The National Voice for Special Needs and Medicare-Medicaid Plans

Dear ASPE Research Colleagues,

This letter is in response to the Assistant Secretary for Planning and Evaluation's Request for Information in response to legislation, Section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 which calls for the Secretary of Health and Human Services (HHS), acting through the Assistant Secretary for Planning and Evaluation (ASPE) to conduct a study evaluating the effect of individuals' socioeconomic status (SES) on quality measures and measures of resource use under the Medicare program. We reviewed the RFI and the research intent and address key areas which consolidate answers to the questions posed:

How are special needs health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors? What are some emerging effective practices?

How are special needs health plans identifying and addressing needs of beneficiaries with social risk factors?

What evidence is available regarding costs and benefits of addressing social risk issues? How are these being evaluated? What are lessons learned?

How are beneficiaries' social determinant of health risks and care complexities intertwined (medical, behavioral/mental health, functional, frailty)?

What SDOH data challenges and promising practices are observed?

Please note we are providing SNP Alliance data and information that has been shared by member health plans and have conducted our own analysis on these issues. We intend to publish some of this information in our own reports, blogs, and case studies, and therefore request it not be further distributed or published at this time without permission.

 For further information about our examination and if clarification is needed, please contact Deborah Paone, DrPH, MHSA, Performance Evaluation Lead for the SNP Alliance or Cheryl Phillips, MD, President and CEO of the SNP Alliance. We can be reached at dpaone@snpalliance.org or cphillips@snpalliance.org. We welcome further discussion about these important questions and this topic. Thank you for the opportunity to provide comment.

Sincerely,

Cheryl Phillips, MD
President & CEO

Deborah Paone, DrPH, MHSA
Performance Evaluation Lead

BACKGROUND
Special Needs Plans and Medicare-Medicaid Plans Serve Populations with Significant Social Risk Factors and Care Complexity

The Special Needs Plan Alliance (SNP Alliance) has 24 separate health plan organizations as members of this nonprofit leadership organization. These 24 health plan organizations have hundreds of plan products, representing over 1.65 million enrolled beneficiaries. These special needs plans (SNPs) and Medicare-Medicaid plans are a subset of Medicare Advantage (MA) plans. SNPs are specifically authorized and designed to meet special care needs of Medicare beneficiary sub-groups. The plan types and subgroups include:

- *Chronic condition SNPs* (C-SNPs): serving persons with certain severe or disabling chronic conditions (e.g., HIV-AIDS, chronic heart failure, COPD, mental illness, etc.).
- *Institutional SNPs* (I-SNPs): serving persons residing in nursing homes or with comparable care needs in the community.
- *Dual eligible SNPs* (D-SNPs): serving persons covered by both Medicare and Medicaid.
- *Fully Integrated Dual Eligible SNPs* (FIDESNPs) and *Medicare-Medicaid Plans* (MMPs) – which are a specific type of D-SNP and provide both Medicare and Medicaid benefits, including long-term services and support.

While SNPS are regulated, evaluated, and paid on the same basis as other Medicare Advantage plans, they are required to provide additional benefits and services to their target/special populations and to implement tailored care management according to unique Models of Care.

Special population groups include *younger people with physical disabilities* (age 18-64), people with *severe complex and disabling conditions* (e.g., ALS, Parkinson's, advanced renal disease, COPD, AIDs-HIV, etc.), and *frail elderly persons* with cognitive, functional, and disease-related impairments.

SNPs work to coordinate an extensive service array with specialized provider networks. Some plans exclusively serve people who are *dually-eligible* for both Medicare and Medicaid. These individuals often require community long- term services and supports, behavioral health services, specialty medical, pharmaceutical, and condition-focused care, as well as other assistance to address their complex needs. The health plan works to integrate and coordinate the two separate programs — Medicare and Medicaid — each with different rules governing how plans and providers may interact with the beneficiary and what can be offered.

SDOH Examination by SNP Alliance
The SNP Alliance is a nonprofit national leadership group of SNPs and MMPs working together with a focus on these complex populations to advance policy and practice within a managed care framework. The Alliance is dedicated to improving total quality and cost performance.

