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VIA ELECTRONIC SUBMISSION TO [ASPEImpactStudy@hhs.gov](mailto:ASPEImpactStudy@hhs.gov)

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**Re: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors**

Dear Ms. DeLew:

Cigna welcomes the opportunity to respond to the Request for Information (RFI) on addressing social risk factors for Medicare beneficiaries issued by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services (HHS). We appreciate ASPE's efforts to understand the impact that social risk factors play in individual health, outcomes of care, and the quality measurement systems used throughout the Medicare program.

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna"), is a global health services organization dedicated to helping people improve their health, well-being, and sense of security. Our subsidiaries are major providers of medical, pharmacy, dental, disability, life and accident insurance, and related products and services, covering 15.2 million customers in the more than 30 countries and jurisdictions in which we operate. Worldwide, we offer peace of mind and a sense of security to our customers seeking protection for themselves and their families at critical points in their lives.

Cigna serves approximately 1.5 million people through our Medicare Advantage (MA), Medicare Prescription Drug Program and Medicare Supplemental products. Our focus on this market has allowed us to develop a unique approach to health care coverage. We have a deep understanding of the needs and challenges facing both patients and physicians, and thus have developed an evolving collaborative model that provides greater access to high-quality preventive care for our customers while offering physicians what they need to deliver that care.

Cigna works closely with clients, customers, and health coaches in the public and private sectors to eliminate the health disparities that continue to plague far too many people and populations. We are committed to cultivating a state of health equity in the marketplace – and to deploying strategic and operational resources to improve access to high-quality health care for our customers.

In 2008, Cigna formed the Health Equity Council, the governing body of our overall strategy to address health equity. Comprised of leaders from across the enterprise, its purpose is to increase awareness, share knowledge, and exchange ideas about health equity; integrate health equity into every business area and to promote collaboration; and establish and monitor progress on the strategy to promote health equity.

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Following a framework similar to HHS's National Partnership for Action to End Health Disparities, Cigna's five-pronged health equity strategy includes:

- Leadership: Broaden and strengthen leadership at all levels to address health disparities and personalize care for each customer;
- Data, research, and evaluation: Identify and prioritize health disparities and evaluate the impact of initiatives to close gaps to care;
- Social determinants of health: Address the social determinants of health that contribute to inequitable health care among our customers and in the community;
- Health care services: Improve health and health care outcomes for racial, ethnic, and underserved populations; and
- Cultural and linguistic competency: Improve the cultural and linguistic competency of a diverse workforce and provider network.

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With that context as background, Cigna offers the following responses and suggestions to the questions posed in the RFI.

**How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?**

Cigna is committed to serving Medicare beneficiaries, including those who are low-income and/or have social risk factors that often make it difficult to access care and achieve better health outcomes. Over 30 percent of Cigna's MA members currently are dually eligible for both Medicare and Medicaid benefits and services. While the majority of our dual-eligible members are enrolled in special needs plans (SNPs) specifically designed to address their needs and assist them with accessing and coordinating benefits across programs, a significant number of dual-eligible members choose to enroll in our regular MA offerings. Dual-eligible beneficiaries, out of all of our beneficiaries, derive the greatest benefit in terms of quality health outcomes – and improved quality of life – from the coordinated care that our MA plans provide.

Our decades of work on behalf of Medicare beneficiaries has shown that achieving high-quality health care and better outcomes is a team effort involving the health plan, providers, and patients. Our experience at Cigna clearly demonstrates that dual-eligible beneficiaries have a more difficult time achieving desired quality health outcomes, such as screenings and preventive services, adhering to prescribed medication regimens, or following through with basic treatment recommendations. Sociodemographic factors, such as language and literacy barriers, nutrition, safe transportation, and housing, play a key role in keeping some members from achieving better outcomes, despite having access to the same local providers, services, and benefits as all members. For example, low-income members may not follow through on recommended screenings or preventive care, or may have difficulty with medication adherence, because they lack access to transportation.

