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

JENNIFER KENT
Director

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Governor

DATE: July 11, 2017

DUALS PLAN LETTER 17-001
SUPERSEDES DUALS PLAN LETTER 15-005

TO: CAL MEDICONNECT MEDICARE-MEDICAID PLANS

SUBJECT: HEALTH RISK ASSESSMENT AND RISK STRATIFICATION REQUIREMENTS FOR CAL MEDICONNECT

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 Medicare-Medicaid plans (MMPs) that are participating in the Duals Demonstration Project, referred to as Cal MediConnect. This DPL supersedes DPL 15-005.

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. To implement this 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 Coordinated Care Initiative (CCI). Welfare and Institutions Code Section (§) 14182.17(h) authorizes the issuance of this DPL.

The three major components of the CCI are:

1. A three-year Duals Demonstration Project (Cal MediConnect) for dual eligible (individuals eligible for Medicare and Medicaid) beneficiaries (Duals) 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 for SPD beneficiaries 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.

DISCUSSION:
The three-way contract[1] (contract) between the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the MMPs requires MMPs to develop and submit to DHCS and CMS for review and approval, two tools or processes.

The first is a risk stratification mechanism or algorithm (risk stratification) that is applied by the MMP to historic enrollee-specific Medi-Cal and Medicare fee-for-service (FFS) utilization data and other data supplied by DHCS and CMS. The risk stratification is used to stratify all new enrollees into higher and lower risk groupings, thus, allowing the MMP to identify those enrollees who have more complex health care needs.

The second tool or process is the HRA, which is used by MMPs to assess an enrollee's current health status, in order to establish a platform to begin building care management and coordination. The HRA will serve as the starting point for the Individual Care Plan (ICP), which will be developed for each enrollee that demonstrates a need for an ICP and will include enrollee goals and preferences, measurable objectives and timetables to meet medical, behavioral health, and LTSS needs. HRAs must be administered within 45 calendar days of enrollment for those identified as higher risk and 90 calendar days for those identified as lower risk.

The HRA includes minimum assessment components to enable comparability and standardization of elements among all MMPs. In addition, MMPs 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 contract and any other guidance that CMS and/or DHCS may issue.

[1] The three-way contract between CMS, DHCS, and the MMP is available at: http://calduals.org/

REQUIREMENTS:

A. Risk Stratification

No sooner than 60 calendar days prior to new member enrollment, DHCS and/or CMS will electronically transmit historical Medicare and Medi-Cal FFS utilization and other applicable data to the MMP for its use in the risk stratification process. This data may include, but is 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; outpatient; inpatient; emergency department; pharmacy; and ancillary services for the most recent 12 months.

MMPs are required to establish a risk stratification mechanism designed for the purpose of identifying new enrollees who are considered to be higher or lower risk. Higher risk for risk stratification purposes means an enrollee who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive his or her initial contact by the MMP within 45 calendar days of enrollment.

After analyzing the historical data, each MMP must identify an enrollee as higher risk if he or she, 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. Higher risk IHSS beneficiaries can be identified in the IHSS assessment files;
- Is enrolled in MSSP;
- Is receiving Community Based Adult Services;
- Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant;
- Has cancer and is currently being treated;
- Has been prescribed anti-psychotic medication within the past 90 days;
- Has been prescribed 15 or more medications in the past 90 days; or
- Has other conditions as determined by the MMP, based on local resources.

Beginning December 1, 2014, all new enrollees who have no historical data must be stratified as higher risk.

B. Health Risk Assessment

MMPs are required to develop an HRA to assess an enrollee's current health risk within 45 calendar days of enrollment for those enrollees identified through the risk stratification as higher risk, and within 90 calendar days of coverage for those identified as lower risk.

In addition, the HRA must include specific LTSS referral and contributory risk factors questions (see Attachment). These questions are intended to assist MMPs 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 referral and contributory risk factors questions must be used verbatim; however, they may be incorporated into the existing HRA and can replace similar existing HRA questions.

As specified in the Continuity of Care DPL16-002,[2] as part of the HRA, the MMP must ask the enrollee if there are any upcoming health care appointments or treatments scheduled and assist the enrollee at that time in initiating the continuity of care process if the enrollee chooses to do so.

MMPs may reach out to enrollees subject to passive enrollment up to 20 calendar days prior to MMP enrollment as long as CMS and DHCS have approved the MMP's request for this process.

HRA reassessments must be conducted at least annually, within 12 months of completing the last HRA, or as often as the health and/or functional status of the enrollee requires.

If an MMP completes an HRA for an enrollee and the enrollee chooses to enroll in a different MMP, the new MMP may utilize the previously completed HRA. If the new MMP chooses to utilize the previously completed HRA, the previous MMP must release the completed HRA to the new MMP within ten business days of the request. In addition, if an HRA was completed within six months of the enrollee changing MMPs, and there is no documented change in the enrollee's health condition, the new MMP is not required to complete a new HRA until there is a change in the enrollee's condition, or within one year of the previous HRA completion, whichever is sooner.

