

Coordinated Care Initiative

DRAFT Assessment and Care Coordination Standards

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This document provides the Assessment and Care Coordination Standards for Medi-Cal managed care health plans (Plans) in the Duals Demonstration (Demonstration). The Department of Health Care Services (DHCS) will require Demonstration Plans to meet these standards.

These standards include some provisions from current Medi-Cal managed care requirements in applicable areas concerning assessment and care coordination standards, edited to reflect the demonstration requirements. This document represents additions and inclusions required by Senate Bill (SB) 1008 (Statutes of 2012, Chapter 33) and SB 1036 (Statutes of 2012, Chapter 45), DHCS policies, and the Dual-Eligible Special Needs Plan (D-SNP) Model of Care, per the Centers for Medicare and Medicaid Services (CMS). The source of the requirement is generally indicated. Any change in requirements where a source is not indicated are proposed changes that are based on stakeholder feedback to the Department of Health Care Services (DHCS).

DHCS will require Plans to meet these standards. During the plan readiness process, DHCS, in collaboration with CMS and DMHC, will undertake a process to review the Plans to ensure their readiness to meet these and other standards and requirements relating to the Demonstration. DHCS will review Plans' policies and procedures to ensure compliance with continuity of care requirements.

DHCS recognizes that Plans will have to revise existing policies and procedures relating to care coordination, case management, utilization management, assessment, stratification, and delegation oversight to incorporate these standards and protocols for LTSS. DHCS recognizes the importance of a thoughtful approach to the incorporation of these standards into existing Plan policies, protocols, and operations. To that end, in connection with Plan readiness, DHCS will consider Plan proposals for implementation of these standards according to a schedule that includes development of internal policies and procedures; revisions to plan case management programs or protocols; development of necessary system changes and internal controls relating to implementation of the standards, staff and provider training on the new policies and procedures, and delegation oversight revisions to ensure compliance with the new standards.

DHCS is seeking stakeholder feedback on these assessment and care coordination standards.

DHCS has undertaken a measured approach to the development of these assessment and care coordination standards. Specifically, it has reviewed preliminary drafts of these standards with the Plans and the impacted demonstration counties to ensure an appropriate reflection of the current processes that Plans and the counties follow in connection with assessment and care coordination. DHCS, after receipt of preliminary feedback and comments from Plans and the counties, is issuing the standards to the full stakeholder community for input and comment. DHCS is also proposing that the Plan, as a critical component of their local stakeholder process, host at least one local community stakeholder meeting dedicated to a review of these proposed standards.

DHCS believes that such local stakeholder feedback, along with the feedback and input that it hopes to receive from its statewide approach to soliciting input and feedback will ensure a full and thoughtful review of these important standards.

These standards incorporate the following goals in conjunction with current Medi-Cal managed care assessment and care coordination requirements.

- Connect the medical assessment/coordination to LTSS and behavioral health assessment/care coordination process.
- Build on the existing knowledge and experience of Plans in the care coordination process for Medi-Cal-only Seniors and Persons with Disabilities (SPDs).
- Incorporate key elements of the D-SNP process to reflect local flexibility, Medicare requirements, and oversight through the National Committee for Quality Assurance (NCQA) review process.
- Incorporate beneficiary protections from SB 1008 (Statutes of 2012, Chapter 33) and SB 1036 (Statutes of 2012, Chapter 45), as well as lessons learned from other states and national guidelines.
- Provide flexibility for Plan-specific modifications, subject to prior written approval by DHCS in consultation with CMS.
- Establish consistent terminology and clear, measurable expectations for Plans.
- Establish clear written reporting requirements relating to the assessment process so that the Plans will be able to establish a basis for any quality withhold relating to compliance with the standards.

CARE COORDINATION GENERAL REQUIREMENTS

DHCS proposes the following general provisions regarding care coordination.