Our dual-eligible population requires tremendous investment in resources such as licensed social workers, behavioral health specialists, nurse practitioners, in-clinic pharmacists, and other physician extenders to address the medical and social issues that often keep them from achieving the same health care goals and outcomes as other members. Ensuring that prescriptions are filled, medications are taken as prescribed, screening appointments are kept, and diagnostic tests are performed often means adding additional benefits such as transportation services, licensed social workers, pharmacists, or advanced care nurses to supplement the traditional care teams that typically meet the needs of non-dual-eligible patients.

Specific examples of the strategies we use to address social risk factors and help enrollees access care, overcome barriers, and achieve improved health are provided below.

## **Delivery of Services**

### Provider and community collaboration

Cigna's collaborative relationships with providers are a cornerstone of our strategy. Our broad and deep relationships with health care providers allow us to connect and support members at multiple touchpoints in their lives and in the communities where they live and work, not just when they connect with us. We build networks of high-quality, efficient providers focused on delivering competitive costs while still providing customers with access to evidence-based care. Cigna also works closely with providers as a valued resource, using data and analytics, for information to improve health care quality, efficiency, and affordability.

Partnerships with community organizations are driven by the characteristics of the communities in which our members live and access care. For our most vulnerable members, we use a "community-based case management" approach in which case managers and licensed social workers embedded in specific locations help identify and connect members in need with local support programs and agencies for assistance in housing, food and nutrition, caregiver assistance, and other barriers to care.

### HealthSpring<sup>1</sup> days

To ensure that our members are able to access needed preventive services, we periodically bring together multiple vendors offering health screenings together at primary care physician (PCP) offices. Members can receive eye exams, blood pressure checks, mammograms, and osteoarthritis screenings in a single visit, and receive additional information and referrals to care management programs as needed. Some provider partners will make their offices available after hours or on Saturdays to conduct these events because they know they are important to their patients, but also because their caregivers or family members may not be available to accompany them during work hours.

### Living Well Centers

In several of our markets we have large numbers of members with social risk factors clustered in urban centers. To better address the needs of these members, Cigna opened physician clinics called Living Well Centers in Baltimore, Philadelphia<sup>2</sup>, and Houston. These centers offer access to primary care and preventive services. In addition to physicians and nurses, the staff includes pharmacists, case managers, and licensed social workers who meet with members to identify social needs and available resources and provide assistance in accessing social services related to housing, nutrition, and other services. In other markets, we operate embedded Living Well Centers in which Cigna care managers work within a primary care practice to deliver services to our members.

Examples of the care and services offered at our Living Well Centers include:

- Hospital discharge follow-up: A hospitalist or case manager ensures each patient is scheduled to see their PCP or be seen at the Living Well Center within 72 hours of discharge.
- Collaboration and engagement: Staff helps establish enrollment in any programs needed to ensure ongoing well-being, care coordination with primary care providers and specialists, care management for 30 days after hospital discharges to assist in identifying barriers, coordinating specialist referrals.

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<sup>1</sup> Cigna-HealthSpring is the name of Cigna's wholly owned subsidiary offering MA and Part D plans.

<sup>2</sup> Cigna no longer owns the Living Well Centers in Philadelphia, but continues to partner with the clinics to offer services to our members in the area.

- Ancillary services: Diabetic education, including individual and group education on the disease, appropriate diet and exercise goals, treatment options, laboratory services, health risk assessments, and preventive services.
- Pharmacy services: Medication reconciliation, counseling, medication and disease state education, assisting patients with prior authorization requirements, and helping them access patient assistance programs.
- Social services: Coordinating care and addressing psychosocial needs/barriers, and assisting in accessing housing, behavioral health, or transportation services.

#### Supplemental benefits

We offer various supplemental benefits in our health plans to address social risk factors and have an internal work group focused on enhancing and identifying additional supplemental benefits for our customers each year. For most of our plans available in 2019, we introduced access to nutritious home-delivered meals at no extra cost for one week following an acute inpatient hospital stay. The meals incorporate individual dietary restrictions and are delivered frozen with preparation instructions. Meal delivery personnel will also visually check the home environment to assess safety.

