Policy:	MA.6022
Title:	**Initial and Annual Health Risk Assessment**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 07/11/2024*
Effective Date:	08/01/2005
Revised Date:	07/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process for ensuring that all OneCare Members receive an initial and annual Health Risk Assessment (HRA) in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima Health shall conduct an initial HRA of a Member's health care needs within ninety (90) calendar days of enrollment.

B. CalOptima Health's OneCare HRA tool is aligned with CalOptima Health's Medi-Cal HRA tool to meet both Medicare and Medi-Cal requirements and to minimize the burden on Members.

C. If the Medi-Cal and Medicare guidance for HRAs conflict, Medicare guidance will be followed.

D. CalOptima Health shall conduct reassessment of a Member's health care needs as follows:

1. Annually for all active Members based on their enrollment anniversary date without a break in service or three hundred sixty-five (365) days from last completed HRA; and

2. When significant changes to a Member's health status occur.

E. CalOptima Health shall mail a new Member packet that contains an initial HRA and instructions for completion of the HRA to a newly enrolled Member in accordance with CalOptima Health Policy MA.4008: Member Handbook Requirements.

F. CalOptima Health shall mail annual HRAs, with instructions for completion, sixty (60) calendar days prior to the anniversary of the last completed HRA or the enrollment anniversary date of the Member if no prior HRA has been completed.

G. The HRA tool shall identify the following elements and directly inform the development of the Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT):

1. Medi-Cal services the Member currently accesses;

2. Any Long-Term Services and Supports (LTSS) needs the Member may have or potentially need; and

3. Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease.

4. Screening of housing stability, food security, and access to transportation in accordance with Title 42 Code of Federal Regulations (CFR) Section 422.101(f)(1)(i).

5. If a Member identifies a caregiver, assessment of caregiver support needs should be included as part of the assessment process.

H. CalOptima Health shall use a risk stratification algorithm to identify the health risk of each Member based on review of:

1. Available utilization data, including Medicaid long-term care utilization data;

2. Relevant and available data from external systems such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and home-and community-based waiver programs, behavioral health (both mental health and substance use disorder data, if available), and pharmacy data;

3. Previously administered Cal MediConnect or Medi-Cal HRA; and

4. Department of Health Care Services (DHCS) Population Health Management Platform.

I. CalOptima Health shall enter and track all HRA information in an electronic database for risk assignment.

J. The HRA shall be used to develop an ICP to meet the Member's medical, functional, psychosocial, social support, and access to care needs.

K. CalOptima Health and a Health Network shall provide services and information appropriate to a Member's risk category as determined by the HRA in accordance with this Policy.

III. PROCEDURE

A. Health Risk Assessment (HRA) Initial Outreach:

1. HRA Mailing: Upon enrollment, CalOptima Health shall provide a Member with an initial HRA and an informational letter including instructions for HRA completion and the process for requesting the HRA in an alternate format. The informational letter will notify the Member that a Personal Care Coordinator (PCC) will be contacting them to assist them in completing the HRA telephonically;

2. HRA Telephonic Outreach: A minimum of three (3) telephonic outreaches will be conducted by the PCC within ninety (90) days of enrollment;

3. The PCC shall attempt to reach the Member through telephone numbers listed in CalOptima Health's medical management system. If those numbers are inoperable, the PCC shall check other electronic systems, Health Network, PCP records, and/or dispensing pharmacy records for alternative telephone numbers;

4. Outreach attempts to offer completion of the HRA telephonically shall be made in a manner consistent with the physical or cognitive needs of the Member;

5. If the Member refuses a telephonic HRA, the PCC will confirm if the Member intends to complete the HRA by mail and offer to mail another copy of the HRA to the Member within this period;

6. If an HRA is not collected, a reminder is mailed to encourage the member to complete their HRA;

7. A Member's refusal to complete the HRA telephonically shall be recorded in CalOptima Health's medical management system, and outreach efforts will cease for this HRA outreach period; and

8. If the Member completes the HRA, the HRA process is complete.

B. Health Risk Assessment (HRA) Annual Outreach

1. HRA Mailing: CalOptima Health Annual HRAs will be mailed to the Member sixty (60) calendar days prior to the anniversary of the last completed HRA or the enrollment anniversary date, if no HRA has been previously completed. The annual HRA will be accompanied by an informational letter including instructions for HRA completion and the process for requesting the HRA in an alternate format. The informational letter will notify the Member that a PCC will be contacting them to assist them in completing the HRA by telephone;