1. Plans will provide care coordination services to all Members as needed, and if requested.
2. Care coordination should reflect a Member-centered, outcome-based approach, consistent with the CMS model of care approach and Medicare requirements and guidance. (D-SNP)
3. Care coordination shall adhere to a Member's determination about the appropriate involvement of his or her medical providers and caregivers, in accordance with the Health Insurance Portability and Accountability Act (HIPAA). (SB 1008)
4. Plans shall use nurses, social workers, the Member's PCP, if appropriate, and other medical professionals as necessary to provide care management and enhanced care management, as applicable, particularly for beneficiaries in need of or receiving LTSS. (SB 1008)
5. Plans shall facilitate a Member's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health and substance use disorder treatment services. (SB 1008)
6. Care coordination will be provided in a way that reflects the cultural, linguistic, and physical needs of the Member.
7. Care coordination policies and Individual Care Plans (ICP) will be developed to comply with Medicare and Medi-Cal continuity of care provisions.
8. Plans must have an agreement with their county social service agency regarding care coordination for IHSS recipients. The agreement must include: a comprehensive, inclusive communications process between the Plan and county; data sharing protocols; the role and purpose of the ICT and who will be served, metrics indicating levels of risk (prioritization); composition and leadership of the CCT; how documentation and data will be recorded and stored; procedures for follow-up and monitoring of cases.
9. Care coordination policies will reflect the principles of self-directed care as follows:
 - a. Plans must have policies and procedures to reflect self-directed care, and shall document in the Member's medical record the Member's choice to self-direct care.
 - b. For Members with IHSS, Plan policies should reflect the Member's ability to hire, fire, and supervise IHSS providers, as well as follow relevant IHSS statute and regulations. Plans are encouraged to consult with the California Department of Social Services (CDSS) and DHCS to confirm policies are consistent with IHSS program requirements.
 - c. Plans shall have policies and Member services personnel to provide any assistance to inform, navigate, connect, and refer as needed by the Member who is self-directing their care.

- d. For Members with cognitive impairment, during the annual reassessment or upon significant change in health status, Plans shall work with Members, or their authorized representative to determine their interest in continuing to self-direct their care.
10. In conjunction with contracted MSSP organizations, Plans shall have a care coordination and management model that supports appropriate referral of Plan Members to the MSSP for assessment, eligibility determination, and services.
11. Plans shall have policies and procedures governing how the Plan will make referrals to MSSP and defining the respective care management roles and duties of the Plan's care coordination team and MSSP care managers.
12. Care coordination policies shall reflect the principles and use of MSSP.
13. Plans shall have a process for conducting an annual review, analysis and evaluation of the effectiveness of the care management program model and processes, and identify actions to be implemented to improve the quality of care and delivery of services. Plans should have a process for developing a plan of correction, with specified timelines, for any out of compliance findings as a result of the annual review, analysis, and evaluation. Plans will work jointly with MHPs, county social service agencies, and other entities as necessary to develop these processes.
14. Plans shall develop care management and care coordination for the Member across the medical and LTSS system, including transitions among levels of care and between service locations. (SB 1008)
15. Plans offer services beyond those required by Medicare and Medi-Cal at the Plan's discretion. (SB 1008)

In addition, DHCS proposes to incorporate the following provisions for care coordination from the National Quality Forum (NQF).

1. Healthcare providers and entities should have structured and effective systems, policies, procedures, and practices to create, document, execute, and update a plan of care with every Member.
2. A systematic process of follow-up tests, treatments, or services should be established and be informed by the plan of care.
3. The joint plan of care should be developed and include Member education and support for self-management and resources.
4. The plan of care should include community and nonclinical services as well as healthcare services that respond to a Member's needs and preferences and contributes to achieving the Member's goals.
5. A program should be used that incorporates a care partner to support family and friends when caring for a hospitalized Member.
6. The provider's perspective of care coordination activities should be assessed and documented.
7. Standardized, integrated, interoperable, electronic, information systems with functionalities that are essential to care coordination, decision support, and quality measurement and practice improvement should be used.
8. An electronic record system should allow the Member's health information to be accessible to caregivers at all points of care.

9. Regional health information systems, which may be governed by various partnerships, including public/private, state/local agencies, should enable healthcare home teams to access all Member information.

RISK STRATIFICATION AND HEALTH ASSESSMENT PROCESS

Plans shall apply a DHCS approved health risk stratification mechanism or algorithm to identify newly enrolled dual-eligible beneficiaries within 44 days of enrollment. Based on the results of the Member's health risk stratification, Plan shall also administer the DHCS approved health risk assessment (HRA) survey within 60 days for dual-eligible beneficiaries deemed to be at a higher health risk, and 90 days for nursing facility residents or those determined to be a lower health risk. The health risk stratification and assessment shall be done in accordance with Welfare and Institutions Code (WIC) Code Section 14182.17(d)(2).

Plans' HRA shall, at a minimum, incorporate the elements of the SF-12 HRA into the HRA tool for the demonstration. Plans shall submit the tool to DHCS and CMS for approval. Plans shall provide the HRA tools to contracted providers.

