PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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<tr><td colspan="4">Policy/Procedure Number: MCCP2019 (previously MCUP3117)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services</td><td colspan="3">☒External Policy
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<tr><td colspan="3">Original Date: Approved by DHCS 04/11/2013, First Committee Review 08/20/2014 (MCUP3117)</td><td colspan="4">Next Review Date: 02/12/2026
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<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 02/12/2025</td></tr>
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I. RELATED POLICIES:

A. MCUP3012 – Discharge Planning (Non-capitated Members)
B. MCUP3039 – Direct Members
C. MCCP2007 – Complex Case Management
D. MCCP2023 – New Member Needs Assessment
E. MCCP2024 – Whole Child Model for California Children's Services (CCS)
F. MPCD2013 – Care Coordination Program Description
G. MCCP2032 - CalAIM Enhanced Care Management (ECM)
H. MCUP3143 - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
I. MCCP2014 – Continuity of Care (Medi-Cal)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Complex Case Management (CCM): The process of applying evidence-based practices to individual members to assist them with the coordination of their care and promote their well-being.
B. 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.
C. Health Care Guide (HCG): A non-clinical Care Coordination staff member who provides support and guidance to members, families, providers community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner while connecting members to available internal and external resources.
D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).
E. Individualized Care Plan (ICP): A member-focused care plan designed to optimize the member's health, function, and well-being.
F. Nurse Case Manager (NCM): A registered nurse in Care Coordination who works with the multidisciplinary team in order to facilitate coordination of the comprehensive medical, behavioral, and

psychosocial needs of the member while promoting quality and cost-effective outcomes.

G. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric members (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

H. Social Worker (SW)/Medical Social Worker (MSW): A social worker in Care Coordination who provides members and/or their families with the supports needed to cope with chronic, acute and/or terminal illnesses, often complicated by other social/environmental or historical factors.

IV. ATTACHMENTS:

A. Health Risk Assessment (HRA)
B. Pediatric HRA
C. HRA Stratification Matrix
D. PHRA Stratification Matrix

V. PURPOSE:

This policy describes the process Partnership Health Plan of California (Partnership) will follow to assess new enrollees who are designated as Seniors and Persons with Disabilities (SPD) and/or California Children's Services (CCS) upon enrollment and at least annually thereafter. The purpose of the assessment is to identify those SPD/CCS members at high risk for adverse health outcomes and to initiate appropriate individualized care plans to reduce that risk and optimize health.

VI. POLICY / PROCEDURE:

A. Member Risk Stratification
Partnership considers all newly enrolled SPD/CCS members as higher risk and therefore they are comprehensively assessed via the Health Risk Assessment (HRA) or Pediatric Health Risk Assessment (PHRA) form to determine their current health risk.

B. HRA/PHRA Process
1. All newly enrolled members designated with an SPD aid code and/or CCS identifier are sent the HRA (Attachment A) or PHRA (Attachment B) via mail within 10 calendar days of enrollment into the plan.
2. The HRA/PHRA forms are reviewed by the Chief Medical Officer, the Health Educator, and by the Consumer or Family Advisory Committee prior to implementation by the health plan, as are any and all revisions to the HRA/PHRA.
3. All newly enrolled SPD/CCS members are contacted telephonically within 45 days of enrollment in order to encourage the member to return the HRA/PHRA.
4. All questions on the HRA/PHRA forms are sent to each SPD/CCS beneficiary according to age upon enrollment. In no instance are any questions in the HRA/PHRA forms sent to a subset of the SPD/CCS population.
5. For those HRA/PHRAs completed, the member's responses will be captured and evaluated as follows:
   a. Adult member responses will be captured and evaluated utilizing the HRA Stratification Matrix (Attachment C) for adult members. Adult members will be placed in low or high risk categories.
      1) Low Risk – members will benefit from basic case management; or
      2) High Risk – member requires complex case management through an individualized care plan (ICP) to prevent adverse health outcomes.
   b. All pediatric members who complete a PHRA are treated as high risk according to policy

MCCP2024 Whole Child Model for California Children's Services (CCS).

C. Care Coordination
   1. Low Risk Members
      a. Adult members who are stratified as low risk based on their responses to the HRA will be contacted by a Health Care Guide (HCG) within 30 calendar days of the returned HRA.
      b. The role of the HCG is to identify barriers to care and safety and to carry out non-clinical interventions to eliminate those barriers. Examples include, but are not limited to:
         1) Work with the primary care provider and/or specialist's offices to coordinate appointments
         2) Contact durable medical equipment (DME) vendors to facilitate timely delivery of appropriate medical equipment
         3) Work with community-based organizations to assist member with access to psychosocial services
         4) Arrange transportation as appropriate
         5) Resolve any claims issues
         6) Provide support and encouragement to the member and caregiver
         7) Evaluate the member for need for additional case management services available through the health plan.
         8) Facilitate referrals for Long Term Support Services (LTSS) needs identified
      c. The HCG, Nurse Case Manager (NCM), and Social Worker (SW) work together. Any clinical issues will be the responsibility of a licensed clinician.
   2. High Risk Members
      a. Adult Members stratified as high risk, as well as all pediatric members who complete a PHRA, will be contacted by a NCM or SW within 14 days of the returned HRA/PHRA, and the member will be offered enrollment into Complex Case Management (CCM) (see policy MCCP2007 Complex Case Management.) The NCM/SW collaborates with a member's interdisciplinary care team and is responsible for the development of the individualized care plan (ICP) for a member stratified as high risk. They are also responsible for providing education and clinical support, facilitating appropriate communication among the interdisciplinary care team, and working closely with outside agencies and available community resources.
      b. The NCM/SW will discuss the HRA/PHRA results with the member and develop an ICP with interventions tailored to the particular needs of the member. The care plan will include, but is not limited to, needs such as:
         1) The member's identified medical care needs
         2) Access to primary and/or specialty care
         3) DME and/or medications
         4) Assessment of member's current use of community resources as well as provision of referrals to appropriate resources and/or services outside of the Plan's benefits (i.e. mental health and behavioral health services, personal care, housing, meal delivery programs, energy assistance programs and services for individuals with intellectual and developmental disabilities)
         5) Identification of the member's caregiver(s) and need for their involvement in the care plan
         6) Identification of an action plan to assist the member with other activities or services needed to optimize their health status, including:
            a) Process/Plan for coordination of care across all settings, including those outside the provider network
            b) Process/Plan for referrals to resolve any physical or cognitive barriers to access care
            c) Process/Plan for helping to facilitate communication among the member's health care

