University of Maryland Health Advantage Comments for:
ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Dual-eligible elderly live at, or near, poverty levels, and therefore are more likely to be home bound, be socially isolated, have poor nutrition, require more social supports and be at risk of institutional level of care. These social factors contribute to the complexity of impacting clinical outcomes for chronic conditions with this subpopulation. The most prevalent chronic diagnoses among this vulnerable population are:

- Diabetes
- Heart disease
- Lung disease
- Mental illness or Alzheimer's disease

In identifying this vulnerable population there is specific focus on multiple domains including: claims data; medical records data including but not limited to pharmacy and lab results; beneficiary outreach, and assessments covering: medical, mental health, psychosocial, functional, cognitive and nutritional needs. During assessment and re-assessment, our clinicians will strive for cost savings by avoiding duplicative services and allowing the beneficiary to remain in the least restrictive environment, example-home versus nursing home.

University of Maryland Health Advantage's approach in identifying the most vulnerable beneficiaries utilizes a comprehensive Health Risk Assessment Tool (HRAT) which gathers information pertinent to a beneficiary's overall health status, as well as identify health risks in the following categories:

- Barriers: to meet the goals and /or comply with the individualized care plan
- Behavioral/Lifestyle: tobacco, alcohol and drug usage; physical activity, nutrition, and oral health
- Benefits/Coordination of Benefits: benefits available and level of understanding; work status; disability
- Cognitive Status: educational level, understanding of health conditions, and ability to follow self-management instructions regarding health; memory/thought processing issues
- Communication: language, visual or hearing limitations, preference or needs
- Cultural/Religious: complementary and alternative medicine utilized; any religious or cultural needs, preferences or limitations that may impact healthcare and/or the individualized care plan
- Functional Level: activities of daily living (ADLs), instrumental ADLs, history of falls; elimination, pain and sleep issues; DME usage/needs

- Health Status/Clinical History: General health history, co-morbidities, allergies, and treatment/surgical history
- Internal Care Management Process: member contact information; HIPAA considerations; consent for engagement/participation; marital status; living arrangement; Care Management status
- Life Planning: Healthcare power of attorney, advance directives, living will, life goals
- Preventative Health/Key Metrics: Sexual health, preventative screenings, and immunizations
- Psychosocial/Mental Health Status: Coping status; depressions/stress/anger; loneliness/risk for social isolation; family and social support
- Resources & Support: Caregiver resources/ level of involvement, external resources utilized
- Safety: health and personal well-being issues: safety concerns
- Utilization/ Treatment: Inpatient and Emergency Department (ED) utilizations, PCP and specialist utilization, current treatment plan and planned interventions

The care management application utilizes analytical tools identified in the complex case management data to proactively identify case management opportunities for those beneficiaries who will gain the greatest benefit from more intensive coordination of care. Regardless of opportunities identified, every dual eligible beneficiary is contacted to offer case management services due to the population's high vulnerability identified above. Once engaged, those beneficiaries that can be located, and/or consent to case management services, are engaged in the next steps for case management.

Beneficiaries, who consent to case management services, are further engaged to ensure they have input into the case management opportunities/barriers identified for the ongoing care plan agreement. Beneficiaries and the UMHA Case Manager also agree to the intensity of their care management support. Beneficiaries are sent a copy of the agreed upon care plan. The beneficiaries also agree to have their primary care physician (PCP) allow input into the care plan by having the completed document shared with them for their input. The beneficiary and/or health plan case manager agree to share this document for the PCP input. Sharing will occur via U.S. mail, follow up input to or from the PCP via telephonic notes and/or during the visit of the beneficiary with their PCP.

The intensity of case management contacts is based on the following definitions:

High Risk Members – Beneficiaries with high resource use and risk, including high frequency of visits, more than 3 hospitalizations or ED visits within three months, treatments, multiple co-morbid conditions, non-adherence with treatment, adults with special needs, and poly-pharmacy.

Medium Risk Members – Beneficiaries with a moderate resource use and risk, and a combination of the following: usually beneficiaries with limited number of co-morbidities (typically 3 or less),

1-2 visits to the ED or inpatient hospitalization within previous 90 days, and limited number of gaps in care.

Low Risk Members – Beneficiaries with a low resource use and risk, and a combination of the following: usually individuals with 2 or less co-morbidities, less than 2 ED visits or inpatient within the previous 90 days, and limited number or no gaps in care.

University of Maryland Health Advantage's Population Management programs for Asthma, Diabetes and Chronic Heart conditions take a population-based approach to the clinical and quality management of these conditions. This approach identifies individuals with chronic conditions, and through the use of disease-specific interventions, attempts to alter the course of the disease. Referrals may be received from a number of sources: University of Maryland Health Advantage staff, practitioners, facility staff, vendors, or self-referral by a beneficiary or caregiver. The Disease Management team works collaboratively with other clinicians and licensed professionals at University of Maryland Health Advantage to improve disease state outcomes and maximize individual member functioning.

All dual beneficiaries are referred to our Case Management program for assessment of their needs. Program components include mailed educational materials, provider education on evidence-based clinical guidelines, telephonic member education, and care coordination. The clinical basis for our program was established by using both the State of Maryland and University of Maryland Health Advantage guidelines for chronic conditions.