Plans shall develop and submit their processes to demonstrate compliance with the following to DHCS and CMS three months prior to implementation of the demonstration, and DHCS will review within one month of submission.

INITIAL RISK STRATIFICATION MECHANISM

A risk stratification mechanism or algorithm designed for the purpose of identifying newly-enrolled Members who have higher-risk and more complex health needs, and those who are at lower-risk, within 44 calendar days of enrollment. "Higher-risk" for initial risk stratification purposes upon enrollment means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health status if they do not receive their initial contact by the Plan within 60 calendar days of enrollment.

Note that Plans may determine their own risk stratification process and categories for ongoing member care management purposes.

The submission for the Initial Risk Stratification process must include:

1. A process for incorporating stakeholder and consumer input into development of the mechanism or algorithm.
2. A process for use of Member-specific information including their historical Medicare and Medi-Cal FFS utilization data provided by DHCS electronically at the time of enrollment. This data may include, but is not limited to, outpatient, inpatient, emergency department, pharmacy, nursing facility, In Home Supportive Services (IHSS), and ancillary services data for up to the most recent 12 months.

3. A process that tests the stratification mechanism or algorithm by using Plan utilization data to stratify currently enrolled dual-eligible Members into three groups: higher-risk, lower-risk, and nursing facility residents.
4. Explanation for how the stratification of enrolled population corresponds to the care coordination approaches.
5. A process for providing stratification results to Members' primary care provider (PCP)/Independent Physician Association (IPA) within 60 days of enrollment. In addition, a process for providing IHSS recipients' stratification results to the county human services agency, and serious mental health (SMI) Members' results to the county mental health agency.

SELF ASSESSMENT

Note: The Medical Evaluation Tool (MET) Self-Assessment process currently used for Medi-Cal only SPDs will not be included in the enrollment process for the demonstration, due to feedback from health plans that this process would not be helpful for the stratification process, or contribute to increased reach rate for the initial enrollment transition.

HEALTH RISK ASSESSMENT (HRA)

Plans shall use an HRA tool survey tool to assess a Member's current health risk, including medical, LTSS, and behavioral health elements.

Health Plans must include the SF-12 Health Survey questions in their HRA tool. The SF-12 is evidence based and valid, and is associated with a significant literature base to predict health care utilization. A standardized HRA across all Health Plans will provide great value to the department addressing clinical, quality, and policy decisions. A common data set on assessments will be helpful for stakeholder reporting purposes.

The tool shall be used within 60 calendar days of enrollment for those identified by the risk-stratification mechanism or algorithm as higher-risk and within 90 calendar days of enrollment for nursing facility residents or those identified at lower-risk for the purpose of developing individualized care management plans for all Members. "Higher-risk" for risk-assessment purposes means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health status if they do not receive their initial contact by the Plan within 60 calendar days of enrollment.

Plans must submit to DHCS the following:

1. A process for incorporating stakeholder and consumer input into development of the tool or process.

2. A process for contacting Members within the required assessment timeframes that will include repeated documented efforts (letter followed by at least two phone calls) to contact each Member.
3. A process for reviewing 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), as well as results of previously administered assessments, and other medical, IHSS, nursing facility, and behavioral health assessments. Also, a process for using the results of the data analysis, stratification, and HRA to identify higher-risk Members and nursing facility residents.
4. The HRA shall be conducted by:
 - i. Personnel trained in the use of the assessment instruments.
 - ii. For higher-risk beneficiaries, personnel who review, analyze, and stratify health care needs include professionally knowledgeable and credentialed personnel such as physicians, nurses, social workers, or behavioral health specialists.
5. Assessment materials shall be available in alternate format, in a culturally, linguistically, and physically appropriate manner. Plans will make arrangements to reach and engage Plan Members with a variety of cultural and linguistic needs. (SB 1008))
6. A process describing how the Plan will identify higher-risk and nursing facility residents' medical care needs, including primary care, specialty care, durable medical equipment (DME), medications, LTSS needs, behavioral health needs, and other needs and develop an individual care management and care coordination plan as needed, within 90 days of enrollment. The care coordination plan will be developed upon completion of the data stratification, and HRA.
7. A process for identifying and assessing the need for, or, as appropriate, making referrals to, home- and community-based services, including Community-Based Adult Services (CBAS), MSSP, IHSS, HCBS flexible benefits, and other community services such as those provided through Area Agencies on Aging. Processes involving IHSS referrals shall be developed jointly with county agencies.
8. A process for identifying the need for including appropriate involvement of caregivers, and obtaining Member approval when the need for such involvement is identified.
9. A process to identify the need for facilitating timely access to primary care, specialty care, DME, medications, and other health services needed by the enrollee, including the need for referrals to resolve any physical or cognitive barriers to access.
10. A process to identify the need for facilitating communication among the Member's health care providers, including mental health and substance abuse providers when

appropriate. These processes shall be developed jointly between the Plan and appropriate county agency.

