Coordinated Care Initiative

DRAFT Assessment and Care Coordination Standards

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GENERAL PRINCIPLES FOR CARE COORDINATION

Care coordination is a required benefit in the Duals Demonstration (Demonstration), and a critical component to achieving the demonstration goals of improved care quality, greater beneficiary satisfaction with care, and enhanced system efficiencies. This document provides the Care Coordination Standards for health plans (Plans) participating in the Demonstration. The Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) will require Demonstration Plans to meet these standards.

These standards cover the care coordination process for both dual eligible beneficiaries and Medi-Cal-only beneficiaries who will receive long-term services and supports (LTSS) benefits through a health plan under the Coordinated Care Initiative (CCI). (Separate standards are under development to dual eligible beneficiaries enrolled in the plans for Medi-Cal benefits only.) These standards cover from the point of initial assessment of a beneficiary's health and functional status, to the delivery of basic and complex case management services. These standards also include requirements for the development of referral and coordination processes for behavioral health services, LTSS, and community-based home- and community based services (HCBS).

These standards were created using elements from the following documents: current Medi-Cal managed care requirements, Senate Bill (SB) 1008 (Statutes of 2012, Chapter 33) and SB 1036 (Statutes of 2012, Chapter 45), DHCS policy letters, and the required elements Dual-Eligible Special Needs Plan (D-SNP) Model of Care, per CMS. The source of the requirement is generally indicated.

These standards will be incorporated into a Plan readiness tool that will be used to assess the participating plans' readiness to implement the Demonstration and provide managed long-term services and supports (MLTSS) to Medi-Cal only beneficiaries. DHCS will review the Plans' policies and procedures to ensure compliance. The standards will also be incorporated into the contract between DHCS, the Plans and CMS. Prospectively, DHCS and CMS will jointly monitor the health plans to ensure fulfillment of these contract requirements for care coordination for enrollees in the duals demonstration.

The standards are based on the following principles:

1. Plans will provide care coordination services to all Members, as needed, in accordance with the Member's individual preferences, and in a way that meets the needs of Members with disabilities. Plans may offer additional services beyond those required by Medicare and Medi-Cal at the Plan's discretion (SB 1008).

2. Plans' care coordination services will reflect:

a. A person-centered, outcome-based approach, consistent with the CMS model of care and Medicare requirements and guidance. (D-SNP)
b. A Member's right to self-direct the provision of long-terms services and supports (SB 1008).
c. A Member's right to determine the appropriate involvement of his or her health care and LTSS providers and caregivers. (SB 1008).

3. Plans will coordinate the Member's care across the full continuum of service providers, including medical, behavioral and LTSS. This includes facilitating access appropriate community-based resources and monitoring skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between facilities and the community.

4. Care coordination will be performed by nurses, social workers, primary care providers, and, if appropriate, other medical or long-term services and supports professionals, and health plan care coordinators.

5. Care coordination will include, at a minimum, the following steps within the prescribed timeframes:
    a. A health assessment process that includes an initial risk stratification and health risk assessment survey, which looks at both health and functional status.
    b. The development of Individual Care Plans (ICP) that comply with Medicare and Medi-Cal continuity of care provisions.
    c. Access to Interdisciplinary Care Teams (ICT), as appropriate and as requested.
    d. Ongoing care management that includes basic and complex case management, and, when appropriate, conducted by nurses, social workers, the Member's PCP, if appropriate, and other medical professionals, in accordance with state and federal law (SB 1008).

HEALTH ASSESSMENT PROCESS

The health assessment process includes two steps: 1) initial risk stratification using an approved algorithm and 2) completion of a health risk assessment using an approved tool (in accordance with WIC Section 14182.17(d)(2)). The initial risk stratification will be completed for each Member within 44 days of enrollment.

Based on the stratification results, Members should be assigned to the following four groups:

- Higher risk: means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health or functional status if they do not receive their initial contact by the Plan within 45 calendar days of enrollment.
- Lower risk
- Community Well: These are all other members who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services
- Residents of nursing homes

For Members identified as higher risk, Plans will administer a DHCS approved health risk assessment (HRA) survey within 45 days.

For Members who are lower risk, community well, or residents of nursing homes, Plans will administer a health risk assessment within 90 days.

The health assessment process must be completed for Members who are enrolled in the duals demonstration and Medi-Cal-only members who receive LTSS.

1. Initial Risk Stratification Mechanism

Plans will implement a risk stratification mechanism or algorithm designed for the purpose of identifying newly enrolled Members into at least the four groups listed above. Plans may use different categories for ongoing Member care management. DHCS will approve this mechanism or algorithm.