Over the last several years, the SNP Alliance has examined peer-review studies, research reports, data analyses, expert committee reports, published case studies, and other resources/references on social determinants of health and the impact these risk factors have on health outcomes and quality of care measurement results. The SNP Alliance also conducts its own surveys of members.

The *SNP Alliance Annual Member Survey* has included questions on social determinant of health (SDOH) risk factors and SDOH data issues for the last two years. We conduct this survey every Fall. Plan insights and the response to SDOH questions are presented in this RFI response. In addition, several of our member health plans provided additional information and response which we included.

SDOH Impact Well Known - The importance of a clean and safe environment, proper education, adequate nutrition, clean water, stable/adequate housing, and access to basic preventive care has been demonstrated in public health studies for centuries as greatly impacting health status (Braveman and Gottlieb, 2014). It is widely understood that these aspects of life and living environment impact a person's health over his/her entire life course, and even across generations. Public health researchers across the world have been reporting on this extensively—particularly in the last three decades. As much as 70% of health status may be determined by such factors. The health consequences of deficits in nutrition, physical activity, housing, as well as from chronic stress (particularly beginning in childhood), violence, and other social risk factors can have both immediate and very long-term effects. Some of the disease related to these factors will not appear for decades. Multiple studies show that certain social risk factors (characteristics of the person or of the community in which the person lives) affect medical, behavioral, and social services care provision/support (what can be accessed, and when, how). These factors also affect individual care-seeking, self-care, and follow-though/engagement. All combine to impact health outcomes observed.

Recognizing the importance of SDOH influence on health services and on evaluation/measurement of the quality of care, several important scientific expert committees and panels have convened and produced sentinel reports. This includes the ASPE report (2016) and NASEM reports (2016, 2017) on social risk factors and implications for quality measurement and value-based payment under Medicare, as well as other expert panel/committee analysis (e.g., NQF Disparities Committee, 2017). This body of work presents strong evidence that social risk factors impact health outcomes independent of the actions of providers or health plans and that there is insufficient information about these social risk factors collected/utilized. The ASPE Report (2016) noted that beneficiaries with social risk factors "had poorer outcomes on many quality measures. . . even when comparing beneficiaries at the same hospital, health plan, ACO, physician group, or facility." Furthermore, they found that: "In every care setting examined, providers that disproportionately cared for beneficiaries with social risk factors tended to perform worse than their peers on quality measures. . . As a result, safety-net providers were more likely to face financial penalties across all fiver operational Medicare value-based purchasing programs in which penalties are assessed" (ASPE, 2016, p. 8, 9).

Clinicians, behavioral health providers, social workers, and others working primarily with people who have significant social risk factors explain that, even when provision of medical care for conditions/diseases meets the highest standards of care or treatment guidelines, optimal health outcomes can be difficult to achieve. They describe the interaction between risk factors and vulnerabilities as being important. Studies of vulnerable communities and population sub-groups support this observation. Such studies suggest that it is not a single factor, but a multiplicity of factors and how they interact or intersect—which exacerbate the negative effects of adverse social risk factors as experienced by a person and thus complicate care provision.

Those working with vulnerable populations refer to Maslow's hierarchy of needs when considering priorities. Access to nutritious food, clean water for drinking and bathing, and a safe, warm, dry place to sleep are basic needs. Many people do not have even these basic needs met. Two other key needs – transportation and economic stability mitigate the person's ability to access these basic needs. For these vulnerable or "at-risk" individuals, medical advice which focuses on things such as checking insulin daily, maintaining a healthy diet, getting a flu shot, having a colonoscopy or taking blood pressure medicine regularly seems quaint, misguided or disingenuous if they have no place to sleep and nothing to eat.

Unfortunately, food, water, and housing are not considered covered health care or long-term services under the Medicare and Medicaid programs and neither public health, health services plans/providers, or other institutions have the policy directive/legislative authority or the necessary resources to ensure these basic daily needs are met. Many of the social risk issues are entrenched in the community and are affected by federal, state, county, or municipal policy, tax base/available resources, regional institutions, social/cultural/community norms, and how the sectors operate (e.g., health care, fire/police, housing, education, transportation correctional services, and business sectors) do or don't work together.