providers

d) Process/Plan for identifying a member's need for other activities/services that would optimize their health status (e.g. self-management skills, health education classes, etc.)
e) For the member in a facility, a plan to ensure discharge planning and coordination is implemented
f) Designated date of follow-up and reassessment as often as necessary, but not less than annually
g) Referrals to LTSS services where applicable

c. For adult and pediatric members stratified as high risk, Partnership shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible members. The ECM benefit is unique and distinct from the care management services or programs offered by Partnership. Refer to policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) for more details.

D. Assessment and Reassessment
1. Populations required to receive an assessment as referenced in the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024 "Population Health Management Policy Guide" (11/28/2022) and the latest version of the DHCS CalAIM: Population Health Management (PHM) Policy Guide include:
   a. Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver)
   b. Those entering CCM, refer to policy MCCP2007 Complex Case Management.
   c. Those entering ECM, refer to policy MCCP2032 CalAIM Enhanced Care Management (ECM)
   d. Children with Special Health Care Needs (CSHCN)
   e. Pregnant Individuals
   f. Seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements, namely:
      1) Members who have been authorized to receive:
         a) IHSS greater than, or equal to, 195 hours per month;
         b) Community-Based Adult Services (CBAS), and/or
         c) Multipurpose Senior Services Program (MSSP) Services
      2) Members who:
         a) Have been on oxygen within the past 90 days;
         b) Are residing in an acute hospital setting;
         c) Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
         d) Have 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 diagnosis of chronic diseases);
         e) Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
         f) Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
         g) Have cancer and are currently being treated;
         h) Are pregnant;

i) Have been prescribed antipsychotic medication within the past 90 days;
j) Have been prescribed 15 or more prescriptions in the past 90 days;
k) Have a self-report of a deteriorating condition; and
l) Have other conditions as determined by the Partnership, based on local resources.

2. Each month, Partnership leverages age-based algorithms to capture emerging risk in the entire population including, but not limited to SPD or CCS members, to promote timely reassessment for members whose risk level demonstrates need for intervention.
   a. The Monthly Utilization Report analyzes claims data and other predictive modeling factors for members based upon age – adults (ages 21 and over) and pediatrics (under age 21).
   b. Any member who shows as high risk on one of these reports will be contacted by Partnership Care Coordination staff for telephonic reassessment, unless the member is currently enrolled in care coordination. Members recently closed to care coordination will be reassessed if their case was closed more than 30 calendar days prior to new risk identification for pediatric members, and 90 days prior to new risk identification for adult members.
   c. In addition, if the Monthly Utilization Report reveals a potential CCS condition in a pediatric member, that case will be referred to the CCS County program for CCS eligibility determination according to policy MCCP2024 Whole Child Model for California Children's Services (CCS).

E. Extended Continuity of Care (COC)
   1. Newly enrolled SPD/CCS members who request continued access to a provider who is not part of Partnership's network will be permitted to remain with that provider for up to 12 months as long as certain criteria are met. Partnership will begin processing requests for extended COC and will follow the COC process as described in policy MCCP2014 Continuity of Care (Medi-Cal).

F. Diversity Equity and Inclusion Training
   1. Partnership provides Partnership-developed sensitivity, diversity, cultural competency and cultural humility, and health equity trainings to Partnership staff; providers and provider staff, and delegated entities and delegate's staff.
   2. Partnership also provides the training to each aforementioned party who serves seniors and individuals living with disabilities. This training is done via webinar.
   3. Documentation of trainings is maintained and is available upon request.

VII. REFERENCES:

A. Welfare and Institutions Code Section 14182
B. DHCS All Plan Letter 22-024: Population Health Management Program Guide (11/28/2022)
C. DHCS CalAIM: Population Health Management (PHM) Policy Guide (May 2024) https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf
D. DHCS All Plan Letter 24-015: California Children's Services Whole Child Model Program (12/02/2024)
E. DHCS All Plan Letter 23-025: Diversity, Equity, and Inclusion Training Program Requirements (09/14/2023)
F. DHCS Medi-Cal Managed Care Plans Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes 2022-2023

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

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Applies to:	☒ **Medi-Cal**	☐ **Employees**

X. REVISION DATES:

MCCP2019 (effective 02/15/17)
10/18/17; *11/14/18; 11/13/19; 09/09/20, 09/08/21; 10/12/22; 11/08/23; 10/09/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

MCUP3117 (04/11/2013 to 02/15/2017)
05/20/15; 04/20/16 to 02/15/17

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.