This stratification will occur within 44 calendar days of enrollment.

At the time of new Member enrollment, DHCS and CMS will electronically transmit historical Medicare and Medi-Cal FFS utilization data to the health plans for use in their stratification process. This data may include, but is not limited to, 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).

Plans will develop and submit policies and procedures that demonstrate compliance with the following requirements to DHCS and CMS three months prior to implementation. DHCS will review them within one month of submission.

Plans will submit to DHCS policies and procedures for the following:

1. Incorporating stakeholder and consumer input into development of the mechanism or algorithm (SB 1008).

2. Showing how the plan will complete stratification within 44 calendar days of enrollment, pending timely receipt of the data from DHCS and CMS.

3. Testing the stratification mechanism or algorithm by using Plan utilization data to stratify currently enrolled dual-eligible Members into at least four groups: higher-risk, lower-risk, (third group) and nursing facility residents.

4. Describing how the stratification of Members corresponds to the care coordination approaches.

2. Health Risk Assessment

Plans will use a health risk assessment (HRA) tool to assess a Member's current health and functional risks, including medical, LTSS, and behavioral health elements. This assessment will serve as the basis for further assessment needs that may include, but are not limited to, mental health, substance use, chronic physical conditions, incapacity in key activities of daily living, dementia, cognitive status, and the capacity to make informed decisions.

In 2015, the state will design, develop and test a universal assessment process, including a universal assessment tool, for long-term services and supports. The process will be developed with stakeholder input, and initially will be tested by a specified group of beneficiaries in a limited number of counties. The development, testing, and implementation of the tool will be subject to the provisions of Welfare and Institutions Code section 14186.36.

Health Plans will conduct the SF-12 Health Survey questions, or another similar health survey, in addition to their HRA tool. A standardized component of the 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.

Plans will submit to DHCS policies and procedures for the following:

1. For meeting the required assessment timeframes:
    a. Within 45 calendar days of enrollment for those identified as higher risk by the risk-stratification mechanism or algorithm, and

   b. Within 90 calendar days of enrollment for nursing facility residents or those identified as lower-risk.

2. 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. Reviewing 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.

4. How the HRA will be conducted by:
   a. Personnel trained in the use of the assessment instruments, and
   b. For higher-risk beneficiaries, professionally knowledgeable and credentialed personnel to review, analyze, identify and stratify health care needs, such as physicians, nurses, social workers, or behavioral health specialists.

5. Making assessment materials available upon request in the Member's preferred written or spoken language and/or alternate formats that effectively communicates the information (SB 1008).

6. Including appropriate involvement of caregivers, and obtaining Member consent when the need for such involvement is identified.

7. Identifying members' medical care and supportive service needs, including primary care, specialty care, durable medical equipment (DME), medications, LTSS needs, behavioral health needs, and other needs to inform the development of an individual care plan, as needed.

8. Identifying members with serious mental health (SMI) receiving county mental health services and members with chronic substance use receiving county drug and alcohol treatment services.

9. Identifying and assessing the need for referrals to home- and community-based services (HCBS), including Community-Based Adult Services (CBAS), MSSP, IHSS, and other community services, such as those provided through Area Agencies on Aging, Centers for Independent Living or Community Care Transitions leads. Referral processes will be developed jointly with the appropriate agencies.

10. Identifying and assessing the need for other activities or services 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.

11. Sharing assessment results with Members, the 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 will be developed jointly between the Plan and appropriate county agency or provider.

INDIVIDUAL CARE PLAN

Plans will develop an Individual Care Plan (ICP) for Members that focuses on helping the Member achieve personally defined outcomes in the most inclusive community setting. The extent of the ICP developed for each Member will be determined by the Plan in consultation with the Member, and shall include criteria specified in its Model of Care.

Plans will develop and submit policies and procedures governing the development of individual care plans (ICPs) three months prior to initial enrollment. DHCS will review submissions within one month of submission.

