Opportunity to Enhance the Use of Health Risk Assessments

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A perfect storm of events is driving payers and providers to better manage the cost of their high-risk Medicare beneficiary population—dramatic changes in Medicare payment policy, growth in Medicare Advantage (MA) plan enrollment, and the aging population will make it impossible to avoid increasing financial risk. To succeed in this era of health system transformation, plans and providers bearing risk – in an accountable care organization (ACO) for example – will need strategies for managing a broad array of care needs for high-risk beneficiaries across multiple settings of care. One data collection tool that offers a particularly strong opportunity to improve identification of high-risk members is the health risk assessment (HRA).

HRAs are able to identify health behaviors and risk factors that would not be picked up in claims data, generating a more complete picture of the member.

To evaluate the state of HRAs used by payers, Avalere Health reviewed government regulations and relevant literature, and conducted interviews with HRA experts to understand common HRA practices, potential shortcomings, and recommendations for improvements.

BACKGROUND: HRAs are health-related questionnaires conducted telephonically, in-person, online, or through the mail. Essentially, HRAs ask members to assess their health status across a variety of dimensions, such as functional impairment (e.g., activities of daily living [ADL] and instrumental activities of daily living [IADL] needs), family history, lifestyle, nutrition, behavior, and social support.

The Centers for Medicare & Medicaid Services (CMS) requires MA plans to administer HRAs as part of the annual wellness visit, which is now required for all MA plan members. CMS does not require that MA plans utilize a specific HRA form, however. Instead, it requested that the Centers for Disease Control and Prevention (CDC) develop guidance on HRA questionnaires and administration. The CDC released recommendations in December 2011, but they were not comprehensive.

MA plans have limited guidance from CMS, and therefore significant flexibility in how they administer and what data they collect via HRAs.

MA plans and vendors often build upon existing HRA questionnaires to create updated or customized versions. Plans can further customize existing HRAs to target specific high priority populations, such as specializing in end-stage renal disease and diabetes prevention and management.

KEY FINDINGS: HRAs can strengthen risk stratification and care management activities by capturing key information about members' health that are not stored in claims data. Specifically, enhanced HRAs can benefit plans and providers by:

- Effectively uncovering risk factors within high-risk Medicare populations.
- Identifying long-term services and supports (LTSS) needs.
- Improving patient satisfaction scores, member retention rates, and members' quality of life.
- Supporting care coordination and care management for identified high-risk beneficiaries.
- Providing a potential positive return on investment through evidence-based care coordination programs. implemented for beneficiaries identified as high-risk through HRAs.

USING HRAS TO ASSESS LTSS NEEDS: HRAs can assess LTSS needs by evaluating the following domains:

- Ability to complete ADLs and/or IADLs
- Behavioral/mental health
- Cognitive function
- Family and caregiver support
- Frailty and fall risk
- Having a regular primary care physician
- Living situation (e.g., lives alone)
- Skin issues (e.g., wounds, ulcers)
- Home safety/accessibility and modifications
- Nutrition and/or access to proper meals
- Transportation

BEST PRACTICE: LifePlans, an HRA vendor interviewed for this study, advises its health plan clients to collect certain data to identify LTSS needs such as whether a member had: (1) difficulty with more than two ADLs and no paid caregivers, (2) three hospitalizations in the last six months, (3) three or more falls, in the last six months, (4) balance problems in the past week, and/or (5) difficulty chewing and/or swallowing.

USING HRAS TO SUPPORT CARE COORDINATION: Currently, MA plans can use enhanced HRA data to refer a member to care management and/or assist in the development of a care plan; however, not all MA plans do this. A key reason why many plans do not use enhanced HRAs that identify non-medical or LTSS needs is because plans typically are not reimbursed for the services that could address those needs. However, MA plans can provide certain supplemental benefits to their members, if the item or service is primarily health related.

MA plans are allowed to provide these supplemental benefits to address functional needs:

- Enhanced disease management (EDM)
- In-home safety assessments
- Home meal delivery for a short duration
- Health and general nutritional education
- Smoking/tobacco cessation counseling
- Post discharge in-home medication reconciliation
- Readmission prevention support
- Telemonitoring
- Transportation support
- Bathroom safety devices
- Gym and fitness membership benefits

Recommendations

Plans should:

- Invest in the HRA process by incorporating key questions to identify LTSS needs and other risk factors not uncovered through claims.
- Use HRA responses to support risk stratification efforts by identifying future high-risk beneficiaries.
- Implement or enhance management efforts for beneficiaries identified as high-risk through HRAs and other data sources to help decrease future costs of these beneficiaries.

IN SUMMARY: To succeed in this era of health system transformation, plans and providers, especially those bearing risk, should invest in the use of enhanced HRAs. HRAs with well-targeted questions allow plans and providers to proactively identify the beneficiaries most at risk of high-cost health care utilization. This is a strategy of increasing importance as MA enrollment continues to grow, providers take on risk, and payments are increasingly tied to quality.

Uncovering non-medical factors through HRAs is crucial for population health management efforts as a significant portion of Medicare spending is attributable to characteristics and behaviors that occur outside of the health care delivery system. However, identifying high-risk members alone does not reduce utilization and spending. In order to reduce spending, plans need to implement effective care management and care transition programs that prevent and reduce high-cost utilization. Plans that use enhanced HRAs to support risk stratification and care management efforts will have a competitive edge in an evolving Medicare paradigm that rewards population management and spending efficiency.

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