If an HRA was not completed by the previous MMP, or the enrollee does not consent to the release of the completed HRA, the new MMP must complete an HRA according to the timelines and requirements specified in this DPL.

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[2] DPLs can be accessed at the following link:
http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx

In-Person HRAs

MMPs are required to first 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. MMPs are required to document and report their outreach efforts to enrollees related to HRAs including: telephone attempts, mailing dates of the HRA, 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.

HRA Procedures and Timelines

1. Higher Risk Enrollees

The following process applies to enrollees who are categorized as higher risk and must be completed by the MMP within 45 calendar days of enrollment:

Time Frame (Calendar Days)	**Activity**
Day 1	Enrollment begins.
Day 1 to Day 30	MMP attempts at least five phone calls (two within ten business days of the enrollment date) and first offers the enrollee the option of an in-person HRA, or if the enrollee agrees, the MMP may complete the HRA by telephone at that time. MMP may send a mailing any time after a good faith effort to contact the enrollee during the first ten business days has occurred.
Day 31 to Day 40	If the MMP is unable to complete the HRA by the 30th calendar day, 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 MMP must attempt another phone call.
6 Months After Enrollment	If the MMP is unable to complete the HRA due to a lack of response from the enrollee, the MMP must mail an HRA to the enrollee.

Step One. Complete HRA In-Person

Each enrollee must first be offered the opportunity to complete the HRA in-person. For higher risk enrollees, an in-person HRA, conducted by a trained or licensed MMP care

manager (e.g. registered nurse, licensed social worker), is preferable, with the HRA leading to comprehensive, in-depth assessment and care planning. The MMP must attempt to contact the enrollee by phone, or in a manner consistent with the enrollee's physical or cognitive needs, at least two times within ten business days of enrollment.

All communications, whether by phone or mail, must inform the enrollee of how the MMP will arrange for an in-person HRA and that it must be provided in a linguistically and culturally appropriate manner.

Step Two. Complete HRA by Telephone
The MMP attempts to contact the enrollee by telephone, making at least five calls within 30 calendar days of enrollment. The first two phone calls must be made within ten business days of enrollment.

When the MMP reaches an enrollee, it must first offer the enrollee an in-person HRA. If the enrollee refuses, the MMP may offer the enrollee the opportunity to complete the HRA by phone or mail.

If the MMP completes the HRA, the HRA process is complete.

If the MMP does not complete the HRA by the 30th calendar day of enrollment, the MMP must complete the process as outlined under Step Three below.

Step Three. Complete HRA by Mail
If the MMP is unable to complete the HRA by the 30th calendar day of enrollment, it must mail the HRA to the enrollee by the next business day. The MMP 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 calendar day of enrollment.

The MMP must provide information in the mailing on how the enrollee can contact the MMP and obtain assistance in completing the HRA by mail.

If the MMP completes the HRA, the HRA process is complete.

If the MMP does not complete the HRA by the 40th calendar day of enrollment, the MMP must complete the process as outlined under Step Four below.

Step Four. Complete HRA by Follow-Up Telephone Call
If the MMP does not receive a response from the enrollee by the 40th calendar day of enrollment, it must again attempt to contact the enrollee by telephone prior to the 44th calendar day. The HRA process must be completed by the 45th calendar day.

Step Five. HRA Six Month Follow-Up
If the MMP is unable to complete the HRA due to a lack of response from the enrollee, it must mail an HRA to the enrollee six months after enrollment.

2. Lower Risk Enrollees
The following HRA process applies to enrollees who are categorized as lower risk, and must be completed by the MMP within 90 calendar days of enrollment.

Time Frame (Calendar Days)	**Activity**
Day 1	Enrollment begins.
Day 1 to Day 30	MMP attempts at least two phone calls within 30 calendar days of enrollment to first offer the enrollee the option of an in-person HRA or, if the enrollee agrees, the MMP may complete the HRA by telephone at that time. MMP may send a mailing any time after a good faith effort to contact the enrollee.
Day 31 to Day 60	If the MMP is unable to complete the HRA by the 30th calendar day, it must mail the HRA to the enrollee by the next business day.
Day 61 to Day 85	If the MMP is unable to complete the HRA by the 60th calendar day, 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 MMP must attempt another phone call.
6 Months After Enrollment	If the MMP is unable to complete the HRA due to a lack of response from the enrollee, it must mail an HRA to the enrollee.

Step One. Complete HRA In-Person
Each enrollee must first be offered the opportunity to complete the HRA in-person. The MMP must attempt to contact the enrollee by phone, or in a manner consistent with the enrollee's physical or cognitive needs, at least two times within 30 calendar days of enrollment.