11. A process to identify the need for providing other activities or services needed to assist Members in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.
12. A process for sharing assessment results and the Individual Care Plan (ICP) with Members, the Interdisciplinary Care Team (ICT), the PCP, the MSSP care manager, county IHSS and behavioral health partners, or any other LTSS providers within 90 days of enrollment. These processes for sharing assessment results for IHSS recipients with county social service agencies shall be developed jointly between the Plan and appropriate county agency.
13. A process to identify the need for coordination of care across all entities, including those outside the provider network and to ensure that adequate discharge planning is provided to Members who are admitted to a hospital or institution.

INDIVIDUAL CARE PLAN

Plans shall develop and submit individual care plans (ICPs) that include the following, three months prior to enrollment, and DHCS will review within one month of submission.

1. A process describing how the Plan will develop an individual care management and care coordination plan as needed, within 90 days of enrollment for all new members. The care coordination plan will be developed upon completion of the data stratification, and HRA.
2. A process for identification of referrals needed to appropriate community resources and other agencies for services outside the scope of responsibility of the Plan, including but not limited to mental health and behavioral health, personal care, housing, home delivered meals, energy assistance programs, and services for individuals with intellectual and developmental disabilities. Processes for IHSS referrals shall be developed jointly with county agencies.
3. A process for the Plan to accept referrals from mental health plans (MHP) when the determination is made that the service should be administered by the Plan.
4. A process of referral from the Plan to the MHP for determination of medical necessity.
5. A process to identify the need for including appropriate involvement of caregivers, and obtain Member approval for such involvement.

6. A process to identify the need for facilitating timely access to primary care, specialty care, DME, medications, and other health services needed by the enrollee, including the need for referrals to resolve any physical or cognitive barriers to access.
7. A process to identify the need for facilitating communication among the Member's health care providers, including mental health and substance abuse providers when appropriate.
8. A process to identify the need for providing other activities or services needed to assist Members in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.
9. A process to identify the need for care coordination across multiple entities, including those outside the provider network, and to ensure that discharge planning is provided to Members who are admitted to a hospital or institution.
10. A process to incorporate Medicare and Medi-Cal continuity of care provisions into the ICP.
11. A process for reviewing and updating the ICP as necessary following a psychiatric or acute hospital admission, particularly for enrollees with SMI.
12. Plans shall develop ICPs for higher-risk Members and nursing facility residents based on the results of the HRA process, with a particular focus on LTSS. (SB 1008)
13. Plans shall consider behavioral health needs of Members and coordinate those services with the county mental health department as part of the Member's care management plan when appropriate. (SB 1008)
14. ICPs shall facilitate a Member's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health and substance use disorder treatment services. (SB 1008)
15. ICPs shall include identification of appropriate providers, facilities, services, and available community and social supports.
16. ICPS shall reflect self-assessment, risk stratification results, clinical data, (effective January 1, 2014) IHSS assessment results, MSSP and CBAS records, behavioral health utilization (if member has a diagnosis of one or more of the specified Diagnostic and Statistical Manual of Mental Disorders), and other data, as well as self- and provider referrals.

17. For Members with an Interdisciplinary Care Team (ICT), the ICP shall be developed by the ICT. (D-SNP)
18. Plans shall consult with the Member, PCP, IHSS social worker, MSSP case manager, behavioral health specialist, family and/or community supports, and other providers as appropriate in the development of the ICP.
19. ICPs shall incorporate appropriate use of LTSS, including IHSS, CBAS, MSSP, nursing facilities, home and community-based services (HCBS) Plan benefits, and Community Based Organization (CBO) services.
20. Plans shall share assessment results and ICP with Members, ICT, PCP MSSP care manager, county IHSS and behavioral health partners, or any other LTSS provider within 90 days of enrollment. For IHSS Members, the sharing of assessment results will be conducted and acted upon according to terms specified in each respective MOU between the plan and county social services agency, and plan and county behavioral health agency.
21. ICPs shall incorporate appropriate use of behavioral health services, including county mental health and substance use, and Drug Medi-Cal services. Identification of providers should promote co-location of service delivery, especially for Members receiving county-administered specialty mental health or Drug Medi-Cal services.
22. ICP information shall be available to beneficiaries in alternative formats that are culturally, linguistically, and physically appropriate and accessible.
23. The Member's ICP should always be made available to the healthcare home team, the Member, and the patient's designees. (National Quality Forum (NQF)).
24. All ICT Members, including the patient and his or her designees, should work within the same ICP and share responsibility for their contributions to the ICP and for achieving the patient's goals. (NQF)