This brings us to posing a few fundamental questions that need to be considered:

- ***What is the defined purpose, role, and authority for health plans and providers serving Medicare and Medicaid beneficiaries?***
- ***Does this role extend to include accountability for social determinant of health deficits among patients and enrolled beneficiaries?***
- ***If so, how far does this extend?***

In the U.S. the focus of health insurance programs is on medically necessary health services for diagnosed conditions. It has not been on social issues. The U.S. does not have a social care program that is a companion to the health care program, unlike some European countries. CMS defines Medicare as "a federal health insurance program for people age 65 or older, under 65 with certain disabilities, and people of all ages with ESRD, to cover a defined set of health services." Medicaid is defined as "a joint federal and state program that helps with medical costs for some people with limited income resources." Key words in these definitions are *health services* and *medical costs.* Another important definition (found on the www.medicare.gov) is *medically necessary* defined as: "health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine."

While providers and health plans are recognizing and responding to social risk factors as important characteristics of their patients/members, they are also recognizing limits to what they can do. It seems apparent that the social determinant of health deficits experienced by people enrolled in Medicare and/or Medicaid will not be able to be addressed by the health care sector alone. Current legal, policy, regulatory, contractual and payment parameters for health plans and providers define the scope of what is covered/not covered, who is eligible, and how the insurance component and delivery component are to operate. These laws, policy, and payment have not been substantially changed to include social care. Thus, even with the best strategy, health plans and providers are beholden to and must abide by the parameters already set and the resources allocated.

The defined parameters and resources set for plans and providers are around health services, medical care, and (under Medicaid) long-term services and supports. To the extent that organizations can reduce costs in one area, e.g., hospitalizations, through improving health status (e.g. through special meal delivery, home adaptations post-rehab surgery, or primary care mobile units) then it is possible to deliver and pay for enhanced services to some people who meet a set of characteristics and criteria that supports the medical necessity and health related definitions.

However, this will only go so far. There is a point where cost savings from other medical/health care utilization is not likely; when services needed are not tied to medical necessity or specific condition management; when payment (e.g., capitation) cannot be stretched any more. Medical care, treatment, and specific services deemed necessary under current medical guidelines must be covered, delivered, and paid for. There is a limit on how much of the capitated payment can be spent on other things which fall outside of the service definitions. What happens then?

There needs to be a reckoning around resource allocation for basic needs at a societal level. Children living in poverty grow up to be adults and eventually most of them age into Medicare. More investment by the society at large must be made to build an adequate supply of basic resources and consider how deficits build and impact all aspects of how our citizens live. Health care organizations, including health insurance and managed care organizations, cannot address these social problems as the current Medicare and Medicaid programs are designed or structured. They cannot make these decisions or solve these issues.

In this response we focus on the questions posed and share our understanding of how special needs plans are working toward effective strategies. We do not have enough empirical information to answer all of the RFI questions definitively, though we find emerging wisdom and lessons learned from what is being done by SNPs and MMPs and what next steps are needed.

RFI Focus Questions - The SNP Alliance Response

How are special needs health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors? What are some emerging effective practices?

High-performing Special Needs Plans (Case Examples)
The taxonomy referenced in this RFI and presented in the recent ASPE research reports conducted by RAND (ASPE, 2018) offered emerging strategies that hold promise. All four case studies from the high-performing Medicare Advantage health plans featured in the RAND report highlight strategies explicitly developed for special needs/chronic care populations. That is because all four of the health plans are ***special needs health plans***, providing care and support to beneficiaries who have complex medical, behavioral/mental health, and social service needs.

They are all also members of the Special Needs Plan Alliance and thus participate in our Annual Member Survey and regular discussions. We present information from these and other member SNPs and MMPs in this response letter.

By design, special needs plans have additional legislative and regulatory requirements to:
- focus on chronic care populations,
- identify beneficiary needs proactively at time of enrollment,
- craft tailored care models that can address the complex and multi-dimensional needs of the special populations enrolled, and
- measure and report on additional quality of care elements under the Medicare Star Ratings program.

