Generating ROI:

Through Integrated Medicare Advantage SDoH Advocacy

SDoH Identification • ICD-10 Documentation • Customization of Care

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Content

Our Mission

To improve lives and positively impact social determinants of health barriers by providing our healthcare partners with the information they need, and people with the advocacy they deserve.

Social Determinants of Health: A Growing Industry Concern

It's no secret that **Social Determinants of Health (SDoH)** play a major role in one's health outcomes and quality of life.

The complex circumstances in which individuals are born and live affect a wide range of health, functioning, and quality-of-life outcomes and risks.

We've all heard how SDoH represents 80% of an individual's health overall.

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SDoH Program ROI: Tying to Revenue Drivers

While everyone recognizes the importance of addressing SDoH barriers, to build a sustainable program we need to be able to show a quantifiable return on investment. But how do we measure and show a ROI?

One approach is to build an integrated SDoH advocacy program that includes wide-ranging SDoH barrier identification, advocacy, and SDoH work that ties directly to traditional revenue drivers.

In so doing, a Medicare Advantage (MA) plan can better serve members with one seamless conversation, and positively impact revenue drivers creating a sustainable program.

For instance, let's consider a 100k member MA plan that currently has 10% dual enrollment, and a dual disenrollment rate (pre-covid) of 18% annually. If the MA plan increases their dual penetration by just 3%, that will generate increased risk adjusted revenue of ***$5M over 3 years***. Additionally, if the dual disenrollment rate is lowered by only 3%, that would allow the plan to ***increase revenue by another $2M*** over the same period[2].

This increased revenue can be used to fund a larger SDoH program to help more members overcome challenges while improving health equity.

Finally, while a reduction in medical expense takes time to manifest, we know that helping members with SDoH barriers, such as social isolation, financial and food insecurity, transportation, and housing will ultimately save medical costs.

Combining these programs with initiatives to increase dual enrollment and Medicaid retention, provides an ROI that allows MA plans to fund outreach while measuring impact and cost savings.

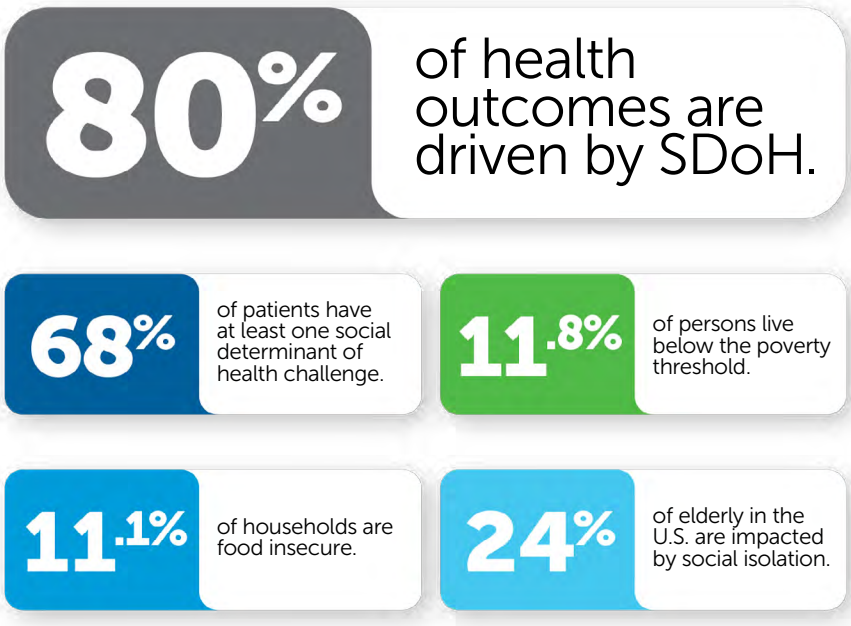

Figure 1

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Algorithms based on demographics can identify members with specific needs — tied to outreach programs enhanced by internal or external staff.

Identify:

Members in Need and the Barriers they Face

The first step in successfully combating SDoH barriers is to identify members who are most in need. Targeting specific populations and personas based on geographic demographics and other socio-economic characteristics is a great place to start for identifying those individuals most likely to qualify for specific benefit programs.

While identifying these members via technology -enabled processes, algorithms, and advanced statistical modeling techniques is surely a necessity, human-to-human contact is most essential.

Technology is important, but the most meaningful impacts are driven by an understanding of the member's "life story" as well as how they receive care.

