CHCS Center for Health Care Strategies, Inc.

Using Initial Health Screens to Identify New Medicaid Beneficiaries with Care Management Needs

Technical Assistance Brief — September 2009

States enrolling aged, blind and/or disabled or Supplemental Security Income populations (ABD/SSI) into Medicaid managed care programs are challenged to quickly identify newly enrolled beneficiaries who may have immediate clinical and psychosocial needs. Promptly linking new patients with needed care management can help reduce exacerbations of chronic conditions and avoid potential costs related to unnecessary emergency department visits or hospital stays.

A variety of strategies can be used by states or their designated health plan/enrollment broker to identify the health needs of newly enrolled beneficiaries, including: referrals from a provider or specialist, a beneficiary's own self-identification, prior claims data, or initial health screens. Traditionally, most states rely on a comprehensive clinical assessment that is conducted during the first visit with a physician or care manager. However, the potential gap in time (e.g., 90-120 days) between enrollment and this assessment often results in missed opportunities to identify beneficiaries with pressing health and care coordination needs.

To address this time lag and focus resources more efficiently, states are increasingly using initial health screens. Initial health screens are *non-clinical* assessments in contrast to in-depth clinical assessments (sidebar). After key or urgent needs have been identified, the state may choose to implement a clinical assessment to more completely understand an individual's needs, prioritize risk levels, and connect them to services that will best meet those needs. Nonetheless, the information about a beneficiary provided by an initial health screen can be invaluable in directing early care coordination efforts upon enrollment.

With funding from the California HealthCare Foundation, the Center for Health Care Strategies (CHCS) surveyed 13 states that enroll the ABD/SSI population in Medicaid managed care to explore the use of initial health screens. This resulting technical assistance brief addresses key considerations for states in developing an initial health screening process.

Initial Health Screens vs. Clinical Assessments

Based on CHCS' work with states, below are descriptions of these two screening tools:

Initial Health Screen: Provide a high-level initial assessment of new beneficiaries to identify immediate care management needs. Screens are typically short in length and are conducted by non-clinical staff at the time of enrollment.

Clinical Assessments: Gather in-depth clinical information about beneficiaries that can be used to identify and prioritize longer-term care management needs. These tools, also referred to as comprehensive health needs assessments or health risk assessments, are designed to be completed by care management staff or the beneficiary's physician during his/her first office visit.

Considerations for States in Designing an Initial Health Screen

1. What is the goal of the initial health screen?

States generally design initial health screening tools to identify immediate or ongoing care management needs of newly enrolled beneficiaries. Nine of the states surveyed used screens for this purpose. These tools can also be used to uncover beneficiary information for additional purposes. For example, surveyed states also use initial health screens to:

- Provide health plans with information about new beneficiaries' needs;
- Track changes in beneficiaries' health over time;
- Identify primary languages spoken by beneficiaries as well as alternative contact information; and
- Assign beneficiaries to the appropriate risk level/category to guide interventions.

Determining the specific goal of the initial health screen is a critical first step to guide states in designing an effective screening tool and implementation process.

2. Should all new beneficiaries be screened or only a higher-risk subset?

States implementing an initial health screen can choose to: (1) screen all new beneficiaries; (2) screen only certain eligibility groups (e.g., TANF beneficiaries, SSI beneficiaries, etc.); or (3) screen only beneficiaries who meet certain clinical and/or psychosocial criteria. Many states conduct initial health screens on all new beneficiaries regardless of eligibility group. Since there is a cost incurred with every screen, however, the decision to screen all eligibility groups or a subset thereof may be influenced by available resources. To use resources efficiently, states may opt to target a subset of beneficiaries for screening, e.g., by mining previous fee-for-service utilization data if available or using an algorithm to identify beneficiaries who have a greater likelihood of care management needs.

3. Who should administer the screen?

States can select one or a combination of the following approaches to administer the health screen: (1) enrollment broker; (2) health plan staff; (3) state or county employees; and/or (4) beneficiary (see Figure 1 for state examples). The potential cost and resources will differ depending on which option(s) a state chooses, with benefits and trade-offs for each. For example, it may cost less to use a self-administered screen than it would to contract with an enrollment broker to administer the screen. However, a state that decides to implement self-administered health screens may be concerned with a low response rate and the resulting staff time and financial costs that may be incurred in following up with beneficiaries.