2. HRA Telephonic Outreach: Telephonic outreach by the PCC begins and completes after HRA mailing as follows: A minimum of three (3) telephonic outreaches will be completed prior to the enrollment anniversary date (if no prior HRA) or date of last completed HRA, if one was collected;

3. The PCC shall attempt to reach the Member through telephone numbers listed in CalOptima Health's medical management system. If those numbers are inoperable, the PCC shall check other electronic systems, Health Network, PCP records, and/or dispensing pharmacy records for alternative telephone numbers;

4. Outreach attempts to offer completion of the HRA telephonically shall be made in a manner consistent with the physical or cognitive needs of the Member;

5. If the Member refuses a telephonic HRA, the PCC will confirm if the Member intends to complete the HRA by mail and offer to mail another copy of the HRA to the Member within this period;

6. If an HRA is not collected, a reminder is mailed to encourage the member to complete their HRA;

7. A Member's refusal to complete the HRA telephonically shall be recorded in CalOptima Health's medical management system, and outreach efforts will cease for this HRA outreach period; and

8. If the Member completes the HRA, the HRA process is complete.

C. A Care Plan will be developed for both initial and annual HRAs for those Members who choose not to complete the HRA using all available data such as, but not limited to, utilization, claims, encounters, and pharmacy.

D. A supplemental assessment shall be completed by the Health Network PCC or Health Network case manager when changes to the Member's health status are reported by:

1. Member, family, or Authorized Representative;

2. Provider; or

3. Case Manager.

E. Changes requiring reassessment include, but are not limited to, the following:

1. Hospital or skilled nursing facility (SNF) admission;

2. Emergency Department (ED) visit;

3. New behavioral health referral;

4. Alteration in mental or functional status;

5. Change in care setting;

6. Significant Change in medication;

7. Change in Long Term Services and Supports (LTSS) level;

8. Multiple falls;

9. Authorization request for an out-of-area Provider; and

10. Unsafe home environment.

F. Based on the Member's health status, an assessment may be mailed with instructions for completion or completed interactively via telephone by the Health Network PCC or Health Network Case Manager.

G. Analysis and Evaluation

1. Upon receipt of a Member's completed HRA, the PCC shall enter all information in the HRA into CalOptima Health's medical management system.

   a. Proprietary software shall electronically process the Member's information and shall assign the Member into a low, moderate, or high-risk category based on a risk algorithm.

2. Registered Nurse (RN) will review with the recommended Care Management Level (CML) and will be generated by CalOptima Health's medical management system based on the Members' responses to the HRA questions.

   a. CalOptima Health shall identify members for Care Management and Coordination based on HRA answers using a proprietary risk algorithm. After review by the OneCare case

manager, a Care Management Level (CML) is recommended for each Member. CMLs include:

i. Basic Monitoring;

ii. Basic Case Management;

iii. Care Coordination;

iv. Complex Case Management; and

v. Intensive, which includes Enhanced Care Management (ECM)-like services.

3. The CalOptima Health Case Manager shall post HRA files on CalOptima Health's secure File Transfer Protocol (FTP) site. HRA files shall include responses for each HRA question and each Member's overall risk score.

4. Using a standardized protocol, CalOptima Health Community Network (CHCN) or the Health Network PCC will review and distribute each HRA bundle to appropriate professional(s) for review.

   a. The CHCN or Health Network PCC shall make the results of the HRA available to the Member's Primary Care Physician (PCP).

   b. The CHCN or Health Network RN case manager shall review and triage the information received and conduct further assessments to verify risk score.

   c. If the CHCN or Health Network PCC or RN Case Manager validates that a Member is in a high-risk category, CHCN or the Health Network shall:

      i. For New Members:

         a) Facilitate scheduling of an appointment for the Member to be seen by the Member's PCP within thirty (30) calendar days;

      ii. For All Members

         a) Conduct further assessments, as appropriate, which may include a home assessment;

         b) The CHCN or Health Network PCC and RN Case Manager shall coordinate with the ICT to support the completion of the ICP, as needed;

