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Sent: Friday, November 16, 2018 9:16 AM
To: ASPE SES IMPACT Study (OS/ASPE)
Cc: Hollie.Wilson; Sarah.Harbin
Subject: ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors
Attachments: ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Good morning! Below are comments from Health Alliance in response to the ASPE RFI. The four bullet points below correspond with the bulleted items on the webpage at https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs-request-information. Thank you.

- **Identify beneficiaries with social risk factors**
  - o Comprehensive health assessments are completed with all beneficiaries engaged in care coordination, and social risk factors are taken into account when developing the plan of care. Beneficiaries are enrolled in care coordination based on high-risk diagnoses, predicted risk scores, provider referral, self-referral, multi-disciplinary team member referrals and proprietary identification and stratification methods. Utilization management nurses involved in reviewing medical records for coverage determinations may also refer beneficiaries to care coordination when social risk factors are identified.

- **Approaches plans and providers have used to address the needs of beneficiaries with social risk factors**
  - o When beneficiaries or providers alert the health plan about social risk factors, a multidisciplinary team of registered nurses, social workers, physicians, and pharmacists work together to identify community resources and/or covered benefits that may help minimize the impact of those risk factors. Face-to-face intervention efforts have been particularly successful, and these include providing care coordination program fliers with pictures of the nursing staff to patients while they are admitted in the hospital and completing home visits with high risk beneficiaries.
  - o From a cost and utilization perspective, a recent approach has involved evaluating the coverage criteria for home-based supports to see if the accessibility of intermittent skilled services can be increased. Another method reviewed the cost of potentially covering custodial care or non-emergency transportation for high risk members in care coordination programs, and this investigation is still

underway. For members with concomitant medical needs, revised preauthorization processes have resulted in a 40% reduction in wait times for medical necessity decisions to be reached.

- **Evidence regarding the impact of these approaches on quality outcomes and the total cost of care**
  - o Social risk factors can have a significant impact on physical and mental wellbeing, but it can be challenging to directly measure their impact on quality outcomes and health care costs. To work around the measurement limitations, the Medical Management leadership team reviews the effectiveness of care coordination efforts via monthly dashboards. These dashboards include a variety of data points, such as Medicare Stars performance, cost saving values assigned by care coordinators to respective interventions completed, the percentage of beneficiaries receiving preventive care, health care utilization patterns, readmission rates, and how the cost of care compares to benchmarks.
  - o Optimizations to the health plan's Medical Management program in 2017 resulted in several successes in 2018, including faster access to services for beneficiaries and 6% reduction in the medical loss ratio for the health plan.

- **Disentangle beneficiaries' social and medical risks and address each**
  - o Following Maslow's hierarchy of needs, the health plan care coordinators inquire about and immediately address social issues such as inadequate housing, lack of access to food, or risk of harm. These needs are assessed both at initial comprehensive assessment with the beneficiary as well as during follow up conversations with beneficiaries. The next stage of care planning involves gathering a detailed history of social risks and medical needs to critically evaluate the relationship between the two. A beneficiary-centric care plan is developed to address modifiable risk factors that are in alignment with beneficiaries' state of readiness for change. Care coordinators partner with providers and community agencies to wrap services around the beneficiaries and promote sustainable progress.

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