Dual-eligible beneficiaries are among the sickest and poorest individuals covered by Medicare and Medicaid. The dual-eligible beneficiaries living in our service areas reflect national data and to have significant medical, behavioral health, and social service needs. Past research has demonstrated that there is considerable diversity within the dual-eligible population in Maryland. This diversity has important implications for these beneficiaries' health spending especially between our target population; FBDEs and QMBs. About three-quarters of dual-eligibles are "full duals" and entitled to all Medicaid benefits, including long-term care services. In addition, Medicaid pays Medicare cost sharing for the FBDEs. The balance of dual-eligibles that are called partial duals such as the QMBs, they do not receive Medicaid benefits except for help with Medicare cost sharing. Dual-eligible beneficiaries are at greater risk for having more chronic conditions, mental illness, and impaired functional abilities putting them at greater risk for nursing home admissions as well as an increased utilization of emergency room, inpatient stays and readmissions. Within this dual population, there are vulnerable subpopulations that require additional services. These include frail beneficiaries having multiple, complex and/or chronic conditions, the disabled (both under 65 and over 65), those with end stage illnesses such as cardiovascular and respiratory, and beneficiaries near the end of life. Due to the specialized needs of this identified population there is a need to prioritize beneficiaries through stratification.

Dual-eligible beneficiaries who are under 65 tend to have a higher rate of serious physical, behavioral, or mental illness and have more comorbidities, are socially isolated, and are more

likely to have difficulty with permanent housing, and higher rate of substance abuse. Language barriers and deficits in health care knowledge of the beneficiary can be obstacles in providing the best care possible. All of these factors have an impact to the health outcomes of our DSNP population. Our multi-faceted clinical team (clinicians, special needs coordinators and social workers) assesses these potential obstacles and uses tools and resources to adjust in these situations. University of Maryland Health Advantage has implemented special provisions to accommodate the beneficiaries in their preferred communication method. Bilingual staff is available as well as a language line and TTY services to better communicate with beneficiaries and caregivers. Also, the staff are trained in using basic medical language to ensure that beneficiary understands the nature of the conversation. In addition, the following is a brief description of some of the specialized benefits which are available to our beneficiaries which are designed to meet the needs of, and improve health outcomes for our vulnerable members:

- Dental Services: Including but not limited to the following services: preventive care (such as cleaning, routine dental exams, and dental x-rays), emergency care visits, including X-rays, dentures, and oral surgery.
- Durable Medical Equipment: Including but not limited to such items as canes, wheelchairs, walkers, commodes, special beds, and monitoring equipment.
- Medical/Surgical Supplies: Including but not limited to items such as urinary catheters, wound dressings, glucose monitors, and diapers.
- Home Delivered Meals, post discharge: A value added benefit which includes preparing, packaging, and delivering meals to member homes during critical transitions of care.
- Home Health: All home health care services, including durable medical equipment (DME) associated with such services; part-time or intermittent skilled nursing care and home health services; physical, occupational, and speech language therapy; and medical social services.
- Transportation: Ambulance services for emergency and for non-emergent medical reasons to doctor appointments by taxi or car transportation
- Vision Care Services: Including the professional services needed for the purpose of diagnosing and treating all pathological conditions of the eye, including eye examinations, vision training, prescriptions, and glasses and contact lenses.
- Over-the-Counter products allowance
- 24/7 Nursing Hotline
- Annual Physical Exam

Due to the complexity of the population across multiple variables including demographic, social and disease burden parameters, University of Maryland Health Advantage places special emphasis on supporting the beneficiaries in the highest risk category exhibiting impactable behaviors that when changed, can support ongoing health and wellness.

University of Maryland Health Advantage has established partnerships with various community organizations that assist in identifying resources for the most vulnerable beneficiaries and/or their caregiver(s). Working closely with community partners and local health departments, our team is able to assist the vulnerable beneficiaries and/or their caregivers in accessing community

services and receiving additional support as needed. After identifying a service need, our team actively solicits, in person or by telephone, a relationship with a service agency if one is not already established. University of Maryland Health Advantage provides the beneficiary and/or caregivers with information including contact name and location. Appointment coordination and/or transportation assistance is also available through University of Maryland Health Advantage.

These established partnerships include, but are not limited to, the following agencies serving adults and seniors:

- Local health departments by county
- Adult day services
- Respite care
- Residential care
- Home delivered meals
- Homemaker services
- Adult companion services
- Transportation
- Health clinics
- Women's health
- Men's health
- Substance Abuse
- Mental health clinics
- Domestic violence
- Specialty health clinics (i.e. Asthma, HIV/AIDs)
- Specialized medical and supplies and office equipment
- Immunizations
- Cognitive development centers
- Senior community centers
- Transitional support services
- Family and caregiver training and education services

If there is already an established relationship between a beneficiary/caregiver(s) with a community resource or agency, the University of Maryland Health Advantage team ensures that relationship is maintained in order to facilitate continuity of care. Each beneficiary's case manager will reach out and coordinate contact information in order to ensure the lines of communication are established.