Figure 1. State Examples: Administration of Initial Health Screens

STATE	Enrollment Broker	Health Plan Staff	Self-Administered	Combination Approach
	PA, TX, VA	MN	IN	MD (self-administered or health plan) NY (enrollment broker or local social service departments) OH (enrollment broker or health plan staff)

4. Should the screen be updated periodically?

Updating patient-specific information is particularly critical to help guide appropriate care management for beneficiaries with disabilities and chronic conditions. Whether it is the state or health plan that periodically updates health screens, a consistent feedback loop can help ensure that important information is integrated into the beneficiary's health record and shared among key players to facilitate proper care management.

If annual updates of health screens are too resource intensive, states could consider re-screening beneficiaries who have a trigger event, e.g., a new diagnosis, emergency room visit, hospitalization, exacerbation of a chronic condition, etc. For example, Indiana requires its care management organizations (CMOs) to update self-administered health screens annually and/or whenever there is a new diagnosis or exacerbation of a disease. To identify these trigger events, the state sends monthly claims data to its CMOs. Ohio and Texas allow their health plans to decide whether or not beneficiaries' health screens need updating, e.g., based on new contacts with the member, change in health status, etc.

5. What types of questions should be included on an initial health screen?

Questions on initial health screens range from basic information, such as the number of prescription medications a beneficiary uses to detailed information about health and functional status (see Figure 2). Most states surveyed use brief initial health screens that are up to two pages in length. Minnesota and Indiana use tools that are longer (four to five pages); Ohio and Pennsylvania ask two to four questions to establish a starting point.

Since it is difficult for states to address beneficiaries' needs without information about mental health and substance use issues, some initial screens may also cover behavioral health issues. To capture this type of information early on, Indiana, Maryland, Minnesota, and Ohio use initial health screens to inquire whether new beneficiaries are receiving treatment or counseling for mental health, substance abuse, or other behavioral health issues.

Similarly, questions about functional status can help pinpoint new beneficiaries with immediate care management needs. Functional assessment questions do not necessarily need to be asked by someone with a clinical background, thus can be added to an initial health assessment. Indiana, Minnesota, and Texas include questions regarding functional status and activities of daily living on initial health screen tools.

Figure 2. Sample Questions and Topics Used in Initial Health Screens[1]

Demographics

- What is the primary language used in your family?
- Are there any additional phone numbers that can be used to reach you?
- Do you anticipate moving from your present address in the next six months?
- Do you know the phone number to get help with Medicaid problems or questions?

Health Conditions

- Do you need to use medical care, mental health, home health, or other health services at least once every three months?
- Do you have any of the following conditions? If so, check all that apply: asthma, behavioral health needs, breathing problems, cancer, congestive heart failure, COPD, dementia, depression, digestive problems, epilepsy, heart disease, hepatitis B, hepatitis C, diabetes, high blood pressure, kidney failure, multiple sclerosis, quadriplegia, schizophrenia, HIV/AIDS, stroke.

PCP or Specialist(s)

- Do you have a primary care provider?
- Do you have a medical problem that requires one or more specialist doctors?

Self-Evaluation of Overall Health

- In general, compared to other people your age, would you say that your health is excellent, very good, good, fair, or poor?

Recent/Planned Health Service Use

- Do you have surgery planned for the future?
- Have you been admitted to the hospital or inpatient behavioral health facility in the past 3 months?
- Have you been seen in the emergency room in the past 3 months?
- Has your child or family member been in the hospital?

Mental Health/Substance Abuse Assessment

- Do you need or get treatment for any kind of mental health, substance abuse/alcohol, or emotional problem?
- Have you been consistently depressed or down most of the day or nearly every day for the past two weeks?

Pregnancy

- Are you currently pregnant? Are you seeing a doctor for this pregnancy?

Prescription Information

- Do you currently need or use medicine prescribed by a doctor (other than vitamins)?
- Are you taking any prescriptions that need to be filled?

6. *Can financial incentives be used to increase initial health screening rates?*

States may consider using incentive strategies with health plans or other outside vendors to encourage early assessments of new beneficiaries. For example, Indiana's CareSelect program uses incentives to motivate its CMOs to follow up with beneficiaries who have not completed a self-administered initial health screen. The state withholds 20 percent of a CMO's care management fee as part of its incentive program. CMOs can receive a performance payment equal to two percent of its care management fee if completed initial health screens are submitted for at least 70 percent of its beneficiaries by the end of the first quarter; 80 percent by the second quarter; 90 percent by the end of the third quarter; 95 percent by the end of the fourth quarter; and 95 percent every quarter thereafter.