            1) The composition of the ICT shall be individualized to meet the Member's needs.

         c) Develop an ICP in accordance with CalOptima Health Policy MA.6009: Care Management and Coordination Process;

         d) Perform supplemental assessments for health status changes.

   d. CalOptima Health shall conduct an on-site performance review for HRA activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

A. OneCare Initial and Annual Health Risk Assessment Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health 2023 MOC, July 8, 2022
C. CalOptima Health Policy MA.4008: Member Handbook Requirements
D. CalOptima Health Policy MA.6009: Care Management and Coordination Process
E. CalOptima Health Policy MA.6032: Model of Care
F. CalOptima Health Policy GG.1619: Delegation Oversight
G. Title 42, Code of Federal Regulations (CFR.), §§ 422.101(f)(1)(i) and 422.112(b)(4)(i)
H. Department of Health Care Services CalAIM Dual Eligible Special Needs Plans Policy Guide, Contract Year 2024, December 2023

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/02/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.6022	Comprehensive Health Assessment	OneCare
Revised	01/01/2006	MA.6022	Comprehensive Health Assessment	OneCare
Revised	03/01/2007	MA.6022	Comprehensive Health Assessment	OneCare
Revised	09/01/2008	MA.6022	Comprehensive Health Assessment	OneCare
Revised	10/01/2013	MA.6022	Initial and Annual Health Risk Assessment	OneCare
Revised	04/01/2016	MA.6022	Initial and Annual Health Risk Assessment	OneCare
Revised	07/01/2017	MA.6022	Initial and Annual Health Risk Assessment	OneCare
Revised	10/01/2017	MA.6022	Initial and Annual Health Risk Assessment	OneCare
Revised	08/01/2018	MA.6022	Initial and Annual Health Risk Assessment	OneCare
Revised	05/01/2019	MA.6022	Initial and Annual Health Risk Assessment	OneCare
Revised	02/01/2020	MA.6022	Initial and Annual Health Risk Assessment	OneCare
Revised	12/31/2022	MA.6022	Initial and Annual Health Risk Assessment	OneCare
Revised	07/01/2024	MA.6022	Initial and Annual Health Risk Assessment	OneCare

IX. GLOSSARY

Term	Definition
Basic Case Management (Care Management Level)	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a Member's health and functional needs. Services are provided by the Primary Care Physician (PC) or by a PCP-supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of services outside the health plan, such as community social services or specialty mental health or Drug Medi-Cal services, are considered basic case management services.
Care Coordination (Care Management Level)	Case management provided to Members who are at moderate risk, but still have an acute or chronic medical condition that requires assessment and coordination of resources in order to maintain the Members in the least restrictive setting; it is provided by the Member's Health Network, in collaboration with their PCP.
Complex Case Management (Care Management Level)	Case Management provided to Members who are at high-risk; defined as having medically complex conditions that include the following but is not limited to: 1. Spinal injuries; 2. Transplants; 3. Cancer; 4. Serious Trauma; 5. AIDS; 6. Multiple chronic illness; or 7. Chronic illnesses that result in high utilization.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Health Network	A Physician Hospital consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Risk Assessment (HRA)	A tool designed to identify potential critical health factors and that is completed by a Member during the initial enrollment period and annually. The weighted score of the answers stratifies care management level based on the overall score.
Individual Care Plan (ICP)	A written plan of care developed after an assessment of a Member's social and health care needs that reflects what services the Member will receive to reach and keep his or her best physical, mental, and social well-being.
Interdisciplinary Care Team (ICT)	A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Legal Representative/ Authorized Representative	An individual who is the Legal Representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity. (Form CMS-1696 may not be used to appoint an Authorized Representative for the purposes of enrollment and

Term	Definition
	disenrollment. This form is solely for use in Claims Adjudication or Claims Appeals process and does not provide broad legal authority to make another individual's healthcare decisions.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Personal Care Coordinator (PCC)	A para-professional whose function is to promote coordination of care by bridging the gap between OneCare and the Physician Medical Group (PMG). The role of the PCC is to facilitate communication between the Member, OneCare, the PMG, the Primary Care Provider (PCP) and the Interdisciplinary Care Team (ICT). The PCC assists the Member to navigate the healthcare delivery system and facilitates access to care and services.