blue california
Promise Health Plan

POLICY & PROCEDURE
Medical Services

Policy Title: Risk Stratification and Health Risk Assessment – Medicare-Medicaid Plans (MMP)		
Policy No: 90.2.53	**Original Date: 03/13**	
Effective Date: 12/18	**Revision Date: 10/13, 10/17, 12/18**	**Revision No: 3**
Department Head: Date:	**Medical Services/P&T Committee: Date:**	
P&P Committee: Date:	**Department(s): UM**	

PURPOSE:

To establish Blue Shield Promise's process for performing risk stratification and health risk assessments for MMP enrollees.

POLICY:

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 Coordinated Care Initiative (CCI). Welfare and Institutions Code Section 14182.17(h) authorizes the issuance of DPL 17-001.

The three major components of 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.

Blue Shield Promise will perform the initial risk stratification and HRA survey for both Los Angeles and San Diego Counties.

1. Blue Shield Promise will utilize a CMS- and DHCS- approved mechanism or algorithm for risk stratification of enrollees that includes the review of historical Medi-Cal fee-for-

service utilization data and Medicare data to prioritize assessment to higher risk and lower risk groups and initiate care planning.

2. Blue Shield Promise will offer each enrollee the opportunity to complete the HRA in-person at an aged upon location.
3. All communications, whether by phone or mail, will inform enrollees how Blue Shield Promise will arrange for an in-person HRA.
4. For mailings, Blue Shield Promise will provide the enrollee with information as to how the enrollee can contact Blue Shield Promise and obtain assistance when completing the HRA by mail.
5. All communications will be provided in a linguistically and culturally appropriate manner.
6. Blue Shield Promise will attempt to contact the enrollee by phone, or in a manner that is consistent with the physical or cognitive needs of the enrollee.
7. In the event that the enrollee is not capable of responding to the HRA questions or requests that an authorized representative respond on their behalf or participate in the survey process, Blue Shield Promise will honor the enrollee's request. Examples of when it is appropriate to utilize a proxy respondent may include but are not limited to, enrollees with severe dementia or severe cognitive and/or behavioral disorders. Blue Shield Promise will obtain the enrollee's consent. If the enrollee is not able to consent, Blue Shield Promise will refer to authorized representative to respond on behalf of the enrollee in accordance with Blue Shield Promise's AOR P&P. Proxy respondents may include the enrollee's caregiver(s) if they are the authorized representative or if they are identified as the authorized observer by the enrollee's authorized representative.
8. Blue Shield Promise will attempt to contact the enrollee in accordance number of attempts and timeframes specified by MMCP DPL 17-001 and based on their risk category. Refer to "PROCEDURE" section.
9. For higher risk enrollees, an in-person HRA, conducted by trained licensed care managers (e.g. registered nurse, licensed social workers), is preferable, with the HRA leading to comprehensive, in-depth assessment and care planning.
10. Blue Shield Promise's assessment process will have the below required elements:
    a. Review of all Medicare and Medi-Cal utilization data (including Medicare Parts A, B, and D, and Medi-Cal IHSS, Multipurpose Senior Service Program (MSSP), skilled nursing facility (SNF), and behavioral health pharmacy data);
    b. Review of results of previously-administered assessments, and other medical, IHSS, nursing facility, and behavioral health assessments;
    c. Identification of referrals to LTSS and appropriate home- and community-based services, such as mental health and behavioral health, IHSS, Community-based adult services (CBAS), MSSP, personal care services, and nutrition programs;
    d. Preference of the enrollee in determining if assessment is completed in person or by telephone;
    e. Identification of caregivers and authorized representatives who may be involved in the individualized care Plan with the enrollee's approval;

f. Identification of the enrollee's current need for supports or services that should be addressed in the immediate future;
g. Identification of the need for referrals to resolve any physical or cognitive barriers to access; access means that the enrollee is not impeded physically, or by lack of provider availability, to contact and receive the full spectrum of Medically Necessary Covered Services.
h. Identification of the need for facilitating communication among the enrollee's health care providers, including mental health and substance abuse providers, when appropriate;
i. Identification of the need to provide other activities or services to assist enrollees in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health or function status; and
j. Identification of the need for more complex care coordination, such as discharge planning.