The plans will submit ICP policies and procedures that include the following:

1. How the ICP will be developed, within 90 days of enrollment for new members upon completion of the data stratification and HRA.
2. Incorporating Medicare and Medi-Cal continuity of care provisions.
3. How the development of the ICP will reflect consultation with the Member, PCP, LTSS providers, behavioral health specialists, family and/or community support providers, and other providers, as appropriate.
    a. Member approval will be obtained for the involvement of any caregivers.
4. For Members with an ICT, the plan will ensure:
    a. The ICP is developed by the ICT, and (D-SNP)
    b. The Member and/or his or her designees and the ICT are working within the same ICP and share responsibility for their contributions to the ICP and achieving the patient's goals (NQF).
5. How the ICP will be shared with the Member, a Member's designee, ICT members, the PCP, MSSP care manager, county IHSS and behavioral health partners, or any other LTSS or health care provider, as appropriate, within 90 days of enrollment.
    a. 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.
    b. Member approval will be obtained for the involvement of any caregivers.
    c. The ICP will be available, upon request, to Members in alternative formats and preferred written or spoken language.

6. Ensuring that the ICPs reflect 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.
7. Making needed referrals 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, housing, home delivered meals, energy assistance programs, and services for Members with intellectual and developmental disabilities. Referral processes will be developed jointly with the appropriate organizations.
8. 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.
9. Facilitating communication among the Member's continuum of providers, including medical, LTSS, mental health and substance abuse providers when appropriate. These communication processes will be developed jointly between the Plan and appropriate organizations.
10. Providing other activities or services needed to assist Members in optimizing their health and functional status, including assisting with self-management skills or techniques, health education, and other modalities to improve health and functional status.
11. Coordinating transitions of care between service locations and multiple entities, including those outside the provider network, to ensure that discharge planning is provided to Members admitted to a hospital or institution.
12. A process for incorporating appropriate use of LTSS, including IHSS, CBAS, MSSP, nursing facilities, HCBS Plan benefits, and community based organization (CBO) services.
13. Considering behavioral health needs of Members and coordinating those services with appropriate behavioral health providers, including the county mental health plan and/or county department responsible for drug and alcohol services as part of the Member's care management plan when appropriate. (SB 1008)
    a. Identification of providers should promote co-location of service delivery, especially for Members receiving specialty mental health or chronic substance use disorder services.

ONGOING CARE MANAGEMENT

1. Comprehensive Care Management

Plans will ensure the provision of comprehensive care management based on the individual needs of each Member. Comprehensive care management includes

person-centered planning and basic and complex case management activities, as appropriate.

Plan will maintain procedures for monitoring care management provided to Members, including but not limited to all medically necessary services delivered both within and outside the Plan's provider network. Policies and procedures will include clear delineation of responsibilities of the primary Plan, subcontracted plan and contracted medical groups, including independent physician associations (IPAs).

Health Plans will follow the requirements below, unless they have an alternative process approved by DHCS.

A. Person-Centered Planning

Care management services for Members will include the concepts of person-centered Planning. 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 Member.

Plans will submit policies and procedures that show the following:

1. How the Plan will provide, or ensure the provision of, person-centered planning and treatment approaches that are collaborative and responsive to the Member's continuing health care needs.
2. How the Plan will provide person-centered planning that includes identifying each Member's preferences and choices regarding treatments, services, settings and abilities.
3. How the Plan will allow or ensure the participation of the Member, and any family, friends, and professionals of their choosing, in any discussion or decisions regarding treatments and services.
4. How the Plan will ensure that Members receive all necessary information regarding treatment and services so that they may make informed choices.

Person-centered planning also will include the member's right to self-direct the provision of long-term services and supports and forego care management services.

Plans will submit policies and procedures to support self-direction that:

1. Inform the Member of his or her right to self-direct services and document a Member's decision to self-direct services.

2. Reflect current IHSS statue and regulations, including an IHSS consumer's right to hire, fire, and supervise IHSS providers.[1]
3. Make personnel available to help inform, navigate, connect, and refer Members who are self-directing their care.
4. For Members with significant decline in health or functional status (e.g., Alzheimer's disease and related dementias), Plans will work with the Members, and/or their authorized representatives, as appropriate, to determine their current needs and interest in continuing to self-direct their care.

B. Basic Case Management Services

Basic case management services are provided by the primary care provider and/or care coordinator, in collaboration with the Plan. The complexity and breadth of these services will range according to the needs of the Member. Members may choose not to receive any case management.

Plans will submit policies and procedures that show their ability to provide basic and complex case management, as described below, and in accordance with their Models of Care:

Basic case management services may include:

1. Clinical information from the provider, such as history/physical and progress notes.
2. Completion of a Health Risk Assessment (HRA).
3. Creation of an Individual Care Plan (ICP).
4. Identification and referral to appropriate providers and facilities (such as medical, rehabilitation, support services, LTSS, and behavioral health) to meet Member care needs.
5. Direct communication with the Member and the Member's providers and family.
6. Member and family education, including healthy lifestyle changes when warranted.
7. Coordination of services outside the health plan, such as referral to appropriate community social services or specialty mental health or Drug Medi-Cal services.