Therefore, it is not surprising that these plan types offer important learning to the field on addressing social risk issues—since these social risk factors are more common in the special needs and Medicare-Medicaid dually eligible populations, and since chronic complex populations are these plans' sole focus. We agree that it is worth examining these four special needs health plans further as they have unique organizational, structural, and mission-based characteristics which may offer an advantage in addressing SDOH issues. From their founding to the present day, such characteristics have been important in shaping care strategies. These characteristics set them apart from many general Medicare Advantage plans. For example, among these four health plan organizations we find the following characteristics among one or more of them:

- ***Health plan part of integrated provider system -*** Health plans which are part of larger integrated healthcare delivery/provider organization with extensive clinical, primary and specialty care, behavioral health, home care, pharmacy, rehabilitation, and other services, with strong internal care management and integrated health data systems. Provider and plan care management activities and information exchange is integrated by virtue of the structure and processes designed and operated under one roof across plan and providers.

- ***Strong primary care and community roots with exclusive focus on chronic care populations -*** Health plans which have roots in community primary care clinics, working closely with advocacy and other organizations to provide primary/preventive services to people with disabilities and other chronic care needs. The mission and purpose continue to be exclusively focused on chronic care populations.

- ***Long-standing commitment to innovation*** These health plans have a long history of investing in innovation to integrate the continuum of services needed by a complex chronic population. For example, two of these plans participated in the "social HMO" demonstration in the 1980s and 1990s, whereby they provided extensive home, community based, and long-term care services in addition to Medicare Part A & B care and treatment to people with long-term care needs and multiple chronic conditions under a capitated agreement. In fact, the Social HMO demonstration helped inform the development of special needs health plans which were authorized by Congress in 2003.

These four special needs health plans are great examples of organizations making the most of their specialty focus on chronic care populations and utilizing their extensive expertise as they continue their work to address the social aspects of health integrated with the medical/clinical care, mental health services, and long-term services and supports needed by these individuals.

That said, we find that many of the Special Needs Plan Alliance health plans have similar strategies. They have set up robust identification, outreach, care management, and specialty and supportive services approaches. They recognize the multidimensional nature of health—and the importance of

early identification of social risk and other care complexity issues. Plans describe this multi-dimensional and interactive cycle where SDOH factors affect care complexity as follows:

> *The advanced age, poor socioeconomic status, and rural location* [of our members] *can result in limited access to healthcare providers, wellness programming, and community supports, transportation barriers, lack of family or community resources, low health literacy, and physical, cognitive, or mental impairments. These barriers can lead to lack of continuity in care, unhealthy behaviors (e.g. lack of physical activity, malnutrition), safety risks, and social isolation. These limitations can result in preventable hospitalizations or readmissions, unmanaged chronic conditions, adverse drug events, increased risk for depression, and declines in physical and mental health, which can lead to more specialized care and, eventually, care in a long-term facility.*

> [Our protocols for delegated care coordinators serving SNP members] *direct the Care Coordinator to identify barriers to the member achieving their health goals, such as language or literacy, lack of or limited access to reliable transportation, a member's understanding of their condition, financial or insurance issues, cultural or spiritual beliefs, among others. The Care Coordinator documents supports needed to achieve the goals, including supports needed to overcome any identified barriers. These may include community and social service supports and resources not covered by Medicaid or Medicare benefits, such as financial assistance, food/meal delivery, housing, legal assistance, ombudsman and advocacy services, and transportation. The Comprehensive Care Plan therefore reflects not only the primary, acute, and long-term care needs of the member, but their mental health, cognitive, and social service needs.*

How are special needs health plans identifying and addressing needs of beneficiaries with social risk factors?

Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?