CARE COORDINATION

1. Comprehensive Case Management Including Coordination of Care Services

Plan shall ensure the provision of Comprehensive Medical Case Management based on the individual health care needs of each Member.

Plan shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all medically necessary services delivered both within and outside the Plan's provider network.

These services are provided through either basic or complex case management activities based on the individual medical, behavioral, and LTSS needs of the Member. Health Plans shall follow the requirements below, unless they have a DHCS approved alternative process.

Case management services for dual-eligible beneficiaries must include the concepts of Person-Centered Planning.

A. Basic Case Management Services are provided by the PCP or Care Coordinator, in collaboration with the Plan. The complexity and breadth of these services will range according to each member's needs. These services may include:

- 1) Initial Health Assessment (IHA)
- 2) Initial Health Education Behavioral Assessment (IHEBA)
- 3) Identification of appropriate providers and facilities (such as medical, rehabilitation, support services, LTSS, and behavioral health) to meet Member care needs.
- 4) Direct communication between the provider and Member/family.
- 5) Member and family education, including healthy lifestyle changes when warranted.
- 6) Coordination of carved out and linked services, and referral to appropriate community resources and other agencies.

B. Plan shall develop methods to identify Members who may benefit from complex case management services, using utilization data, clinical data, LTSS data, and any other available data, as well as self and physician referrals. Complex Case Management services shall include:

- 1) Basic Case Management Services
- 2) Management of acute or chronic illness, including emotional and social support issues by an ICT.
- 3) Intense coordination of resources to ensure Member regains optimal health or improved functionality.
- 4) With Member, ICT, and PCP input, development of ICPs specific to individual needs and updating of these plans at least annually.

C. Person-Centered Planning for Dual-Eligible Members

Person-Centered planning actively engages the member in his or her health treatment and LTSS planning and service delivery process, with an emphasis on identifying the strengths, capacities, preferences, needs and desired outcomes of the individual. The plan of care developed focuses on assisting him or her achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the he or she has identified, including medical, professional staff, family and friends. The identified

personally-defined outcomes and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes becomes part of the plan of care.

1. Upon the enrollment of a dual-eligible Member, Plan shall provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the dual-eligible Member's continuing health care needs.
2. Person-Centered Planning shall include identifying each dual-eligible Member's preferences and choices regarding treatments and services, and abilities.
3. Plan shall allow or ensure the participation of the dual-eligible Member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.
4. Plan shall ensure that dual-eligible beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

D. Plans must provide evidence of policies and procedures, that have been jointly developed with county social service agencies, which address the process the Plans will use to communicate with county social services offices when they are informed or have determined that there has been a change in the consumer's condition that may result in the need for a reassessment of IHSS authorized hours.

E. Plan shall develop specific care coordination provisions for nursing facility residents. Plan must monitor nursing facility utilization and develop care transition plans and programs that move beneficiaries back into the community to the extent possible. (SB 1008). Such transition care planning shall include assessment of the need for Home- and Community-Based Services, and involve Members, family, legal representatives, PCPs, nursing facility personnel, behavioral health representatives, and other health care and community-based providers.

F. Plan shall monitor and support members in the community to avoid further institutionalization.

G. Plan shall have a process for conducting an annual review, analysis and evaluation of the effectiveness of the care management program processes and identify actions to be implemented to improve the quality of care and delivery of services. Plan shall have a process for developing a plan of correction, with specified timelines, for any out of compliance findings as a result of the annual review, analysis, and evaluation. Plan shall coordinate the review process with county mental health and social service agencies.

2. Discharge Planning and Care Coordination

Care coordination should be provided for transitions among levels of care and between service locations. (SB 1008)

Plan transition of care policies must be submitted to DHCS and CMS for approval.

Plan shall ensure the provision of discharge planning when a dual-eligible Member is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the dual-eligible Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Discharge planning shall be done in coordination with hospital discharge planners.

Health Plans shall follow the requirements below, unless they have a DHCS approved alternative process.

