NSCLC
National Senior Citizens Law Center
PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

April 30, 2013

Department of Health Care Services
Delivered via email to: info@calduals.org

Re: Comments on Health Risk Assessment Health Plan Guidance

The National Senior Citizens Law Center submits these comments with regard to the Health Plan Guidance for "In-Person, Telephone, and Mailing Standards for Health Risk Assessments"(hereinafter, "Guidance") the Department of Health Care Services released on April 16, 2013, for comment.

As an initial matter, we note that the MOU requires this guidance to be finalized by April 30, 2013 after a 14 day public comment period. By not releasing the draft for comment until April 16, 2013, we question whether DHCS has allowed enough time to actually consider the comments provided by NSCLC and other organizations. We hope that future policies and procedures that are essential to the successful implementation of Cal MediConnect are also shared for public comment, but under timelines that allow for careful consideration of those comments.

Health Risk Assessment Tool

HRA Tool Development

We understand that the assessment tool to be utilized for the Health Risk Assessment (HRA) is currently still in development. When describing the tool, the Guidance explains that the HRA's goal is to provide an ***in-depth*** assessment to "identify primary, acute, long-term supports and services, and behavioral health and functional needs" and that the HRA will "incorporate standard assessment questions, such as SF-12..." (Guidance, p. 1). Conversely, DHCS has verbally indicated that the HRA will serve as a ***high-level*** screening tool accompanied by later administered in-depth assessments. Regardless of whether the HRA serves as an in-depth or high-level screening tool, we urge DHCS to develop a tool that can identify actual health-related needs. The SF-12 and VR-12 were developed and are primarily used to monitor quality of care provided by plans, for estimating health status and disease burden to determine risk adjustments, and to compare disease burden among different populations. These tools were not developed to determine what needs an enrollee has, but rather as a tool to compare outcomes. In fact, these surveys entirely fail to address long-term supports and services.

If the only goal of the HRA is to verify that enrollees have been placed in the proper risk stratification category, higher versus lower, then the SF-12 may likely suffice for this purpose. If, however, the HRA is intended to screen for health care needs and assist in the development of a person-centered plan as contemplated by the MOU, then DHCS must develop a tool that incorporates questions that identify specific health care needs, including long-term supports and services, and inventories an enrollee's individual needs, strengths, preferences and goals. The enrollee's subjective perspective is vital in assuring a comprehensive assessment to support a person-centered plan.

Purpose

The purpose of the HRA should be limited to screening for and identifying health care needs. The assessment should not be utilized by the health care plans to subsequently deny or refuse services. Health plans should develop additional assessment processes to determine eligibility for specific health care services, which include consultation with the enrollees' health care providers and care plan team. Most importantly, the health plan's provision of services should not be contingent on the completion of the HRA. In other words, the health plan should not be able to deny an enrollee services because an HRA has not been completed.

Consistency

We also believe that the assessment tool that DHCS ultimately develops should be uniformly adopted by the health care plans. The use of a universal tool across plans facilitates consistency and the validity of the assessment. Furthermore, a universal assessment allows for a more streamlined and efficient means of administering the assessment. For the same reasons, the HRA tool should be utilized for enrollees in the Coordinated Care Initiative overall, not exclusively for enrollees in Cal MediConnect.

Accessibility

The HRA tool should be written at no more than a sixth-grade reading level and should be available in accessible formats and in the different threshold languages outlined in the MOU. The Guidance should advise the plans that they are required to conduct the assessment in alternative formats that are culturally, linguistically, and physically appropriate.

Health Plan Guidance for In-Person, Telephone and Mailing Standards

Telephone Contacts

Under both the high-risk and low-risk procedure, plans first attempt to contact an enrollee by telephone to complete the HRA by either an in-person meeting or by telephone. The Guidance outlines how many times the plans must attempt to contact the enrollee by telephone. We believe the Guidance should also advise plans that attempts to contact an enrollee should take place at different times on different days to maximize the probability that an enrollee will be contacted by phone.

Enrollee Contact

The Guidance does not address what happens when an enrollee is not capable of completing the HRA. Likewise, the Guidance does not address situations in which a caregiver or family member should assist with completion of an HRA, as for example, when an enrollee has a diagnosis of dementia. In situations where an enrollee has a guardian or is otherwise incapable of completing the HRA, health plans should have guidance on what procedures to take to contact caregivers, family members or other designated parties while ensuring compliance with HIPAA and other privacy rules and regulations. Plans should also be provided guidance on how to obtain permission from an enrollee to complete the HRA with an individual other than the enrollee. Such a process would ensure that the HRA is truly an effective tool in assessing an enrollee's health care needs rather than just a hollow requirement.

In-Person Assessments

The Guidance emphasizes that enrollees will be informed that they have the right to an in-person assessment at every contact, including contact by telephone and by mail. We applaud the inclusion and emphasis on this right. In most circumstances, in-person assessments will provide valuable information that may not be apparent through a telephone assessment or mail assessment. Providing assessments telephonically has repeatedly proven to be an ineffective means of assessing health and managing care.[1] Plans should emphasize to enrollees their right to an in-person assessment at a location most convenient to them and why an in-person assessment is preferable. At the same time, plans should ensure that enrollees understand that they have the choice to complete the assessment by telephone and mail. Ultimately, plans should strive to obtain in-person assessments while affording enrollees with maximum choice in the process.

We appreciate that we were given the opportunity to review the Guidance prior to its finalization. We look forward to continued participation in this process and once the HRA tool has been developed, we urge DHCS to share the tool with stakeholders for comment.

Sincerely,

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[1] See, for example, Ezra Klein, *If this was a pill, you'd do anything to get it*, Washington Post, Wonk Blog, April 28, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/04/28/if-this-was-a-pill-youd-do-anything-to-get-it/