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



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DATE: June 12, 2014

MMCD POLICY LETTER 14-005
(SUPERSEDES POLICY LETTER 12-004)

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: REQUIREMENTS FOR HEALTH RISK ASSESSMENT
OF MEDI-CAL SENIORS AND PERSONS WITH DISABILITIES

PURPOSE:

This Policy Letter (PL) supersedes PL 12-004 and provides clarification of certain requirements for the risk stratification and Health Risk Assessment (HRA) of Medi-Cal Seniors and Persons with Disabilities (SPDs). These policies apply to all newly enrolled SPDs in all Medi-Cal managed care health plans (MCPs). This PL also clarifies requirements for use of the Health Information Form/Member Evaluation Tool (HIF/MET) for MCPs operating under the County-Organized Health Systems (COHS) model of managed care.

BACKGROUND:

State and federal law permit the Department of Health Care Services (DHCS) to require SPDs who do not have other health coverage (i.e., Medi-Cal only SPDs) to enroll in MCPs. These laws include Welfare and Institutions (W&I) Code Section (§) 14182 that was added as part of Senate Bill (SB) 208 (Steinberg, Chapter 714, Statutes of 2010) to further the goals of the State's Section 1115 Waiver, "A Bridge to Reform" (1115 Waiver). W&I Code § 14182 permits DHCS to implement the statute's requirements through a PL. The Centers for Medicare and Medicaid Services (CMS) approved the 1115 Waiver and issued Standard Terms and Conditions (STCs) that defined goals and objectives the State must fulfill to qualify for federal financial participation under the 1115 Waiver.

W&I Code § 14182, subsections (b) and (c), requires MCPs to develop two processes to identify the relative health risk of each SPD member. MCPs submit the processes they develop to DHCS for review and approval. All MCPs must use these tools or processes to develop individualized care management plans for their SPD members who have been determined to be at higher risk of requiring complex health care services.

The first process is a risk stratification mechanism, or algorithm (a step-by-step procedure for decision-making). MCPs use it to analyze health care utilization data they receive from DHCS for each of their newly enrolled members. This data represents the members' prior health care utilization under Medi-Cal Fee-for-Service (FFS). MCPs

analyze this data or HIF/MET data, when it exists, to identify members with higher risk and more complex health care needs.

The second process is an HRA survey. MCPs use the HRA survey to assess each 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 as lower risk.

DHCS is required to provide CMS with detailed information about the MCPs' HRA processes to ensure that each MCP's assessment method includes the specified components. DHCS must monitor and report on MCP activities and develop MCP performance measures specific to the SPD population.

DHCS has added language to its contracts with MCPs to include these State and federal requirements. This PL describes how MCPs will implement these requirements.

POLICY:

Each MCP must submit its policies, procedures, and tools related to health risk stratification and HRA to DHCS for approval. These materials must demonstrate that the MCP is conducting health risk stratification and HRAs for all newly enrolled SPDs, as follows:

A. Risk stratification mechanism or algorithm.

- 1) Each MCP shall use a risk stratification mechanism or algorithm to analyze member-specific FFS utilization data and HIF/MET data and identify members with higher risk and more complex health care needs. The MCP must complete this stratification within 44 calendar days of enrollment. If FFS utilization data and/or HIF/MET data is not available, the MCP must determine by other means if SPD members are higher or lower risk.

For risk stratification purposes, "higher risk" means Medi-Cal members who are at an increased risk of having an adverse health outcome or worsening of their health status if they do not have an individualized care management plan. Higher risk individuals include but are not limited to members who:

- a. Have been on oxygen within the past 90 days;
- b. Are residing in an acute hospital setting;
- c. Have been hospitalized within the last 90 days, or have had three or more hospitalizations within the past year;
- d. Have 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);

- e. 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);
 - f. Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
 - g. Have cancer, and are currently being treated;
 - h. Are pregnant;
 - i. Have been prescribed antipsychotic medication within the past 90 days;
 - j. Have been prescribed 15 or more prescriptions in the past 90 days;
 - k. Have a self-report of a deteriorating condition; and
 - l. Have other conditions as determined by the MCP, based on local resources.
- 2) To implement the risk stratification, MCPs are required to submit the following to DHCS for approval:
- a. The process for incorporating stakeholder and consumer input into development of the risk stratification mechanism or algorithm;
 - b. The process for electronically accessing member-specific health information, including the member's historical Medi-Cal FFS utilization data provided by DHCS at the time of enrollment. This data may include, but is not limited to, outpatient, inpatient, emergency department, pharmacy, and ancillary services data for the most recent 12 months;
 - c. The process for accessing information obtained from the completed HIF/MET (for MCPs operating under the non-COHS models) that is a member's self-assessment of his or her health status that DHCS's enrollment broker electronically provides to MCPs when new members enroll. A sample HIF/MET can be found at the following link:
www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/MET/MET_MU_0003754_ENG_1010.pdf;
 - d. The process used by County Organized Health System MCPs for including the HIF/MET in each member welcome packet; alternatively, the process used by COHS MCPs for including questions from the HIF/MET in the HRA (see Section B below). An MCP that includes the HIF/MET in its member welcome packets must modify the HIF/MET (see link above) to include information specific to the MCP, such as the return address and MCP contact information so members have the ability to ask questions and send mail;
 - e. The process that tests the stratification mechanism or algorithm by using MCP utilization data to stratify currently enrolled SPD members into higher and lower risk groups; and