Yes, social risk data is being collected, accessed, and mined by SNPs and MMPs. Our examination finds that social risk data are being used in many ways to better define needs, identify those most at risk, and initiate more proactive outreach to affected individuals. Special needs plans have several strategies for identifying high risk/high need members (with SDOH and other factors) proactively using multiple sources of information. This triggers attention (e.g., algorithm for stratification that includes SDOH factors which will trigger referral to high risk care management). Once a set of risk factors are identified this is combined with information about care complexity issues also raised (medical, behavioral health issues). Plans then engage their own plan managers or delegated care coordinators to work together with other care coordinators at the clinic, county, or other setting, social workers, community health workers, navigators, and others to work across primary, acute, long-term, rehab, home/community, and mental health settings.

In the *SNP Alliance Annual Member Survey*, we posed the question to SNP Alliance health plan members about what sources of data—internal to the health plan or external—the plans are using to access information on social determinants of health risk factors faced by their enrolled members. Here are the 2017 aggregated results from 14 health plans responding to these questions (2018

survey is underway). All of the plans reported using multiple sources to find social risk factor information on their members.

Sources of SDOH information included:

- Health risk assessments (HRA)
- Internal care management records and care team assessments/care coordinator files
- Member services information gathered through phone contact (outreach, 1:1 member support)
- Claims data, encounter data, including ICD-10 "z" coded visits
- Member surveys
- Initial member enrollment forms and information sources
- Medical record information from providers
- External care management records
- State long-term services and supports data
- State Medicaid data
- American Community Survey data
- Census data
- County data, county health rankings
- Community (regional) health assessments
- Health care measurement agencies (e.g., Minnesota Community Measurement)

Concerns about and limitations of many of these data sources (e.g., at the plan level and for creating a national approach to having a consistent set of SDOH information available) include:

- Lack of consistent/standardized SDOH definitions, instruments, methods, items or scales across organizations, states, or providers.
- Timeliness issue -Data relevancy and accuracy decays over time.
- Privacy and confidentiality - HIPAA or State privacy law concerns impacting data sharing of some SDOH items; also involves rules and practice around obtaining Release of Information for permission from the member/individual to share SDOH data.
- Geographic units of analysis in these data sources may be too large; they do not offer neighborhood level information that helps pinpoint SDOH issues.
- Information is in a dataset that cannot be easily searched; too labor-intensive or special programming required; furthermore, data does not refresh – it is static.
- Lack of health information exchange platform, structure, processes – particularly leaving out home and community-based service providers and non-health care (e.g., housing, food, transportation providers). Health information exchange efforts by states are still focused on medical care providers—this is a real limitation.
- Variability in when and how data is released

With these as acknowledged limitations, we examined information provided by our member health plans to understand which sources were most commonly used or mined for SDOH information, e.g., to create enhanced information profiles on their enrollees, to target more extensive outreach, conduct additional data analytics for risk stratification, and tie to care management services.

Our examination showed that the most frequently reported source of SDOH data was health risk assessments which are required of special needs plans but not general Medicare Advantage health

plans. Other top sources were: internal care management records and care team assessments, member surveys, member services/client support contact, enrollment forms, and external medical records, claims data, and encounter data.

- Health risk assessments (100% reporting have SDOH data; 86% currently use for SDOH information)
- Internal care management records (93% reporting, 79% using for SDOH)
- Member surveys (79% reporting, 71% using for SDOH)
- Claims data (71% reporting, 71% using for SDOH)
- Member services/client support contact (71% reporting, 43% using for SDOH)
- Enrollment forms (71% reporting, 50% using for SDOH)
- External medical records (64% reporting, 50% using for SDOH)
- Encounter data (43% reporting, 36% using for SDOH)

(Source: *SNP Alliance Annual Member Survey 2017*, unpublished data).

Health Risk Assessments - In 2016 and 2017 we facilitated several shared learning educational sessions among SNP Alliance members to explore operational aspects and learn more about approaches for health risk assessments. We found there was variability in the content, focus, comprehensiveness, length, and mode of administration across special needs plans on these health risk assessments. However, most HRAs included at least a small set of questions/items pertaining to the individual's living situation, self-perception of health status, functional status, primary medical/behavioral health/or other conditions, and primary health concerns, some also ask about use of hospital and ER services.