Health Plans shall establish transitions of care policies that incorporate the following strategies from the NQF:

- a. Decision making and planning for transitions of care should involve the Member, and, according to Member preferences, family, and caregivers (including the healthcare home team). Appropriate follow-up protocols should be used to assure timely understanding and endorsement of the plan by the Member and his or her designees.
- b. Members and their designees should be engaged to directly participate in determining and preparing for ongoing care during and after transitions.
- c. Systematic care transitions programs that engage Members and families in self-management after being transferred home should be used whenever available.
- d. For high-risk chronically ill older adults, an evidence-based multidisciplinary, transitional care practice that provides comprehensive in-hospital planning, home-based visits, and telephone follow-up, such as the Transitional Care Model, should be deployed.
- e. Healthcare organizations should develop and implement a standardized communication template for the transitions of care process, including a minimal set of core data elements that are accessible to the Member and his or her designees during care.

Minimum criteria for a discharge planning checklist must include:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, DME, and other services received, such as IHSS, MSSP, or CBAS.

B. Documentation of pre-discharge factors, including an understanding of the medical condition by dual-eligible Member or a representative of the dual-eligible Member as applicable, physical and mental function, financial resources, and social supports.

C. Services needed after discharge, setting preferred by the dual-eligible Member/representative of the dual-eligible Member and hospital/institution, setting agreed to by the dual-eligible Member/representative of the dual-eligible Member,

specific agency/home recommended by the hospital, specific agency/home agreed to by the dual-eligible Member/representative of the dual-eligible Member, and pre-discharge counseling recommended.

D. Post transition discharge policies and procedures shall cover criteria to include, but not limited to, access to necessary medical care and follow up, medications, durable medical equipment and supplies, transportation, and integration of community based LTSS programs.

E. Coordination with county agencies for IHSS and behavioral health services, MSSP providers and CBAS centers, CBOs such as Area Agencies on Aging, and nursing facilities, as appropriate. For IHSS, the plan's coordination process should be developed jointly with county social service agencies and consider state requirements for counties regarding discharge planning.

F. Policies and procedures governing expedited MSSP assessment and eligibility determination as part of the Plan's care coordination process for Plan Members who are being discharged from the hospital or at risk of immediate placement in a SNF.

G. Summary of the nature and outcome of Member involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

H. For beneficiaries receiving county-administered specialty mental health or Drug Medi-Cal services, plan shall have procedures for:

- a. Notification of the ICT of hospital admission (psychiatric or acute) and coordinating a discharge plan.
- b. Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a Member's medical problems based on changes in the Member's mental health or medical condition.

Out-of-Plan Case Management and Coordination of Care

Plan shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services.

REASSESSMENT AND REVIEW

DHCS proposes the following provisions regarding reassessment:

1. Plans shall conduct an annual comprehensive reassessment (including medical, LTSS, behavioral health utilization data analysis and risk stratification) within 12 months of last assessment, or as often as the health of the enrollee requires.

Reassessment may be conducted by phone, email, or in-person for beneficiaries in lower-risk group, and must be conducted in person for higher-risk group and nursing facility residents. (D-SNP)

- a. For IHSS recipients, upon request and when feasible, plan reassessments may be conducted in conjunction with in person, in home, county IHSS reassessments.
 - b. For SMI or Drug Medi-Cal Members, reassessment conducted in conjunction with behavioral health specialist.
2. Plans shall regularly use claims data (including IHSS and behavioral health data) to identify Members at high-risk, using newly diagnosed acute and chronic conditions, or high frequency emergency department or hospital use, or IHSS or behavioral health referral.

RESPONSIBILITIES AND QUALIFICATIONS OF CARE COORDINATOR

DHCS proposes the following provisions regarding care coordinators:

Plans shall ensure that care coordinators who administer the HRA, prepare the ICP, conduct care transitions, and assemble the ICT meet the following qualifications and conduct the following activities:

1. The requirement for the education and experience level of the care coordinator will be determined by the health plan according to the needs of the member. For members identified as high risk, care coordinators must have substantial training regarding medical, LTSS, and behavioral health services.
2. Depending upon the needs of the member, the duties of the care coordinator may include:
 - a. Direct communication between the provider and Member/family;
 - b. Member and family education;
 - c. Coordination of carved-out and linked services, and referrals.
 - d. Promotion of co-location of service delivery, particularly for Members with receiving county-administered specialty mental health or Drug Medi-Cal services.
 - e. Intense coordination of resources to meet ICP goals;
 - f. With Member and PCP input, development of an ICP specific to individual needs, and updating of these plans at least annually.
 - g. Person-Centered Planning.
 - h. Assessment of clinical risks and needs
 - i. Medication review and reconciliation
 - j. Medication adjustment by protocol
 - k. Enhanced self-management training and support
 - l. Frequent Member contact
 - m. Set up ICT