All communications, whether by phone or mail, must inform the enrollee of how the MMP will arrange for an in-person HRA and that it will be provided in a linguistically and culturally appropriate manner.

Step Two. Complete HRA by Telephone
The MMP attempts to contact the enrollee by telephone, making at least two calls within 30 calendar days of enrollment.

When an MMP reaches an enrollee, it must first offer the enrollee an in-person HRA. If the enrollee refuses, the MMP may offer the enrollee the opportunity to complete the HRA by phone or mail.

If the MMP completes the HRA, the HRA process is complete.

If the MMP does not complete the HRA by the 30th calendar day of enrollment, the MMP must complete the process as outlined under Step Three below.

Step Three. Complete HRA by Mail
If the MMP is unable to complete the HRA by the 30th calendar day of enrollment, it must mail the HRA by the next business day.

The MMP 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 calendar day of enrollment. The MMP must provide information in the mailing detailing how the enrollee can contact the MMP and obtain assistance in completing the HRA by mail.

If the MMP completes the HRA, the HRA process is complete.

If the MMP does not complete the HRA within 60 calendar days of enrollment, it must mail a second HRA to the enrollee by the next business day. If the MMP has not completed the HRA by the 85th calendar day of enrollment, the MMP must complete the process as outlined under Step Four below.

Step Four. Complete HRA by Follow-Up Telephone Call
If the MMP does not receive a response from the enrollee by 85th calendar day of enrollment, it must again attempt to contact the enrollee by telephone prior to the 89th calendar day. The HRA process must be completed by the 90th calendar day.

Step Five. HRA Six Month Follow-Up
If the MMP is unable to complete the HRA due to a lack of response from the enrollee, it must mail an HRA to the enrollee six months following enrollment.

3. Cal MediConnect Opt-Out Population
For those enrollees who opt-out of Cal MediConnect and are mandatorily enrolled in a Medi-Cal managed care health plan (MCP) for their Medi-Cal only benefits, the

requirements set forth in All Plan Letter (APL) 17-012 apply.[3] The MCP must develop an ICP for higher risk enrollees based on the results of the risk stratification with a particular focus on MCP covered services. The MCP is required to conduct an annual comprehensive reassessment for the ICP within 12 months of the last assessment, or as often as the health of the enrollee requires. Reassessments may be conducted in-person or in the setting of the enrollee's choosing.

4. Transitioning Dual Eligible Special Needs Plan (D-SNP) Population

MMPs are required to complete the Cal MediConnect HRA for transitioning D-SNP beneficiaries and may use information obtained from a D-SNP HRA that was completed during the prior 12 months to complete the Cal MediConnect HRA. Where there are exactly the same or similar questions between the D-SNP and Cal MediConnect HRAs, the MMP is not required to ask these same questions. MMPs are still required to support the beneficiary's transition into the MMP, which may include coordination of continuity of care and changes in formularies or plan benefit packages. It is expected that MMPs will still contact transitioning D-SNP beneficiaries within the time-frames specified in the three-way contract, but that the HRA portion may be significantly shortened due to the information that will be already available by the D-SNP to the MMP.

5. Members Enrolled in Hospice

MMPs are not required to complete an HRA process for enrollees in hospice; however, MMPs must ensure coordination of care between MMP and hospice care providers and allow for the hospice interdisciplinary team to professionally manage the care of the patient as outlined in Title 22, California Code of Regulations, § 51349 and Social Security Act, §1861 (dd) (42 United States Code 1395x).

C. MMP Reporting Requirements under Cal MediConnect

No later than 45 calendar days following the first quarter of enrollment**,** and quarterly thereafter, in a manner specified by DHCS and CMS, MMPs must report to DHCS:

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;

2. The number of newly enrolled Duals 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;

[3] All Plan Letters are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

3. The number of newly enrolled Duals during the previous quarter in each risk category who were successfully contacted (in-person, phone, or mail) and by what method;

4. The number of enrollees contacted during the previous quarter that completed the HRA six months after enrollment, as described in this DPL;

5. The number of newly enrolled Duals during the previous quarter who were successfully contacted and who completed the HRA (both partially and in total) including how (e.g. in-person, phone, or mail) and the number who declined the HRA;

6. The number of newly enrolled Duals during the previous quarter who completed the HRA and who were then determined to be in a different risk category (higher or lower) than was established for those enrollees by the MMP during risk stratification;

7. Any other data related to HRAs, as specified by DHCS and CMS in the MMP reporting templates.

Lastly, MMPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including APLs and DPLs. DHCS's readiness review process includes a review of each MMP's delegation oversight. MMPs must receive prior approval from DHCS for each delegate.

If you have any questions regarding this DPL, 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 Medicare-Medicaid Plans (MMPs) 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 MMPs 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.

<u>Tier 1 LTSS Questions:</u>

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