More than 50 percent of our plans provide customers with transportation to and from doctor appointments and the pharmacy. By providing a convenient, timely, safe ride, we can ensure at-risk customers keep their appointments and get the medications they need to better manage their chronic conditions or prevent them from developing the conditions in the first place.

To address home safety, we are offering bathroom safety devices in almost all of our plans. A home safety assessment is completed to determine what safety devices may be necessary in the bathroom. Covered items include safety railings, grab bars, raised seats and non-slip tread strips.

#### Access2Care/Lyft partnership

By offering a variety of benefits to meet the unique needs of our diverse customer population, we can ensure our customers have the assistance that best suits their individual needs. Cigna-HealthSpring partnered with Access2Care and Lyft to offer transportation benefits after hearing from providers and customers that transportation is often a barrier to obtaining needed services.

Through Access2Care's partnership with Lyft, we are able to empower our more tech-savvy customers to use their smart phones to connect with Lyft drivers and take control of their transportation to appointments. This then allows us to focus on transportation of our special needs customers who may be in a walker or wheelchair and need extra assistance from Access2Care drivers.

Lyft has an excellent ride delivery reputation, is one of the nation's largest and fastest growing transportation companies, and is available in many of our markets. Lyft was also among the first companies to express interest in partnering with health companies.

If the customer is ambulatory and has a smart phone, Access2Care will schedule the customer's Lyft trip over the phone. The customer does not have to download the Lyft app or enter credit card information, as commercial Lyft riders do. The customer will receive text message notifications when the trip is confirmed, when the driver is on his or her way and when the driver has arrived. When dropped off at his or her appointment, the customer will receive a link to click when the appointment has ended and they are ready to be picked up.

One of the benefits of our joint partnership with Access2Care and Lyft is the data they are able to provide us with surrounding customer benefits, rides taken, and customer satisfaction. This data allows us to make sure we are providing the most value to our customers.

We are excited about our transportation program and are looking to enhance this offering. For instance, we are investigating on-demand hospital discharge transportation. Currently, customers need to arrange transportation through Access2Care/Lyft at least six hours in advance.

For our more tech-savvy customers, we hope to be able to offer a transportation app that can be downloaded to their phones. The app would be specific to Cigna-HealthSpring customers, and not the same as the traditional Lyft app. We also are looking into other technologies for people who do not have a cell phone to access the same transportation services.

Finally, we are considering the feasibility of transportation to and from other health and wellness-related sites, such as grocery stores or senior centers.

#### Home-based care delivery

Cigna has years of proven success in helping physician practices transform from dependence on fee-for-service to engagement and partnership in value-based arrangements, rewarding them for the outcomes they achieve rather than the volume of services they provide. CareAllies, a Cigna subsidiary, brings together our existing, successful provider enablement capabilities from across the enterprise to provide this partnership, including through Alegis Care, another Cigna subsidiary, which serves homebound Medicare and Medicaid patients.

Providers for Alegis Care chronic care management and complex care programs identify and address various social determinants that affect the health of our customers. As home care providers, we enter the patient's home and are able to independently evaluate multiple aspects of a patient's environment during a single visit. We can then take this information and involve other providers, such as licensed social workers, case managers, and ancillary staff including physical and occupational therapists, to work as a team to improve access to care and address any barriers. Our ability to work together and support each individual patient is demonstrated by the example of an Alegis Care patient, Betty:

*Betty is a woman with an intellectual disability who lived with her mother and brother until her mother passed. Her brother then became Betty's sole caregiver. He enlisted the help of her PCP due to worsening behavioral issues brought on by the mother's death. The PCP tried different sedatives to calm her behavior, however, this inadvertently led to over-sedation, multiple hospital admissions, and hospital-acquired complications. Betty became malnourished, developed bedsores, and was unable to walk or feed herself. It was at this time that Alegis Care became involved. An Alegis Care physician went into the home, spent time with Betty and her brother, learned about the specific challenges he faced and developed strategies to deal with her outbursts without using medications. Over time, her medications decreased and, with physical and occupational therapy, and the help of a licensed social worker, Betty began to improve. Betty is now walking, eating, and enjoying trips to the shore with her brother. We attribute this success to not only hard work on the brother's part but also to the multidisciplinary approach taken to address this patient's specific needs.*