- n. Case rounds, monthly ICT meetings as needed
- o. Refer beneficiaries to community resources or other agencies for needed medical or social services or items outside the Plan's responsibilities. Referrals for IHSS shall be done in coordination with county social services agency. (TBL)
- p. Facilitate communication among a Member's health care and PCPs, including LTSS and behavioral health providers when appropriate. (SB 1008)
- q. Engage in other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status. (TBL)
- r. Facilitate timely access to primary care, specialty care, medications, and other health services needed by the Member, including referrals to address any physical or cognitive barriers to access. (TBL)
- s. Initial Enrollment Recommendation: To facilitate communication between Plans and social service agencies, particularly during the initial enrollment period, DHCS and the CDSS recommends that Plans consider identifying a limited group of care coordinators that work with county social service agencies, as well as a limited group of care coordinators that work with county behavioral health agencies.

INTERDISCIPLINARY CARE TEAM (ICT)

DHCS proposes the following provisions regarding ICTs.

Plans shall comply with the with following requirements

- 1. Plans shall support multiple levels of interdisciplinary communication and coordination, such as individual consultations among providers, county agencies, and Members. (D-SNP)
- 2. Plans must have an ICT to coordinate the delivery of services and benefits. (D-SNP)
- 3. Plans will support an ICT as needed for each Member. Plans will make the initial determination of which Members need an ICT, although every Member shall have access to an ICT if requested.
- 4. Plans will not require a Member to participate in an ICT if that Member objects. (SB 1008)
- 5. The ICT shall be led by professionally knowledgeable and credentialed personnel such as physicians, nurses, social workers, restorative therapists, pharmacists, psychologists. (D-SNP model of care)
- 6. The membership of the ICT will include the Member and/or authorized representative, PCP, Plan care coordinator or manager, and may include the following persons, as needed, and if available:
 - a. Hospital discharge planner.
 - b. Nursing facility representative.

- c. Pharmacist, physical therapist, other specialized provider.
 - d. IHSS social worker, if receiving IHSS.
 - e. IHSS provider if approved by Member.
 - f. MSSP care manager, if enrolled in MSSP.
 - g. CBAS provider, if enrolled in CBAS.
 - h. Behavioral Health specialist for Members receiving county-administered specialty mental health or Drug Medi-Cal services.
 - i. Other professionals as appropriate.
7. The role of the ICT is care management, including assessment, care planning, and authorization of services, transitional care issues and working closely with IHSS, CBAS, and NF providers to stabilize medical conditions, increase compliance with care plans, maintain functional status, and meet individual Members' care plan goals.
 8. Plans shall have procedures for notifying the ICT of hospital admission (psychiatric or acute) and coordinating a discharge plan for Members receiving county-administered specialty mental health or Drug Medi-Cal services.
 9. Plans shall adhere to a Member's determination about the appropriate involvement of his or her medical providers and caregivers, according to HIPAA.

SUBCONTRACTS

DHCS proposes the following provisions regarding subcontracts.

Plans will be required to comply with the following provisions regarding subcontracts, in addition to the provisions included in Exhibit A, Attachment 6, Section 14. Subcontracts, and other contract provisions.

Subcontracts for Assessment and Care Coordination

1. The Plan shall be responsible for compliance with these standards as will be set forth in the Plan's contract and in an All Plan letter on this topic.
2. Care coordination is central to the policy objective of the CCI in general and the duals demonstration in particular.
3. The Plan shall not delegate responsibility for assessment or care coordination to subcontractor unless and until it has done the following:
 - i. Documented the scope of the subcontractor's responsibility for these standards in a written contract with such subcontractor ;
 - ii. Consulted with county social services agencies regarding the scope of the subcontractor duties related to IHSS referrals and communication with county agencies, and revised as necessary any existing MOU or written agreements to reflect subcontractor responsibilities as they relate to members with IHSS.
 - iii. Submitted such contract to DHCS MMCD for review and approval in accordance with the terms of the contract with DHCS;

- iv. Conducted a readiness review of such subcontractor to ensure that the delegate has the systems, infrastructure, staffing and operational capacity to fulfill its obligations under the contract with the Plan and meet these standards;
 - v. Established policies and procedures that document how the subcontractor will coordinate activities between and among the Plan, all providers, and the Member, and that document the circumstances under which the Plan will de-delegate responsibilities for these activities.
 - vi. Established required elements of Member data sharing, and data reporting on process and quality measures, including frequency of reporting and content.
4. In the event that the Plan delegates responsibility for these critical services and functions, it will provide a detailed report on its delegation oversight activities to DHCS among its reporting requirements.
 5. Plan shall provide either a single entity as a point of contact for the county social service agency, or jointly develop an alternative process with the county social service agency.

