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**DATE:** July 11, 2017

ALL PLAN LETTER 17-013  
(SUPERSEDES POLICY LETTER 14-005)

**TO:** ALL MEDI-CAL MANAGED CARE PLANS

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

**PURPOSE:**

This All Plan Letter (APL) provides clarification of certain requirements related to the risk stratification process, which may include utilization of Health Information Form (HIF)/Member Evaluation Tool (MET) data (when it exists), and Health Risk Assessments (HRA) for 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 APL supersedes Policy Letter 14-005<sup>1</sup>.

**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 Demonstration Waiver titled, "A Bridge to Reform" (1115 Waiver). W&I Code § 14182 permits DHCS to implement the statute's requirements through an APL. 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(b) - (c), require 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.

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<sup>1</sup> Policy Letter 14-005 can be accessed at the following link:  
<http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx>

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 SPD members. This data represents the SPD member's prior health care utilization under Medi-Cal Fee-for-Service (FFS). MCPs must analyze this data or HIF/MET data (when it exists), per the requirements contained in this APL, to identify newly enrolled SPD 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 newly enrolled 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 APL describes how MCPs will implement these requirements.

## **POLICY:**

MCPs must comply with the following policies by January 1, 2018.

Each MCP must submit its policies, procedures, and tools related to health risk stratification and HRAs 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 or HIF/MET data (when it exists) and identify newly enrolled SPD 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. HIF/MET Process (to comply with Title 42, Code of Federal Regulations, Section 438.208(b))
    - 1. The process used by MCPs for including the HIF/MET in each newly enrolled SPD member's welcome packet including a postage paid envelope for mailing back the completed form;
    - 2. The process used by MCPs within 90 days of each new SPD member's date of enrollment to make at least two telephone call attempts to remind new SPD members to return the HIF/MET and/or to collect the HIF/MET information from new SPD members;
    - 3. The process for utilizing information obtained from the completed HIF/MET within 90 days of each new SPD member's date of enrollment to complete

an initial screening of each new SPD member's needs. 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](http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/MET/MET_MU_0003754_ENG_1010.pdf);

4. The process, upon an SPD member's disenrollment, to make any HIF/MET assessment results available to the SPD member's new MCP upon request;
  - d. 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
  - e. The process for stratifying members who lack Medi-Cal FFS utilization or HIF/MET data 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 SPD member's current health risk. MCP's 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 newly enrolled SPD 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.) In addition, the HRA must include specific Long-Term Services and Supports (LTSS) referral questions (see Attachment). These questions are intended to assist MCPs in identifying members who may qualify for and benefit from LTSS services. These questions are for referral purposes only and are not meant to be used in classifying high and low risk members. The LTSS questions must be used verbatim; however, they may be incorporated into the existing HRA and can replace similar existing HRA questions. After completion of the HRA, the MCP must develop Individualized Care Plans (ICPs) for members found to be at higher risk and coordinate referrals for identified LTSS, as needed.
- 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-m 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.
- m. The process for utilizing the standardized LTSS referral questions (Attachment) to identify and ensure the proper referral of members who may qualify for and benefit from LTSS services.

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

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief  
Managed Care Quality and Monitoring Division

Attachment

## Attachment

### Long-Term Services and Supports Referral Questions

#### Background:

In 2016, the Department of Health Care Services (DHCS) announced several strategies designed to improve referrals to Long Term Services and Supports (LTSS), including creating and releasing standardized LTSS referral questions for all Medi-Cal managed care plans (MCPs) to administer during the Health Risk Assessment (HRA) process. DHCS convened a workgroup to develop recommendations to increase the effectiveness of the questions.

The workgroup identified four different categories of risk factors: social determinants, functional capacity, medical conditions, and behavioral health conditions. These risk factors address the spectrum of challenges a beneficiary may face, reflecting a whole-person approach to understanding the need for LTSS. The workgroup developed standardized LTSS referral questions to address the most directly connected risk factors. Each of the questions seeks to identify whether a beneficiary is experiencing risk factors that make them a candidate for LTSS services that will help keep them in their home and community. The questions are organized in the following two tiers and MCPs must take a holistic view of questions in both tiers to identify beneficiaries in need of follow-up assessments:

- Tier 1 contains questions directly related to LTSS eligibility criteria, and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
- Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.

The headings in *italics* are not part of the questions, but provide the intent of the questions.

#### Tier 1 LTSS Questions:

*Activities of Daily Living Functional Limitations / Instrumental Activities of Daily Living Limitations / Functional Supports (Functional Capacity Risk Factor)*

**Question 1:** Do you need help with any of these actions? (Yes/No to each individual action)

- a) Taking a bath or shower
- b) Going up stairs
- c) Eating
- d) Getting Dressed
- e) Brushing teeth, brushing hair, shaving
- f) Making meals or cooking

- g) Getting out of a bed or a chair
- h) Shopping and getting food
- i) Using the toilet
- j) Walking
- k) Washing dishes or clothes
- l) Writing checks or keeping track of money
- m) Getting a ride to the doctor or to see your friends
- n) Doing house or yard work
- o) Going out to visit family or friends
- p) Using the phone
- q) Keeping track of appointments

If yes, are you getting all the help you need with these actions?

*Housing Environment / Functional Supports (Social Determinants Risk Factor)*

**Question 2:** Can you live safely and move easily around in your home? (Yes/No)

If no, does the place where you live have: (Yes/No to each individual item)

- a) Good lighting
- b) Good heating
- c) Good cooling
- d) Rails for any stairs or ramps
- e) Hot water
- f) Indoor toilet
- g) A door to the outside that locks
- h) Stairs to get into your home or stairs inside your home
- i) Elevator
- j) Space to use a wheelchair
- k) Clear ways to exit your home

*Low Health Literacy (Social Determinants Risk Factor)*

**Question 3:** "I would like to ask you about how you think you are managing your health conditions"

- a) Do you need help taking your medicines? (Yes/No)
- b) Do you need help filling out health forms? (Yes/No)
- c) Do you need help answering questions during a doctor's visit? (Yes/No)

*Caregiver Stress (Social Determinants Risk Factor)*

**Question 4:** Do you have family members or others willing and able to help you when you need it? (Yes/No)

**Question 5:** Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)



*Abuse and Neglect (Social Determinants Risk Factor)*

**Question 6a:** Are you afraid of anyone or is anyone hurting you? (Yes/No)

**Question 6b:** Is anyone using your money without your ok? (Yes/No)

*Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)*

**Question 7:** Have you had any changes in thinking, remembering, or making decisions? (Yes/No)

Tier 2 LTSS Questions:

*Fall Risk (Functional Capacity Risk Factor)*

**Question 8a:** Have you fallen in the last month? (yes/No)

**Question 8b:** Are you afraid of falling? (Yes/No)

*Financial Insecurity or Poverty (Social Determinants Risk Factor)*

**Question 9:** Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)

*Isolation (Social Determinants Risk Factor)*

**Question 10:** Over the past month (30 days), how many days have you felt lonely?  
(Check one)

- None – I never feel lonely
- Less than 5 days
- More than half the days (more than 15)
- Most days – I always feel lonely