11. The Health Risk Assessment (HRA) will be the starting point for the development of the individual care plan. This assessment will service as the basis for further assessment needs that may include, but are not limited to, mental health, substance use, chronic physical conditions, incapacity in key activities of daily living, dementia, cognitive status, and the capacity to make informed decisions.
12. Blue Shield Promise will utilize all information received through the health risk assessment process to make referrals to LTSS agencies for those enrollee's identified in the initial assessment as needing LTSS
13. Blue Shield Promise will communicate results of the health risk assessment to the enrollee's primary care provider (PCP)
14. The provision of medically necessary services is not contingent on the completion of the HRA
15. Blue Shield Promise will provide care coordination and discharge planning for enrollees who are admitted to a hospital or institutional care facility (see P&P 90.2.8 Post Acute Discharge and Transitional Care Planning).
16. In the event that a beneficiary disenrolls from Blue Shield Promise and enrolls with another plan, Blue Shield Promise will provide the receiving plan with the HRA results after receiving proof of the beneficiary's approval to share this information. Likewise, if Blue Shield Promise receives a new enrollee, Blue Shield Promise will obtain the enrollee's approval to obtain their HRA results from the former plan. All procedures associated with the sharing of HRA results shall comply with HIPAA rules and the MMCP DPL 17-001. (Plans are awaiting clarification from DHCS regarding the requirement that a new HRA must be conducted for all enrollees).

PROCEDURE:

Blue Shield Promise will review historical Medi-Cal and Medicare data upon enrollment to prioritize assessment and care planning

I. Risk Stratification Process:

The risk stratification process is designed for the purpose of identifying and classifying newly enrolled members to either a high risk or at low risk category. The high risk category delineates members that may have complex medical conditions and/or have a high probability for potential hospitalization. The Blue Shield Promise Risk stratification Tool is comprised of the following criteria to qualify a member to the high risk stratification level. The criteria is as follows:

- Has been on oxygen within the last 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.
- Is enrolled in MSSP.
- Is receiving Community Based Adult Services (CBAS).
- Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant.
- Has cancer, currently being treated.
- Has been prescribed anti-psychotic medication within the past 90 days.
- Has been prescribed 15 or more prescriptions in the past 90 days.
- Has other conditions as determined by the PLAN, based on local resources.

To facilitate identification of individuals enrollee needs, the assessment process will incorporate review of:

1. All Medicare and Medi-Cal utilization data (including Medicare Parts A, B, and D, and Medi-Cal FFS, Medi-Cal In-Home Supportive Services (IHSS), Multipurpose Senior Service Program (MSSP), Skilled Nursing Facility (SNF), behavioral health pharmacy, and outpatient, inpatient, emergency department, pharmacy, and ancillary services data),
2. Results of previously administered assessments, and
3. Other medical, IHSS, nursing facility, and behavioral health assessments DHCS and/or CMS will electronically transmit historical Medicare and Medi-Cal FFS utilization and other data to Blue Shield Promise no sooner than 60 days prior to new enrollee coverage. Once the data file from DHCS and/or CMS is received, the data is run through the Risk Stratification tool. This process will stratify the members into two categories and separate files created. One will be labeled High Risk the other will be Low Risk.

The risk stratification process will be tested by running the risk stratification tool against existing dual eligible member utilization data. The data will include pharmacy, claims and encounter data for a 12 month period. The existing membership will be stratified into a High Risk and Low Risk group for testing purposes only.

II. Health Risk Assessment and Identification of Needs:

The Health Risk Assessment (HRA) is a survey used to comprehensively assess a member's current health status. The member will be contacted to complete the HRA within 45 calendar days of enrollment in the "higher-risk" stratification and within 90 calendar days of enrollment in the "lower-risk" stratification. "Higher-risk" refers to enrollees who are at increased risk of having an adverse health outcome or worsening of their health and functional stats if they do not receive their initial contact within 45 calendar days of coverage date.

The HRA has been developed with input from both stakeholders and consumers. For this purpose, input has been obtained from the Medical Services Committee and the Public Policy Committee.

