DHCS Care Coordination Project: MCP Assessment of Risk and Need

Background

Medi-Cal requires managed care health plans (MCPs) apply a DHCS approved health risk stratification mechanism or algorithm and assessment to identify newly enrolled Seniors and Persons with Disabilities (SPD) beneficiaries who have higher risk and more complex health care needs. There is a similar risk stratification and assessment process required for California Children Services (CCS) beneficiaries, enrolled in Whole Child Model counties. However, there is not an overarching requirement by DHCS for plans to conduct a risk stratification and assessment process for all MCP beneficiaries to identify risk and need, other than the minimal basic and complex case management requirements of the contract.

Within the Case Management and Coordination of Care section of the MCP contract, DHCS outlines a number of required health assessments, screenings, and required linkages to other delivery systems for applicable beneficiaries. Medi-Cal beneficiary health assessments are important for care coordination, but the current structure of assessments has inefficiencies that inhibit the quality of care. In many cases, these plan and provider assessment and screening requirements were layered upon each other over time without a comprehensive design structure, which results in gaps and redundancy. This is in addition to assessments being conducted in other delivery systems such as Mental Health, Substance Use Disorder, Dental, Long-Term Supports and Services, Regional Centers, etc. The DHCS care coordination project provides an opportunity to redesign a more efficient and comprehensive structure of assessment for all Medi-Cal managed care members, and to tie the MCP assessment to risk stratification that drives appropriate health care actions. The guiding principle is to provide only the right assessment questions to the right people, at the right time, in the right method. Current MCP assessment requirements are listed in the “Additional Information” section below. The focus of this discussion document is the MCP Risk Assessment Process. There will be a separate discussion for preventive services and clinical screenings.

Framing the Issue

In general, feedback from stakeholders is that DHCS should redesign assessment requirements as one part of a comprehensive care coordination structure, which will

reduce gaps and redundancy by accounting for all scenarios as part of one design process. As part of this structure, specific information sources and criteria, such as the enrollment of a new MCP member or change in condition, should trigger a risk assessment (and stratification). The results of the assessment/stratification determine specific follow-up actions, including linkage to additional care coordination services. Additional stakeholder feedback is noted below:

- The following assessments/processes (bulleted below) should be replaced with a single standardized risk stratification process, which includes assessment of risk and need for all members:
    - Initial Health Assessment (IHA) and the included Staying Healthy Assessment-Individual Health Education Behavioral Assessment (SHA-IHEBA)
    - Health Information Form/Member Evaluation Tool (HIF-MET)
    - Health Risk Stratification and Assessment (HRA) Survey for SPDs
- Regarding the assessments listed above, the elements that are more appropriate to be delivered in the clinical setting (provider focused clinical screenings, etc.) should be accounted for in the overall care coordination structure, but, to avoid redundancy, these do not need to be addressed through MCP Risk Stratification requirements or a separate additional Medi-Cal provider assessment like the IHA and SHA-IHEABA.
- Some assessment questions are not scientifically validated and evidence-based. The SHA-IHEBA is an example.
- Assessment requirements should not be targeted based on aid code, such as requiring the HRA process only for SPDs.
- In some cases, the method of administration of assessments is inappropriate or ineffective.
- MCPs need to assess risk to ensure appropriate services and resources are made available to the member. A provider is conducting preventive screenings and/or diagnosing and treating an illness. The MCP risk assessment questions should be appropriate for this task, and many other issues should be addressed 1) only at the provider level, and 2) when the provider has a strategy at hand to address any needs indicated by the response.
- The initial MCP risk assessment information should be captured in an electronic format that can be shared with DHCS.
- Align with NCQA methods and tools for assessments and screenings where possible.

<u>Additional Information</u>

- **Assessment and Screening Background Chart**:
  This chart provides summary information on several Medi-Cal assessments and screenings. See attached chart.
- **CFR Title 42 § 438.208 (b)(3) Final Rule Language Regarding Assessment**:
  "*Each MCO, PIHP, and PAHP must provide that the MCO, PIHP or PAHP makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.*"

- **Partnership Health Plan Care Coordination Assessment Library Document**: This document provides an overview of several Medi-Cal assessments, including the applicable population, timing, what entity requires the assessment, the purpose, and content. See attached document.

Discussion Questions.

1. What are the pros and cons, and issues we should consider, for developing a single, uniform, initial MCP-level risk assessment process for new MCP enrollees that would allow for the elimination of the current IHA, SHA-IHEBA, HIF-MET Tool and HRA? (For this question, assume that 1) only questions appropriate for an MCP-level assessment of risk would occur, 2) other necessary clinical screenings and actions would occur in appropriate settings thereafter, and 3) plans would shift from monitoring IHA/IHEBA assessment completion to monitoring the completion of actual preventive services and that the member received the right resources.)
2. Other states consider the items listed below for their MCP risk assessment process. Is this list comprehensive?
    a. Behavioral, developmental, physical, and oral health needs (including preventive care services, medical services, continuity of care, an evaluation of the need for supportive services, and referrals to specialist and community resources based on evidence of unmet care needs);
    b. Current medications and adherence to medications as prescribed;
    c. Ability to function independently and organize his/her own health needs;
    d. Long Term Services and Supports (LTSS);
    e. Circle of support/caregiver;
    f. Assistance with activities of daily living;
    g. Use of community-based services and supports;
    h. Social determinants of health (including housing and housing instability, social or geographical isolation, access to basic needs such as food, clothing, household goods, health literacy and cultural and linguistic needs, and access to private transportation).
3. What types of data should be used for the MCP risk assessment process? Is the list below comprehensive?
    a. MCP administrative data, previous screening or assessment data
    b. Claims or encounter data (including all fee-for-service and encounter data provided by DHCS)
    c. Pharmacy data
    d. Laboratory data
    e. Electronic health records, and
    f. Results of contractor predictive modeling or specific algorithms, and member-provided survey information (to the extent the MCP is successful in making contact with the member as part of the initial risk assessment).
4. For the portion of the initial MCP risk assessment that requires member-provided information, are all of the following appropriate survey methods, and are there other options: phone, in-person, completed electronically online or via mailed

survey? (For this question, assume the survey information will be transposed into electronic format that allows for data mining of field input.)

5. What data elements of the initial MCP risk assessment information should shareable in an electronic format?
6. How can the MCP use a Population Health Management strategy and risk stratification to identify populations and subpopulations to ensure the right people are getting the appropriate level of resources based on data and need, as opposed to targeting services by aid code?
7. Assuming medium/high risk members will be regularly assessed for risk through assigned case/care management program; how often should the MCP reassess no/low risk members, and based on what triggers or changes in condition?