Policy:	GG.1323
Title:	**Seniors and Persons with Disabilities and Health Risk Assessment**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s /Michael Hunn 08/23/2023*
Effective Date:	11/01/2012
Revised Date:	04/01/2023
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process for identifying the relative health risk of each Medi-Cal Seniors and Persons with Disabilities (SPD) Member and using an SPD Member's health risk status and Health Risk Assessment (HRA) in the development of an Individual Care Plan (ICP) through the case management process.

II. POLICY

A. CalOptima Health shall identify the health risk of each newly enrolled SPD using a proprietary Risk Stratification algorithm as outlined in the Population Health Management Policy Guide.

B. CalOptima Health shall use an internally developed, proprietary Risk Stratification algorithm to identify newly enrolled SPD Members who have higher-risk and more complex health needs.

C. The Risk Stratification algorithm shall incorporate Member-specific utilization data, to identify Members with higher risk and more complex healthcare needs.

D. Based on the results of the Risk Stratification algorithm, Members shall be assessed using an HRA survey that includes the standardized LTSS questions from Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide as follows:

1. Higher-risk Members within sixty (60) calendar days of enrollment.

    a. Medi-Cal Members with LTSS needs will have assessment begin within thirty (30) days.

E. Members shall be referred to the appropriate level of Case Management based on the results of the HRA.

F. CalOptima Health or a Health Network shall use the HRA to develop a care plan, individualized to meet Member's medical, functional, psychosocial, social support and access to care needs.

III. PROCEDURE

A. Risk Stratification Algorithm

1. The Risk Stratification algorithm shall incorporate Member-specific data that signifies each Member's clinical history and specific utilization data to assess the health risk of a Member. The Member-specific data criteria are listed below:

    a. Have been on oxygen within the past ninety (90) calendar days;

    b. Are residing in an acute hospital;

    c. Have been hospitalized within the last ninety (90) calendar days, or three (3) or more times within the last twelve (12) months;

    d. Have had three (3) or more emergency room visits in the last twelve (12) months,

    e. Have a behavioral health diagnosis or developmental disability, in addition to one (1) or more chronic medical diagnosis or a social circumstance of concern within the last twelve (12) months;

    f. Have End Stage Renal Disease (ESRD), Acquired Immunodeficiency Syndrome (AIDS), or a recent organ transplant last twelve (12) months;

    g. Have a diagnosis of cancer and are currently being treated;

    h. Are pregnant;

    i. Have been prescribed anti-psychotic medication within the past ninety (90) calendar days;

    j. Have filled fifteen (15) or more prescriptions within the past ninety (90) calendar days;

    k. Have a self-report of a deteriorating condition;

    l. Is authorized to receive In Home Supportive Services (IHSS) for greater than or equal to one-hundred-ninety-five (195) hours per month;

    m. Participates in the Community-Based Adult Services (CBAS) program; and/or

    n. Participates in the Multipurpose Senior Services Program (MSSP); and

2. On a monthly basis, CalOptima Health shall run the Risk Stratification algorithm to determine high risk Members.

3. CalOptima Health shall utilize historical Medi-Cal Fee-For-Service (FFS) utilization data in its Risk Stratification if provided by the DHCS.

B. Health Risk Assessment Outreach

1. CalOptima Health shall make three (3) attempts to reach by phone:

    a. Call attempts will be completed within sixty (60) calendar days of enrollment.

b. Members who do not respond or are unreachable will receive an Unable to Contact (UTC) letter.

C. Health Risk Assessment Analysis and Evaluation

1. Upon receipt of a Member's completed HRA, CalOptima Health shall enter all information in the HRA into an electronic database.

2. Information from the HRA shall be used to develop a Member's ICP.

D. Case Management Process

1. Based on risk algorithm level and HRA, Members shall be referred to either:

a. Basic case management, provided by the Primary Care Provider (PCP), in collaboration with CalOptima Health or a Health Network; or

b. Care Coordination and Complex case management, provided by CalOptima Health or a Health Network in collaboration with the PCP.

2. CalOptima Health or a Health Network shall ensure that higher risk Members receive Complex Case Management, in accordance with CalOptima Health Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management.

3. Complex Case Management involves a comprehensive assessment of a Member's condition, determination of available benefits and resources, and development and implementation of a Case Management plan with performance goals, monitoring, and follow-up.

