher risk and within 105 calendar days of enrollment for those identified at lower risk for the purpose of developing individualized care management plans for those SPDs identified as higher risk. "Higher risk" for the risk assessment purposes means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health status if they do not have an individualized care management plan. The submission must include:

1. A process for incorporating stakeholder and consumer input into development of the tool or process.
2. A process for contacting members within the required assessment timeframes that will include repeated efforts (letter followed by at least two phone calls) to contact each member.
3. A process for stratifying members into at least two groups, those needing basic and those needing complex care management.
4. A process describing how the Plan will identify medical care needs, including primary care, specialty care, durable medical equipment, medications, and other needs and develop an individual care management and care coordination plan as needed.
5. A process for identification of referrals needed to appropriate community resources and other agencies for services outside the scope of responsibility of the managed care health plan, 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.
6. A process to identify the need for including appropriate involvement of caregivers.
7. A process to identify the need for facilitating timely access to primary care, specialty care, durable medical equipment, medications, and other health services needed by the enrollee, including the need for referrals to resolve any physical or cognitive barriers to access.
8. 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.
9. A process to identify the need for providing other activities or services needed to assist members in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

10. 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.
11. 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.

C. Plan Reporting Requirements

Beginning **October 1, 2011**, and quarterly thereafter, Plans shall report to MMCD, at a minimum:

1. The number of newly enrolled SPD members 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.
2. The number of newly enrolled SPD members during the previous quarter in each risk category who were successfully contacted (Plan received phone or mailed response) during the previous quarter and by what method.
3. The number of newly enrolled SPD members during the previous quarter who were successfully contacted and who completed the risk assessment survey (answered all questions) and the number who declined the risk assessment survey.
4. The number of newly enrolled SPD 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 members by the plan during the risk stratification process.

If you have any questions regarding the requirements of this Policy Letter, please contact your MMCD contract manager. We look forward to supporting plans in your implementation of the risk stratification and assessment processes for the new mandatory enrolled Medi-Cal-only SPDs.

Sincerely,

Original Signed by Bob Martinez for

Tanya Homman, Chief
Medi-Cal Managed Care Division