C. Complex Case Management

Plans will develop methods to identify Members who may benefit from complex case management services, using utilization, clinical, and any other available data across the medical, LTSS and behavioral health domains, as well as self and physician referrals.

Complex Case Management services will include:

[1] Plans should consult with the California Department of Social Services (CDSS) and DHCS to confirm policies are consistent with IHSS statute and regulations.

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 maintains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline, and avoids institutionalization, when possible and appropriate.
4. With Member, ICT, and PCP input, development of ICPs specific to individual needs and updating of these plans at least annually or if a significant change in condition occurs.

D. Coordinating care management with external organizations

For Members who receive services through external county agencies or community-based organizations, Plans will provide evidence of policies and procedures for care management that include the following:

1. Agreements with the county social service agency regarding the coordination of care management for IHSS recipients. These agreements will be developed jointly with the respective agency and, at a minimum, include: a comprehensive, inclusive communications process between the Plan and county; data sharing protocols; the role and purpose of the ICP, metrics indicating levels of risk (prioritization); composition and leadership of the Interdisciplinary Care Team (ICT) with input from the Member; how documentation and data will be recorded and stored; procedures for follow-up and monitoring of cases.

2. Agreements with the county Mental Health Plans and departments responsible for drug and alcohol services regarding care coordination for Members receiving behavioral health services through the county or county-contracted providers. These agreements will be developed jointly with the respective agency and, at a minimum, include: a comprehensive, inclusive communications process between the Plan and county; data sharing protocols; the role and purpose of the ICP, metrics indicating levels of risk (prioritization); composition and leadership of the ICT with input from the Member; how documentation and data will be recorded and stored; procedures for follow-up and monitoring of cases.

3. Contracts with MSSP organizations that include processes for referrals, assessment, eligibility determination, services delivery and delineation of roles and responsibilities for care management.

4. Care management provisions for nursing facility residents that monitor nursing facility utilization and develop care transition plans and programs to move

beneficiaries back into the community to the extent possible (SB 1008). Specifically, Plans will:

a. Work to identify, in consultation with the MDS 3.0 Section Q, individuals who have expressed an interest in returning to the community and coordinate with the California Community Transitions/Money Follows the Person local lead entities to facilitate the Member transition to the community, where desired.

5. 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 will have a process for developing a corrective action plan, with specified timelines, for any out of compliance findings as a result of the annual review, analysis, and evaluation.

a. In cases where Members are using county-provided social services or behavioral health services, plans will coordinate this review process with the respective county agency.

2. Planning for Care Transitions

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

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

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

Minimum criteria for a care transitions planning checklist (SPD contract requirements):

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 or functional status by dual-eligible Member or a representative of the

dual-eligible Member as applicable, physical and mental health status, 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 will 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 substance use services, plan will have procedures developed jointly with the county agencies for:
   1. Notification of the ICT of hospital admission (psychiatric or acute) and coordinating a discharge plan, if applicable.
   2. 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.

REASSESSMENT AND REVIEW

DHCS proposes the following provisions regarding reassessment:

1. Plans will conduct an annual comprehensive reassessment for the individual care plan (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 will be conducted in person or in the setting of the Member's choice for higher-risk group and nursing facility residents (D-SNP).

a. For IHSS recipients, upon the recipient's request and when feasible, plan reassessments may be conducted in conjunction with in person, in home, county IHSS reassessments.

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

2. Plans will regularly use electronic health records and claims data (including IHSS, other LTSS 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.

3. Plans will 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 county mental health plans and alcohol and drug departments, county social service agencies, and other entities as necessary to develop these processes.

RESPONSIBILITIES AND QUALIFICATIONS OF CARE COORDINATOR

Plans will 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 will have substantial training regarding medical, LTSS, and behavioral health services.

2. Depending on 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 specialty mental health or chronic substance use disorder 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. Enhanced self-management training and support
j. Frequent Member contact
k. Set up the ICT
l. Case rounds and ICT meetings as needed
m. Refer beneficiaries to community resources or other agencies for needed medical or social services or items outside the Plan's responsibilities, in cooperation with the respective agencies (SB 1008)[2]
n. Facilitate communication among a Member's medical care, LTSS and behavioral health providers when appropriate (SB 1008).
o. 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. (SB 1008)
p. 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. (SB 1008)

INTERDISCIPLINARY CARE TEAM (ICT)

Plans will comply with the with following requirements regarding ICTs:

1. Plans will have the ability to facilitate and support an ICT to coordinate the delivery of services and benefits as needed for each Member. Plans will make the initial determination of which Members need an ICT, although every Member will have access to an ICT if requested.