4. CalOptima Health or a Health Network shall ensure that Complex Case Management processes include, but are not limited to:

a. Identification of Members who require coordination of care or service coordination for medical services, such as, access to primary and specialty care, Durable Medical Equipment (DME), supplies and medications:

i. Facilitate and ensure timely access to services; and

ii. Coordinate services provided in and out of plan.

b. Identification of Members who require referrals to home and community-based services, community resources, and available services and benefits, including but not limited to:

i. Mental health and behavioral health services;

ii. Personal care;

iii. Housing;

iv. Home-delivered meals;

v. Energy assistance programs; and

vi. Services for Members with intellectual and developmental disabilities.

c. Evaluation of the Member's need for and appropriate involvement of a caregiver or family in, and decision making about, the Member's treatment plan;

d. Evaluation of the Member's mental health status, and psychosocial and cognitive functioning, to facilitate access to primary care, specialty care, and other health services to meet the physical and cognitive need of the Member including;

i. Need for referrals to resolve any physical barriers to access; and

ii. Need for referrals to resolve any cognitive barriers to access.

e. Interdisciplinary Care Team (ICT) structure for facilitating the collaborative process of communication and development of the Member's care plan among the Member's medical, behavioral health (mental health and substance abuse) and ancillary Providers;

f. Identification and facilitation of referrals for Members who require referrals to disease management program, health education, counseling or self-management support;

g. Identification and facilitation of referrals for Members who may qualify for and benefit from LTSS services;

h. Coordination of Member's care across the continuum of health, from outpatient or ambulatory to inpatient settings;

i. Ensure a comprehensive reassessment of a Member's health status under the following circumstances:

i. With changes to Member's health status;

ii. Identification of barriers; and

iii. At least annually.

j. Ensure the development of the Member's ICP, in conjunction with the Provider, Member and/or their caregiver;

k. The ICP shall include prioritized goals, personalized to meet a Member's specific needs that consider the Member and caregiver Member's preferences, and desired level of involvement in the case management plan.

IV. ATTACHMENT(S)

A. CalOptima Health Medi-Cal SPD Health Risk Assessment
B. CalOptima Health Pediatric SPD Health Risk Assessment

V. REFERENCE(S)

A. California Section 1115 Waiver: Bridge to Reform
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management
D. Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, Issued December 2022
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Policy Guide (Supersedes APL 17-012 and 17-013)
F. Welfare and Institutions Code, §14182

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
05/21/2015	Department of Health Care Services (DHCS)	Approved as Submitted
08/18/2023	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	11/01/2012	GG.1323	Senior and Persons with Disabilities and Health Risk Assessment Policy	Medi-Cal
Revised	09/01/2014	GG.1323	Senior and Persons with Disabilities and Health Risk Assessment Policy	Medi-Cal
Revised	07/01/2015	GG.1323	Senior and Persons with Disabilities and Health Risk Assessment Policy	Medi-Cal
Revised	12/01/2016	GG.1323	Seniors and Persons with Disabilities and Health Risk Assessment	Medi-Cal
Revised	11/01/2017	GG.1323	Seniors and Persons with Disabilities and Health Risk Assessment	Medi-Cal
Revised	01/01/2019	GG.1323	Seniors and Persons with Disabilities and Health Risk Assessment	Medi-Cal
Revised	04/01/2020	GG.1323	Seniors and Persons with Disabilities and Health Risk Assessments	Medi-Cal
Revised	04/01/2022	GG.1323	Seniors and Persons with Disabilities and Health Risk Assessments	Medi-Cal
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IX. GLOSSARY

Term	Definition
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Basic Case Management	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP), or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.
Community-Based Adult Services (CBAS)	An outpatient, facility-based service program that delivers Skilled Nursing Care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the Medi-Cal 2020 Waiver, to eligible Members who meet applicable eligibility criteria.
Comprehensive Medical Case Management	Services provided by a Primary Care Provider, in collaboration with CalOptima Health or a health network to ensure the coordination of Medically Necessary health care services, the provision of preventive services, in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
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 health questionnaire, used to provide members with an evaluation of their health risks and quality of life.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the member's social and health care needs that reflects the member's resources, understanding of his or her disease process, and lifestyle choices.

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).
In-Home Supportive Services (IHSS)	Services provided to Members by the County in accordance with the requirements set forth in Welfare & Institutions Code Section 14186.1(c)(1), and Article 7 of the Welfare & Institutions Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.
Long Term Care	Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Multipurpose Senior Services Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.
Quality Improvement Committee (QIC)	The CalOptima Health committee that is responsible for the Quality Improvement (QI) process.
Risk Stratification	A systematic process for identifying and predicting member risk levels relating to health care needs, services, and coordination.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the Department of Health Care Services (DHCS).