Our nurse practitioners and physicians are able to document family support, accessibility of care, and barriers to medication adherence as well as the safety of the home environment during our visits. We are uniquely positioned to identify risk factors of social determinants of health when welcomed into their home. As part of our best practices, our providers complete an assessment template that can then lead to the involvement of other disciplines to address specific concerns. We check pill bottles for adherence, open the refrigerator to determine

need for food services, and evaluate the safety of the living situation. Depending on the needs of the individual patient, we can also enlist our licensed social worker to help patients overcome barriers to accessing food assistance and home health aides. We can discuss improving medication adherence with the help of our pharmacists and enlist physical and occupational therapists to ensure the safety of our customer. Through this process, we are able to understand and address the individual's barriers to care and how we can support each patient, given his or her unique health situation, needs, and challenges.

### Data

#### Cigna data collection tool

To support our complex care programs, Aegis Care developed an electronic assessment tool on social determinants of health that is incorporated into its medical record. The template is copied below.

#### Social Determinants of Health

10/18/2018

Identify situations where there appears to be a deficiency significant enough to cause a barrier to this patient's health care. Please add additional comments as would be helpful for outreach purposes.

##### Family Dynamics/Support Systems

- Yes  No Living alone with 2 or more chronic conditions.
- Yes  No Living alone with significant fall risk.
- Yes  No Inadequate supportive care to meet patient's needs.
- Yes  No Inadequate support plan that can progress with decline in health

Primary caregiver: \_\_\_\_\_  
Power of Attorney: \_\_\_\_\_  Same as primary caregiver.  
Other Caregivers: \_\_\_\_\_

##### Access to Care

- Yes  No Inadequate transportation for medical needs.
- Yes  No Inadequate finances to cover co-pays for appointment/prescriptions.
- Yes  No Trouble navigating complexities of health care system, (i.e. knowing which provider to see; dealing with claims)
- Yes  No Inadequate provider availability in the community (enough primary or specialty providers)

##### Home Environment

- Yes  No Lack of stable housing.
- Yes  No Lack of cleanliness.
- Yes  No Excessive clutter.
- Yes  No Home infestation.
  - Bed Bugs  Rodents
  - Fleas  Cockroaches
- Yes  No Lack of running water/plumbing.
- Yes  No Lack of electricity.
- Yes  No Lack of heating.
- Yes  No Lack of air conditioning
- Yes  No Inadequate access to food.

##### Barriers to Medication Adherence

Are there barriers to medication adherence?  Yes  No

If yes, check all that apply:

- Cannot afford medication
- Does not understand instructions.
- Prefers not to take.
- Cannot swallow/administer

Other: \_\_\_\_\_

Does patient understand why they are taking their medications?  Yes  No

##### Readiness to Change

Is patient/family engaged in aging process?  Yes  No

If yes, check where they are in readiness to change:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Challenges to Engagement

Other Concerns:

<input type="radio"/> Yes	<input checked="" type="radio"/> No	Inadequate food quality.
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Substance abuse in home environment.
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Uses assistive device. <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Oxygen or other respiratory device
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Inadequate home environment for medical needs.
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Dysfunctionally barrier to health care.
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Mental health challenges in the home environment.
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Does not feel safe in home/community.
<b>Personal</b>		
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Inadequate coping skills.
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Inadequate organization skills.
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Inadequate compliance.
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Language barriers (English as a second language).
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Work setting difficulties (inability to leave work for appts).
<input type="radio"/> Yes	<input checked="" type="radio"/> No	Recent loss of significant person in patient's life.