2. 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, MSSP, and NF providers to stabilize medical conditions, increase compliance with care plans, maintain functional status, and meet individual Members' care plan goals.

3. The ICT will be led by professionally knowledgeable and credentialed personnel such as physicians, nurses, social workers, restorative therapists, pharmacists, psychologists. (D-SNP)

[2] 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.

4. The membership of the ICT will include the Member and/or authorized representative if willing or able to participate, PCP, Plan care coordinator, 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.
    i. Other professionals as appropriate.

5. Plans will support multiple levels of interdisciplinary communication and coordination, such as individual consultations among providers, county agencies, and Members. (D-SNP)

6. Plans will have procedures for notifying the ICT of hospital admission (psychiatric or acute), and coordinating a discharge plan, if applicable.

7. Plans will not require a Member to participate in an ICT if that Member objects. (SB 1008)

8. Plans will adhere to a Member's determination about the appropriate involvement of his or her medical providers and caregivers, according to HIPAA and, for patients in substance use disorder treatment, CFR 42, Part 2.

SUBCONTRACTS

Plans will be required to comply with the following provisions regarding subcontracts for assessment and care coordination:

1. The Plan will 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 will 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. Consulted with the county mental health plan and/or department responsible for drug and alcohol services regarding the scope of the subcontractor duties related to behavioral health 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 using county behavioral health services.
iv. Submitted such contract to DHCS MMCD for review and approval in accordance with the terms of the contract with DHCS;
v. 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;
vi. 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.
vii. 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 will provide either a single entity as a point of contact for the county social service and behavioral health agency, or jointly develop an alternative process with the county social service and behavioral health agency.

PLAN REPORTING REQUIREMENTS

Plans will report to Medi-Cal Managed Care Division within 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 health risk assessment and the number who declined the health risk assessment.

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

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

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 management are for health plans to achieve an optimal level of wellness for members, improving care coordination, and resource management/cost containment.

Basic Case Management: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a Member's health and functional 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 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.

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.

Care Coordinator: A clinician or other trained individual employed or contracted by the Primary Care Provider or the Participating Plan who is accountable for providing care coordination services, which include assuring appropriate referrals and timely two-way transmission of useful patient information; obtaining reliable and timely information about services other than those provided by the primary care provider; participating in the initial assessment; and supporting safe transitions in care for enrollees moving between settings. The Care Coordinator serves on one or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each enrollee on whose ICT he or she serves.

Health Risk Assessment (HRA): A risk-assessment survey tool that will 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.

Individualized Care Plan - The plan of care developed by an enrollee and an enrollee's Interdisciplinary Care Team or health plan**.**

Interdisciplinary Care Team (ICT): A team of primary care provider and Care Coordinator, and other providers at the discretion of the enrollee that work with the enrollee to develop, implement, and maintain the Individualized Care Plan.

Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities**.** As described in California Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following:

1) In-Home Supportive Services (IHSS) provided pursuant to Article 7 of California Welfare and Institutions Code (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.)
2) Community-Based Adult Services (CBAS)
3) Multipurpose Senior Services Program (MSSP) services
4) Skilled nursing facility services and subacute care services

Medical Home: A place where a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home will include at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards as set forth in W&I Code 14182(c)(13)(B).

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/Provider (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, obstetrician/gynecologist (OB/GYN) or geriatrician. A PCP may also be a nurse practitioner, physician's assistant, specialist or clinic.

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.

Self-Directed Care: Includes the ability for Members to:

- Decide whether, how and what long-term services and supports to receive to maintain independence and quality of life, as authorized by a physician or other appropriate medical professional, if the participant is an IHSS recipient, and within state rules.
- Select their health care providers in the health plan network (or as allowed for by continuity of care provisions) and control care planning and coordination with their health care providers.
- Have access to services that are culturally, linguistically, and operationally sensitive to meet their needs, and that improve their health outcomes, enhance independence, and promote living in home and community settings.
- Be able to hire, fire, and supervise their IHSS provider, as currently allowed in California's IHSS program.

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:

- 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;
- Psychiatric inpatient hospital services;
- Targeted Case Management.

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

1. A provider of health care services who agrees to furnish Covered Services to Members.
2. 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.