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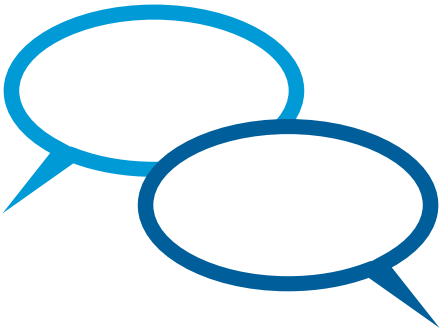

CMS stated that collection of information related to SDOH can better inform plans of enrollees' challenges and reduce barriers to optimal care and quality of life.[3]

Capture:

Barriers and Surface Solutions

Plans should consider developing a clear roadmap for capturing all SDoH barriers, relying heavily on the advocate's ability to flow the conversation organically according to information given by the member. A Health-Related Social Needs Screening Tool is a good starting point for an SDoH assessment.

"Leading with help" and deploying one dynamic conversation in which the advocate has the training and resources to be responsive as well as proactive in addressing what the member is concerned with, enables opportunities to address SDoH barriers that directly tie to revenue and quality drivers.

Creating scripted, concise, and effective SDoH Assessments helps to build trust with the member and enhances the Health Risk Assessment (HRA) completion process. Once barriers are captured, the advocate should be prepared to start addressing them by surfacing solutions in one call.

The identification and systematic capture of SDoH barriers is clearly a growing CMS priority. On May 9th CMS published its Final Rule for the Medicare 2023 Contract Year. In it, CMS took a significant step toward helping vulnerable Medicare members receive the help they need by mandating DSNPs to include SDoH barrier questions in the annual HRA. The writing is on the wall, and this initiative will likely expand from here.

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Common SDoH Barriers:

Food Insecurity

- 1 in 8 adults and 1 in 6 children are in households that are food insecure
- SNAP participation has been shown to reduce food insecurity by 30%
- More than 25% of people who are food insecure are not eligible for SNAP, and 18% of SNAP eligible people are not enrolled
- Annual healthcare costs for food-insecure adults were $1,834 higher than for food secure adults

Financial Insecurity

- In the United States, 1 in 10 people live in poverty
- 34.6% of families spent more than 30% of income on housing
- 29.4% of the working-age population aged 16 to 64 years were unemployed in 2018
- 11.8% of persons were living below the poverty threshold in 2018

Transportation[4]

- Each year, 3.6 million people in the United States do not obtain medical care due to transportation issues
- Transportation is the third most commonly cited barrier to accessing health services for older adults
- 65% of patients said transportation assistance would help with prescriptions fills after discharge

Social Isolation[5]

- Social relationships, or the relative lack thereof, constitute a major risk factor for health—rivaling the effect of cigarette smoking, blood pressure, blood lipids, and obesity
- Approximately one-quarter of Americans aged 65 and older are considered to be socially isolated
- Social isolation increases risk of dementia, stroke, and heart disease by 50%, 32%, and 29% respectively

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Integrate:

Dual Eligible Advocacy and Other Revenue Driving Services

Dual eligible advocacy – encompassing both creating new Medicaid/MSP enrollment and assisting existing dual MA members with annual renewals – represents a powerful opportunity to provide meaningful assistance to members, while generating a clear return on investment. The population of members who face SDoH barriers will inherently overlap significantly with the dual eligible/enrolled population.

By leading with help, our advocates at BeneLynk are able to start the conversation with a member by addressing the member's most immediate concern, and then evaluating opportunities to assist the member with new dual enrollment. In so doing, we cast a wider net, speaking to more members and identifying additional new dual enrollment opportunities.

Veteran Access to Care

Another example of a revenue driver that can be integrated into wider SDoH outreach is the identification of veterans, and specifically VA utilization in the MA population.

- 22% of Medicare Advantage members are veterans of the United States Armed Forces
- 5% of Medicare Advantage members use the VA for some of their healthcare needs[6]
- Veterans have access to services others do not. This presents both opportunities and challenges for MA plans

By documenting the care that these veterans receive outside of the MA network, plans can increase appropriate risk adjusted capitation and close quality gaps, creating a measurable ROI to support the broader SDoH program.

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Document:

Barriers with ICD-10 Z Codes

Care teams document SDoH data by using ICD-10-CM codes ("Z codes"). Z codes became available in fiscal year 2016; however, their adoption has been slow. CMS reports that Z codes were used for 1.6% of Medicare FFS beneficiaries in 2019[7]. To expand usage, the CDC/National Center for Health Statistics (NCHS) approved new SDoH code assignments that took effect on October 1, 2021.