The HRA incorporates questions to elicit specific information to address the current needs of the member. The assessment will incorporate standard assessment questions, such as VR-12 as specified by the State. Below is a sample of specific information which is elicited from the HRA questions. This includes but not limited to the following: (See attached HRA)

- Identify medical care needs, including primary care, specialty care acute, long-term services and supports (LTSS), behavioral health, chronic disease management, cognitive and depression screening, and alcohol and/or substance use treatment and counseling needs.
- Identify need for durable medical equipment, fall risk prevention, medications, and caregiver support and respite. Identify needs for community resources and other agencies for services outside the scope of responsibility of the Plan, including but not limited to:
    - Mental health, services and substance use disorder services
    - Personal care, housing, home-delivered meals
    - Energy assistance programs
    - Services for individuals with intellectual and developmental disabilities
- Identify needs for facilitating timely access to all the resources above, including the need for referrals to resolve any physical and/or cognitive barriers to access.
- Identify the need for facilitating communication among the enrollee's health care providers, including:
    - Primary care and specialty providers
    - LTSS providers (CBAS, IHSS, MSSP, NF)
    - Mental health and substance use disorder providers when appropriate
- Identify the need for providing other activities or services needed to assist enrollees in optimizing their health status, including:
    - Assisting with self-management skills or techniques

  - Health education
  - Home modification
  - Home care services and support above and beyond IHSS
  - Back up emergency caregiver when a personal care services provider, such as IHSS, is absent
  - Other modalities to improve health status
- Identify the need for coordination of care across all settings including post transition care coordination and follow up planning to ensure care coordination is effective and appropriate outside the provider network.

All outreach efforts will be documented including: telephone attempts, mailing dates of the HRA survey, enrollee refusals to participate in the HRA process, requests for in-person HRA's, 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 will be conducted by:

- Personnel trained in the use of the assessment instrument.
- Professional knowledgeable, licensed and/or certified personnel to review, analyze, identify and stratify health care needs for higher risk enrollees, such as physicians, physician assistants, nurse practitioners, registered nurses, licensed social workers, or behavioral health specialists.
- Personnel must also be trained for cultural and linguistic competency, needs of individuals with functional impairment, and LTSS needs.

A. Health Risk Assessment Step-by-Step Process

The following process applies to enrollees who are categorized as higher risk and must be completed within 45 days of the enrollee coverage date.

<u>High-Risk Time Frame Activity</u>

For higher risk enrollees, an in-person HRA, conducted by trained or licensed care managers (e.g. registered nurse, licensed social workers), is preferable, with the HRA leading to comprehensive, in-depth assessment and care planning.

Day 1
Enrollee beings coverage in the Plan

Day 1 to Day 30
Blue Shield Promise and/or its contracted vendor attempts at least five phone calls (two within ten business days of the enrollee's coverage date) and first offers the enrollee the option of an in-

person HRA. If the enrollee agrees to an in-person HRA, Blue Shield Promise will schedule the future meeting date and time to take place at an agreed upon location prior to day 20.

If the enrollee refuses the in-person HRA option, the Blue Shield Promise and/or its contracted vendor will offer the opportunity to complete the HRA by phone or mail. If the enrollee requests a telephonic HRA, Blue Shield Promise and/or its contracted vendor will complete the HRA by telephone at the time of the call or at a time agreed upon with the enrollee.

Blue Shield Promise and/or its contracted vendor may send a mailing any time after a good faith effort (good faith effort is defined as: two phone calls attempted during the first ten days of the enrollee's coverage date) but no later than the next business day after the 30th day following the enrollee's coverage date.

Day 31 to Day 40:
If the Blue Shield Promise and/or its contracted vendor are unable to complete the HRA by day 30, it must mail the HRA to the enrollee by the next business day.

Day 41 to Day 45:
If the enrollee has not completed a HRA by day 40 after the enrollee's coverage date, Blue Shield Promise and/or its contracted vendor will again attempt to contract the enrollee by telephone prior to the 44th day.

6 months after enrollment:
If Blue Shield Promise and/or its contracted vendor are unable to complete the HRA due to a lack of response from the enrollee, it must mail an HRA survey to the enrollee six months following the enrollee's coverage date.

Lower Risk Time Frame Activity:
The following process applies to enrollees who are categorized as lower risk, and must be completed by the Plan within 90 days after the enrollee's coverage date.

Day 1:
Enrollee is enrolled into the plan.