PLAN REPORTING REQUIREMENTS

Plans shall report to MMCD 135 days after the end of each quarter the minimum following information:

1. The number of newly-enrolled dual-eligible Members during the quarter who have been determined to be at higher-risk and lower-risk by means of the risk-stratification mechanism or algorithm.
2. The number of newly-enrolled dual-eligible Members during the quarter in each risk category who were successfully contacted (Plan received phone or mailed response) during the quarter and by what method.
3. The number of newly-enrolled dual-eligible Members during the quarter who were successfully contacted and who completed the risk assessment survey (answered all questions) and the number who declined the risk-assessment survey.
4. The number of newly-enrolled dual-eligible Members during the 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 Members by the Plan during the risk-stratification process.

DEFINITIONS

Case Management: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. This may also

include members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. 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 case management services.

Care Coordination: Services which are included in Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.

Care Coordinator: May be a health care professional, and may be a primary care physician, social worker, or RN. A care coordinator is the member's first contact with the health care system and triages the member's further access to the system, coordinates member care, and provides referrals to specialists, hospitals, laboratories, and other medical services. The care coordinator's experience and education may vary according to the level of health care needs of the individual member.

Care Management: A collaborative process to manage the medical, social, behavioral and mental health conditions of health plan members, using evidence-based and integrated clinical care. The goals of care coordination are for health plans to achieve an optimal level of wellness for members, improving care coordination, and resource management/cost containment.

Complex Case Management: The systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.

Health Risk Assessment (HRA): A risk-assessment survey tool that shall be used to comprehensively assess a member's current health risk within 90 calendar days of enrollment. "Higher-risk" for risk-assessment purposes means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health status if they do not have an individualized care management plan.

Interdisciplinary Care Team (ICT) or Care Coordination Team (CCT): A group of professionals ranging from medical and behavioral health, to HBCS services that focuses on team-based, multi-disciplinary care coordination rather than on a single care coordinator tailored to each member's individual needs.

Member Evaluation Tool (MET): The information collected from a health information form completed by beneficiaries at the time of enrollment by which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. Plan shall receive the MET from the enrollment broker with the enrollment file and shall use

the MET for early identification of members' healthcare needs. For newly enrolled SPD beneficiaries Plan must use the MET as part of the health risk assessment process.

Person-Centered Planning: A highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of Case Management and Discharge Planning.

Primary Care Physician (PCP): A physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). A PCP may also be a specialist or clinic.

Primary Care Provider: A person responsible for supervising, coordinating, and providing initial and primary care to Members; for initiating referrals; and for maintaining the continuity of Member care.

Reassessment (Comprehensive): A detailed assessment of health plan members at specified intervals and/or after a change in health status.

Risk Stratification: The process of ranking, through the use of historical utilization data, the complex and specialized needs of its members based on outcome of health risk assessments.

Specialty Mental Health Provider: A person or entity that is licensed, certified, or otherwise recognized or authorized under State law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service:

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

B. Psychiatric inpatient hospital services;

C. Targeted Case Management.

Subcontract: A written agreement entered into by the Plan with any of the following:

A. A provider of health care services who agrees to furnish Covered Services to Members.

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Plan specifically related to fulfilling the Plan's obligations to DHCS under the terms of this Contract.

Sub-Subcontractor: Any party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

NON-DEMONSTRATION DUAL-ELIGIBLE BENEFICIARIES

The demonstration assessment and care coordination requirements for Plans will apply to dual-eligible beneficiaries not enrolled in the demonstration, with the following additions:

1. For waiver beneficiaries, assessment and care coordination activities will be conducted in collaboration with the waiver providers and services.
2. For beneficiaries with developmental disabilities, assessment and care coordination activities will be conducted in collaboration with regional centers and related services.
3. Health Plans must administer an HRA as described above to Non-demonstration members only if they are receiving LTSS.
4. If the member is currently a member of the Plan, an HRA is not required.