Z codes can be used to inform care plans and improve patient outcomes, as well as to understand challenges faced by entire communities. Z codes encompass barriers such as transportation, housing instability, family conflict, social isolation, and many more.

The key piece to the puzzle is being able to link the documentation to the resources that help members live their healthiest lives. This means employing a standardized approach to screening, documenting, and surfacing solutions to address the social needs that impact members.

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Utilize Z Codes:

Enhance Quality Improvement Initiatives

SDoH data gathered and tracked using Z codes can have a profound impact on your plan's initiatives including enhancing patient care, improving care coordination and referrals, social needs interventions, identifying population needs, supporting quality measurement, and much more.

1. Collect SDoH Data
Any member of a care team can collect SDoH Data.

2. Document SDoH Data
Can be documented at intake through HRA's and other screening tools.

3. Map Data to Z Codes
Coding, billing, and EHR systems help coders assign standardized data and map to Z codes.

4. Use SDoH Z Code Data
Analysis can help improve quality, care coordination, and experience of care.

5. Report SDoH Data Findings
SDoH data can be added to key reports to inform value based care opportunities.

Figure 2

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Impact:

Outcomes and Drive Quality Care

Evaluating current measures is a great indicator of how your plan is impacting outcomes via a comprehensive SDoH program. Plans should pay close attention to the real-time components of their SDoH programs that are going to contribute to more long-term success.

Examples include:

- Creating new dual enrollees leads to increased capitation.
- Helping people with Medicaid renewal increases member satisfaction, plan loyalty, retention rates, and increases capitation.
- Human-to-human communication and assistance with enrollment in community and government programs helps improve member engagement in multiple programs and lowers cost by removing barriers to care.

  Additionally, plans should consider how the transition to value-based payment models has helped to transform care delivery by tying reimbursement to patient outcomes instead of volume.

Since SDoH programs play a key role in overall health outcomes, costs will inherently be cut substantially for health systems and payers, as members are less likely to need costly medical care if their social needs are met.

Although it may take some time to realize the impact of this cost-cutting ROI, the fact remains that combatting barriers via comprehensive SDoH programs has a positive outcome for all parties involved.

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Click on the image to access Benelynk's article on our commitment to a diverse and inclusive environment.

Conclusion:

What you Can Do

Clearly there is an inherent challenge in identifying and documenting SDoH barriers. You don't want to ask members to open up about SDoH challenges, without being able to help. That's why an integrated SDoH program makes sense.

- **Step 1 - Lead with help:**
  Start every conversation by asking what challenges the member is facing. Provide live human-to-human advocacy to build trust and loyalty.
- **Step 2 - Document barriers:**
  Facilitated by ICD-10 Z codes, documentation helps to prioritize patient outreach strategies and inform solution deployment for optimal impact. Documentation leads to analysis and execution that can help improve quality, care coordination, risk adjusted revenue, and member experience.
- **Step 3 - Surface solutions:**
  Once you understand and document what challenges your members are facing, surface solutions to link them with the community and government programs and benefits they deserve to help them live their healthiest lives.
- **Step 4 - Measure and report impacts:**
  Report SDoH data to identify unmet needs. Data can be shared with social service organizations, providers, payers, health systems, and other clinicians.

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To help combat SDoH barriers, MA plans and other stakeholders from across the health and human services ecosystem should collaborate on key initiatives such as the expansion and improvement of Z code applicability through participation in the Gravity Project, forging community partnerships with organizations, and advocacy to CMS.

Continued education to key stakeholders on the critical need to screen, document, and report SDoH data could further assist in identifying opportunities for advancing health outcomes.

Sources

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To learn more about our SDoH solutions, please click on any of the icons to follow us on social media or visit our website at **BeneLynk.com**

About BeneLynk

BeneLynk is a national provider of social determinant of health (SDoH) solutions for Medicare Advantage and Managed Medicaid health plans. We serve plans and their members by creating a human-to-human connection and providing the assistance a member needs to get the benefits they deserve.

By employing one dynamic conversation that flows organically to meet social determinant of health challenges, we build stronger human connections that are supported by innovative technology.

All of our services are customized to the specific geography where we provide services and provide the members with the specific information they need to keep their benefits in place.

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