Day 1 to Day 30:
Blue Shield Promise and/or its contracted vendor attempts at least two phone calls within 30 days of the enrollee's coverage date to first offer the enrollee the option of an in-person HRA. If the enrollee agrees to an in-person HRA, Blue Shield Promise and/or its contracted vendor will schedule the future meeting date and time to take place at an agreed upon location prior to day 30.

If the enrollee refuses the in-person HRA option, then Blue Shield Promise and/or its contracted vendor will offer the opportunity to complete the HRA by phone or mail. If the enrollee requests

a telephonic HRA, Blue Shield Promise and/or its contracted vendor will complete the HRA by telephone at the time of the call or at a time agreed upon the enrollee.

Blue Shield Promise and/or its contracted vendor may send a mailing any time after a good faith effort (good faith effort is defined as: two phone calls attempted during the first thirty days of the enrollee's coverage date) but no later than the next business day after the 30th day following the enrollee's coverage date.

Day 31 to Day 60:
If Blue Shield Promise and/or its contracted vendor are unable to complete the HRA by day 30, it must mail the HRA to the enrollee by the next business day.

Day 61 to Day 85:
If Blue Shield Promise and/or its contracted vendor are unable to complete the HRA by day 85, 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, Blue Shield Promise and/or its contracted vendor must attempt another phone call prior to the 89th day.

6 months after enrollment:
6 months after enrollment if Blue Shield Promise and/or its contracted vendor are unable to complete the HRA due to a lack of response from the enrollee, it must mail an HRA survey to the enrollee.

B. Health Risk Assessment Tier-Categories
The HRA has the capability to stratify the member into tier levels to designate the acuity and level of intervention needed. The HRA questions are individually weighted based on the answers to determine a numerical score. The total HRA question scoring calculation defines the Tier Level. The tiers are on a numerical scale of 1 – 3. A Tier 1 and 2 would require basic case management and Tier 3 would require complex case management.

III. Communication

All communications shall be provided in a linguistically and culturally appropriate manner. Assessment materials will be available upon request in the enrollee's preferred written or spoken language and/or alternative formats that effective communicate the information.

Upon completion of the HRA process the HRA Summary, and Individualized Care Plan generated for the High Risk Members, assessment results will be shared with the enrollees, caregivers and/or authorized representative with enrollee consent, the ICT, the primary care physician, as appropriate, the MSSP care manager, county IHSS and behavorial health partners, or any other LTSS providers within ten days of completion of the HRA. These processes for

sharing assessment results will be developed jointly with the appropriate county agency or provider.

IV. Reassessments:

Reassessments will be conducted at least annually, within 12 months of last assessment, or as often as the health of the enrollee requires.

In order to determine the need for reassessments, Blue Shield Promise will regularly use encounter and claims data (including IHSS, other LTSS and behavioral health data) to identify enrollees at high-risk, using newly diagnosed acute and chronic conditions, or high frequency emergency department or hospital use, or IHSS or behavioral health referral.

For enrollees with serious mental illness or chronic substance use disorder, upon request and when feasible, reassessments may be conducted in conjunction with behavioral health specialists.

Blue Shield Promise shall consider the reason why the assessment needs to be updated, the enrollee's needs and heath or functional status, and the preference of the enrollee when determining the mode by which updates will be completed.

REPORTING:
No later than 45 days after the end of the first quarter of coverage, and quarterly thereafter and in a manner specified by DHCS and CMS, Blue Shield Promise shall report:

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 mechanism or algorithm.
    a. The number of newly enrolled members 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 mechanism or algorithm.
2. The number of newly elected members during the previous quarter in each risk category who were successfully contacted (in-person, phone, or by mail) and by what method.
3. The number of newly enrolled members during the previous quarter who were successfully contacted and who completed the risk assessment survey (both partially and in total) including how (e.g. in-person, phone or by mail) and the number who declined the risk assessment survey.
4. The number of newly enrolled 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 enrollees by the Plan during the risk stratification process.
5. Any other date related to HRAs, as specified by DHCS and CMS in plan reporting templates.

REFERENCES/AUTHORITIES:

CMS-CA MOU for Medicare-Medicaid Enrollees
Welfare & Institutions Code Section 14182.17(d)(2)
Duals Plan Letter 17-001