- f. The process for stratifying members who lack FFS claims data or HIF/MET into higher or lower risk groups within 44 days.
- 3) MCPs that choose to consider all newly enrolled SPD members as higher risk may ignore the requirements in Section A.2 above) and apply the requirements of Section B within 45 days for all members.

B. Health Risk Assessment Survey.

- 1) Each MCP must use the HRA to comprehensively assess each newly enrolled member's current health risk. Each MCP must complete the HRA within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk and within 105 calendar days of enrollment for those identified as lower risk. The HRA is then used to re-classify all members as higher or lower risk. (For some members, this re-classification based on the HRA may be different from their earlier classification based on the stratification tool.) After completion of the HRA, the MCP must develop individualized care plans (ICPs) for members found to be at higher risk.
- 2) Each MCP must submit the following to DHCS for approval:
 - a. The process for incorporating stakeholder and consumer input into development of the HRA;
 - b. The process for contacting members within the required assessment timeframes that includes repeated efforts (letter followed by at least two phone calls) to contact each member;
 - c. The process for stratifying members into at least two groups based upon the findings of the HRA: those at lower risk (needing basic care management) and those at higher risk (requiring an ICP and complex care management). As in Section A.1 above, "higher risk" means members who are at increased risk of having an adverse health outcome or worsening of their health status if they do not have an ICP. When MCPs conduct HRAs for all members, they must include all elements described in Sections B.2.d-I below;
 - d. The process describing how the MCP will identify medical care needs, including:
 - i. Primary care;
 - ii. Specialty care;
 - iii. Durable medical equipment (DME);
 - iv. Medications; and
 - v. Any other needs.

- e. The process for identifying the referrals a member needs to appropriate community resources and other agencies for services outside the MCP's scope of responsibility, including but not limited to the member's need for:
 - i. Mental health and behavioral health services;
 - ii. Personal care;
 - iii. Housing;
 - iv. Home-delivered meals;
 - v. Energy assistance programs; and
 - vi. Services for individuals with intellectual and developmental disabilities.
- f. The process for identifying a member's need for and appropriate level of involvement of caregivers;
- g. The process for identifying a member's need for help in facilitating timely access to primary care, specialty care, DME, medications, and other health services, including:
 - i. The need for referrals to resolve any physical barriers to access; and
 - ii. The need for referrals to resolve any cognitive barriers to access.
- h. The process for identifying a member's need for help in facilitating communication among the member's health care providers, including:
 - i. Primary care and specialty providers; and
 - ii. Mental health and substance abuse providers, when appropriate.
- i. The process for identifying a member's need for other activities or services that would help the member to optimize his or her health status, including:
 - i. Assistance with self-management skills or techniques;
 - ii. Health education; and
 - iii. Other methods for improving health status.
- j. The process for identifying a member's need for coordination of care across all settings, including those outside the MCP's provider network;
- k. The process for ensuring that a member admitted to a hospital or institution receives appropriate discharge planning; and
- l. The process for determining how frequently to contact a member for reassessment (at least annually) and the circumstances or conditions that require the MCP to re-determine a member's risk level.

C. MCP Reporting Requirements.

MCPs shall report to DHCS 135 days after the end of each quarter, at a minimum:

1. The number of newly enrolled SPD 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. For MCPs who choose the stratification method described in A.3 above, this number is all newly enrolled SPD members during the quarter;
2. The number of newly enrolled SPD members during the quarter in each risk category who were successfully contacted (MCP received member's response by telephone or mail) during the quarter and by what method;
3. The number of newly enrolled SPD members during the quarter who were successfully contacted and who completed the risk assessment survey (answered all questions) and the number who declined the risk assessment survey; and
4. The number of newly enrolled 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.

Data must be submitted in the DHCS-required format. The reporting instructions and template are located with the posting of this Policy Letter at <http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx> and will be labeled as "PL 14-005 Attachments."

If you have any questions on the reporting documents and/or requirements, please contact Sarah Reed, Research Analyst, at Sarah.Reed@dhcs.ca.gov.

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

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Acting Deputy Director
Health Care Delivery Systems

Attachments