Health Risk Assessment: Comments

Organization: The SCAN Foundation
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1	Introduction	"…health plans will be required to stratify their newly enrolled population into the High-Risk and the Low-Risk."	We recommend that this statement be clarified. If this is an activity that is to occur prior to the conduct of the Health Risk Assessment (HRA) (as described in the Care Coordination Standards draft document), please describe how plans are to conduct this risk stratification and what data will be available to plans to conduct the risk stratification over what time period. According to this draft guidance, plans are to begin on day one of enrollment to attempt completion of the HRA. If data cannot be shared with the plans prior to enrollment, please clarify how risk stratification can be completed prior to enrollment.
1	Overview of HRAs in the CCI MOU	…the HRA will be the starting point for developing the enrollee's individual care plan. This tool will serve as the basis for further assessment needs that may include, but are not limited to, mental health, substance abuse, chronic physical conditions, incapacity in key activities of daily living, dementia, cognitive status, and the capacity to make informed decisions. -Participating plans will provide enrollees with an in-depth assessment process to identify primary, acute, long-term supports and services, and behavioral health	We recommend that the purpose(s) of the HRA be clarified. For example, it is not clear if the HRA is envisioned as a screening tool to assess relative risk level, or whether it is envisioned that the HRA documents an individual's range of health and functional needs to be used in developing a plan-of-care. DHCS has indicated that the HRA is more of an initial health screening tool and a "starting point for developing the enrollee's individual care plan" for "an in-depth assessment process." Yet, it is not clear the extent to which this is part of the initial HRA process and what specifically will be required of plans outside of the HRA process. This document implies that there will be other assessments completed based on need identified in the HRA. If this is the intent, we recommend it be made explicit, with requirements specified. We recommend that the HRA be focused solely on identifying risk level across medical and functional domains. Health plans be required to conduct more in-depth universal assessment to

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		and functional needs. This assessment will incorporate standard assessment questions, such as SF-12, as specified by the state.	document need for long-term services and supports. This universal assessment should be developed and use uniformly by all health plans.
1	Overview Standardized HRA or common data elements	Plans are required to use an HRA survey tool that has been approved by the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS)...this assessment will incorporate standard assessment questions, such as the SF-12, as specified by the State.	Based on a recent stakeholder call (April 23rd, 2013), the state reported that it has not determined whether to require a single, standardized HRA tool across plans or require that plans use common set of core questions. Regardless of the tool employed, it is critical that a standardized, core set of measures be required in the HRA across plans to document both health and functional needs in order to ensure that similar individuals across plans are evaluated at the start of the care planning process using similar measures.
1	Overview: SF-12	This assessment will incorporate standard assessment questions, such as SF-12, as specified by the state.	The SF-12 (now called the VR-12) is not an adequate tool to use in identifying risk in the dual eligible population, particularly those with functional impairments. This item set has been demonstrated to be useful as a risk adjuster for mortality and widely used in outcomes measurement for clinical trials. However it is not a sufficiently sensitive instrument for detecting differences on a person level in a highly vulnerable population. Therefore, we recommend that the state clarify its intent for using this tool given it may not adequately differentiate risk in the population for outcomes of interest. The state may want to consider however, its value in measuring change in risk in the population overall over time, assuming these data will be reported by health plans to the state.

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N/A	HRA completion across modalities		The enrollee will have the ability to choose the modality with which the HRA will be completed (in-person, by phone, or in writing). We recommend that HRA items required by the state for all plans to use be valid and reliable across modalities, to increase confidence that the responses provided are an accurate reflection of the enrollee's actual need regardless of how the HRA was completed. This is particularly critical for items that measure functional status.
N/A	HRA data collection		The state has not indicated the extent to which the HRA data captured by the plans will be collected by the state. We recommend that the state collect and analyze the HRA data over time to understand the needs of the population. Further, this data can be potentially used for further case mix adjustment of rates and used in evaluations of quality of care and evaluation of the overall demonstration.
N/A	HRA process oversight		We recommend that the state specify how it will monitor the HRA implementation process across plans to ensure consistency in application and use of HRAs for care planning purposes.
N/A	Training standards		The state has not specified what training standards, if any, will be required for individuals conducting the HRA. We recommend that training requirements be specified, with minimum standards including cultural sensitivity training, needs of individuals with functional impairment, and how to screen for cognitive and functional needs.

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N/A	Language Requirements/ Accessibility		We recommend that, at a minimum, the HRA be translated into the major threshold languages in each participating county. Interpreters should be available for enrollees completing the HRA by phone or in person, particularly for those individuals who are unable to read their primary language. Those completing the HRA in writing should receive the HRA in the language of their choosing. Further, those who have visual or hearing impairments, appropriate modifications in the administration of the HRA should be employed to accommodate the enrollee. We further recommend that the guidance issued on the HRA detail how and when alternate languages and formats will be used, depending on setting of HRA completion (e.g., in person, by phone, or in writing).
3, 6	In-person HRA		We recommend that the HRA guidance outline the requirements for completing the HRA in-person. The guidance should explicitly state that for those individuals who agree to an in-person HRA, the HRA should be conducted in the setting of the enrollee's choosing. This could be their home, their provider's office/clinic, or some other setting that the individual deems acceptable. Page 6 states that that low-risk, dual eligible beneficiaries have the option of completing the HRA in person. However, "Step One" in the process describes completing the HRA by telephone. We recommend that "Step One" describe the in-person option and "Step Two" describe the option of completing the HRA by telephone.

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N/A	Reassessment of Need		The HRA process specifies how individuals who are enrolling in Cal MediConnect will be assessed for relative risk level. However, it is unclear how individuals will be re-assessed for risk level after enrollment in the plan and prior to completion of the annual HRA. For example, if an individual falls in the low-risk category upon enrollment, it is very likely that his/her situation could change within a few months' time period and end up in a higher risk category, signaling a need for a new plan of care. We recommend that the state specify how risk will be reassessed for enrollees after the initial HRA process and prior to completion of the annual HRA.
N/A	N/A		The draft guidance released by the state provides no instruction for how proxy response should be treated when completing the HRA. We recommend that the state make explicit when it is appropriate for proxy respondents to be used and who they should be in relation to the enrollee. If this state delegates this responsibility to the health plans, the state should also make this determination explicit.