**Intervention Recommendations:**  
Selecting a checkbox here does NOT create an order. If an order is needed, place order in Assessment and Plan.

Provider home visit follow-up.  
 Social Work Referral  
 Behavioral Health Referral  
 Case Management Referral  
 Discussion with PCP

Yes  No Adult Protective Services contacted  
Date Contacted | / /

Notes: \_\_\_\_\_

[Save & Close](#)

Hit "Save & Close" to update the Social Determinants of Health for the patient.

### Barriers to data collection

Cigna developed this template to capture social risk factors for our home-based care delivery service team. Ideally information about these risk factors would be shared across providers and with the support agencies with which we partner to help our members access services. Unfortunately, we are often barred from sharing the information by privacy laws such as the Health Insurance Portability and Accountability Act (HIPAA) without explicit permission from the members or care providers. Cigna fully supports the protections afforded under HIPAA, but also recognizes that it creates a barrier to offering our members comprehensive assistance in overcoming social risk factors to improve health.

In addition to barriers caused by restrictions on the sharing of information, technological issues also create barriers to using data in this way. Information on social risk factors is often contained in many different systems used by a variety of agencies. The data are often not available in a readily accessible format that can be added to a patient's medical record or accessed by providers.

Another way to better use data to support the identification of social risk factors would be to improve on existing available codes, known as "Z codes." These codes allow providers to identify certain elements of social risk factors and append them to a claim. Improved awareness and education around these codes and their use, along with more consistent use of such codes, would assist health plans in identifying risk factors for beneficiaries.

### Data analytics

For the past several years, Cigna has been exploring opportunities to more effectively identify and address the social needs of our customers in order to drive better health outcomes. Socioeconomic conditions within a community determine important aspects of social organization, structure, stratification, and/or the environment where individuals live. These aspects together can mold and influence the health of people living in the community. Many studies demonstrate the relationship between under-resourced communities and poor health outcomes. One way to determine and/or characterize a community is to use several U.S. Census indicators representing the multi-dimensional aspect of a community and combine them to arrive at a composite score.

In 2018, Cigna created the Social Determinants Index (SDI), a relative composite metric that characterizes a community at the Census-tract level based on the following six domains: economy, education, cultural, health coverage, infrastructure, and food access. A lower SDI score represents a Census tract with a lower level of social determinants risk factors than a community with a higher SDI score.

The SDI is designed to help us better understand the potential health disadvantages a community and the individuals within that community may face based on their geographic location. A health disadvantage is the inability of people to fulfill basic human needs required for full social participation and optimal health and well-being. These needs include, but are not limited to, economic security, food, housing, safety, transportation, and education.

While the data that populates the SDI is primarily Census data, and inferences made at an individual level may not accurately depict the individual's situation, Cigna is using the SDI to better understand the challenges in a local community that may be influencing health status, health care utilization and outcomes. It allows us to design unique, carefully targeted interventions to help Cigna customers overcome the barriers that impact their ability to focus on their health. It also improves our ability to evaluate the relationship between social determinants of health and health inequalities.

We are beginning to implement the SDI throughout the various clinical programs that support our members. For example, an evaluation of Cigna case management programs revealed the impact of SDI in case management engagement and outcomes. The evaluation demonstrated that as the SDI increases, a customer's likelihood to engage in case management decreases; however, when customers with a higher SDI do engage, there is a medical cost savings and reduction in emergency room visits. Once implemented, the SDI provides us with an opportunity to ask questions regarding social determinants of health to help address barriers by searching for resources available within their community, such as transportation to appointments or food banks or financial assistance.

### **Summary**

Cigna's approach to addressing the social risk factors and needs of our Medicare members reflects the strong commitment we have made to serving low-income and dual-eligible members, and recognizes the multiple challenges that these individuals face in accessing care and improving their health. No single solution or program can erase these challenges. We continue to identify new barriers and opportunities to improve care and outcomes for these members.

Thank you for your consideration of these comments. Cigna would welcome the opportunity to discuss these issues with you in more detail at your convenience.

Respectfully,



David Schwartz