Alternatives to Using a State-Developed Initial Health Screen

Depending on each state's unique environment, there could be several reasons (e.g., limited resources, health plans have established screening instruments, etc.) why a state may choose not to conduct an initial health screen on all new beneficiaries. Four of the surveyed states — Arizona, Florida, Michigan,[2] and Oklahoma — do not conduct state-level initial health screens. Following are alternative approaches from these four states as well as Wisconsin, which uses multiple screening approaches:

1. State specifies in its health plan contracts a minimum set of requirements that an initial health screen must address. Arizona and Wisconsin[3] created contract language for their health plans that specifies the key elements that must be included in an initial health screen. In both cases, the health plans are responsible for developing the format and process for implementing the screens. Both states require their health plans to ask beneficiaries about clinical and psychosocial conditions, functional ability, and social, environmental, and cultural factors. In addition to the state's required elements, health plans can also include additional questions.

> ***Excerpt from Arizona's health plan contract (section D):*** *Care planning is based on face-to-face discussion with the member and/or member representative that includes a systematic approach to the assessment of the member's strengths and needs in at least the following areas: functional abilities; medical conditions; behavioral health; social/environmental/cultural factors, and existing support system.*[4]

> ***Excerpt from Wisconsin's health plan contract (section 9):*** *The assessment shall be comprehensive and consistent with the following […] The assessment process shall address all of the following: Diagnoses and health related services; Mental health and substance use; Demographic information (including ethnicity, education, living situation/housing, legal status); Activities of daily living (including bathing, dressing, and eating); Instrumental activities of daily living (including medication management, money management, and transportation); Overnight care and employment; Communication and cognition (ability to communicate memory); Indirect supports (family, social, and community network); General health and life goals; Any other health-related domain identified by the Department.*[5]

2. State leaves the decision to use (or not use) an initial health screen up to its health plans. Florida and Michigan do not screen newly enrolled managed care beneficiaries. Health plans in these states are given the option to screen new beneficiaries, but screens are not monitored by the state. Both states responded that several of their health plans conduct assessments via outbound calls or mailed assessments to new beneficiaries.

3. State uses previous utilization history or other tools (i.e., predictive modeling) to identify subset of newly enrolled beneficiaries for screening. Oklahoma uses a predictive modeling tool to identify candidates for the state's Health Management Program, which is designed for the highest-risk, highest-cost beneficiaries. The state then conducts a clinical assessment for beneficiaries who have been identified as candidates for care management by the predictive modeling tool. Similarly, Florida's PCCM program does not use an initial health screen at the point of enrollment. Instead, historical claims data are used to determine beneficiary eligibility for appropriate care management.

Conclusion

As more states transition beneficiaries with complex needs out of fee-for-service into programs that manage their care more effectively, states need tools that can quickly identify the immediate care needs of newly enrolled beneficiaries. Although initial screens do not take the place of a comprehensive clinical assessment, these tools can uncover critical information to identify beneficiaries with care management needs upon enrollment and connect them to much-needed services. Intervening promptly to connect new beneficiaries with necessary care can help improve the quality of care received by beneficiaries, reduce exacerbations of chronic conditions, and ultimately, avoid costs related to unnecessary inpatient or emergency department visits.

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs.

Additional Resources

Samples of State Health Screens – Medicaid stakeholders interested in designing or revamping an initial health screening tool can visit CHCS' website at **www.chcs.org/initial_health_screens** to download a variety of sample tools.

Endnotes

[1] Sample questions are taken from the following states' survey tools: Indiana, Minnesota, Ohio, Texas, Virginia, and Wisconsin.
[2] Michigan is about to pursue its own research to better understand the types of initial health screens used by other Medicaid agencies.
[3] Wisconsin conducts initial health screens for beneficiaries in its Badger Care program (TANF program), but not for SSI beneficiaries in its managed care program. In mid-June 2009, the state launched an online health screen for its adults without dependent children program.
[4] Excerpt from Chapter 1600 case management policy 1620 case manager responsibilities Rev: 10/01/2007, 09/01/2005 Arizona Health Care Cost Containment System 1620-1 Rev: 02/01/2005, 10/01/2004. AHCCCS Medical Policy Manual.
[5] Excerpt from Wisconsin HMO SSI contract January 1, 2007 – December 31, 2007.