From this work (Source: SNP Alliance member discussions), we found that there were generally two approaches for conducting HRAs and utilizing them as a core component of their care management strategy. One approach involved a shorter HRA telephonic screen with subsequent comprehensive targeted follow-up. The other approach involved a more comprehensive assessment, usually conducted face to face, which signaled the initiation of enhanced care management. The HRA initiated a member-to-care manager relationship for ongoing communication and follow-up.

This information and subsequent discussions provide insight into the reasons why HRA as a SDOH data source has limitations. Issues include: what information is collected, the data definitions and scales for SDOH factors, how/when the information is obtained, how complete it is, and on what kind of information platform the dataset is maintained, what query or search options are enabled/available, and who has access to the information.

From the information we've gathered through discussions, care managers use the HRA SDOH information if it is available to them in a timely way. The care managers had easier access to HRA information if they were directly able to utilize the plans shared information platform and if HRAs were conducted by the plan. This was harder if the HRAs were conducted through delegated care managers who were in agencies throughout a state or region and had their own legacy and independent information systems. Without a shared information exchange method, the HRA information was sometimes only available through separate reports that were not integrated into a data set that the care managers or data analytics/population health staff could query.

The reduced utility of health risk assessment data to provide SDOH information is also affected by the following considerations:

(1) HRA data is collected at enrollment and annually thereafter so may not be current/reflect the individual's current circumstances,

(2) some plans have a fairly high rate of refusal or non-response by beneficiaries to requests to participate in an HRA, and

(3) the person may already be identified as high risk and therefore is already receiving extensive care management and community resources. In this case, the care manager has more current and in-depth information about the individual/member on SDOH and other issues than what the HRA can offer,

(4) the timeliness (e.g., within 90 days of enrollment) target for HRA completion can conflict with clinicians or care managers desire to have a thorough assessment—this coupled with difficulty (time lost) in reaching the member may mean that the health plan either accepts a partial HRA or does not meet the time target.

Under Medicare Stars measures for special needs plans, the HRA completion rate is one measure of quality that general Medicare Advantage plans do not have to meet. However, all special needs plans are required to invite members to participate in a Health Risk Assessment at time of enrollment and at least annually thereafter. High completion rates can be difficult to achieve among people with complex medical and behavioral conditions as well as significant social determinant of health risk factors. These individuals are less likely to complete the HRA via mail, telephone, or in-person.

Plans have shared some of the challenges in encouraging HRA participation and in getting these assessments completed. The first challenge is reaching the person to ask for participation (or to set up a home visit to conduct the HRA). Members with high social risk characteristics on top of condition complexities have multiple daily challenges. People with high SDOH risk factors are more likely to change addresses and phone numbers frequently, have lower levels of health literacy, and generally refuse survey participation. Special needs health plans make as many as five attempts to reach the member to conduct the HRA. The non-response, unable to be reached, and refusals are documented. Plans also explain that, in generally (especially with telephonic or mailed methods) the HRA completion rate declines as the HRA instrument increases in length. Likewise, the more sensitive questions, particularly around some social risk factors can be off-putting to some beneficiaries, either resulting in "no answer" or shutting down the survey prematurely "let's be done now." Asking sensitive questions by phone when there is not an established relationship with the individual is particularly difficult and may be counterproductive if the member refuses future calls as a result. These are considerations for crafting any strategy to collect SDOH information.

Other Top Sources - Other top sources of SDOH data reported included plan care management records, member surveys, member services/contact data, and claims data. The care management SDOH data where there is active and ongoing support to a member may be most up-to-date. Plans report that other sources, including claims, encounter data, state LTSS assessments, etc., may have a long lag time from collection to availability and therefore the timeliness, relevance, or accuracy of the data decays.

A few plans have had some success in utilizing "Z" code information (from encounter data) together with other sources when working with medical clinics who serve a high proportion of the plan's members or with a specific group of patients where a targeted intervention/program is being deployed. The ICD-10 Z codes—particularly Z55 to Z65—can be very useful for understanding reasons for encounters in greater depth. They are proving one source of information that can be helpful when a circumstance or problem is present which influences health status but is not itself an illness or injury and where the plan is working with clinics for enhanced outreach and support (for more information see: https://www.icd10data.com/ICD10CM/Codes/Z00-Z99). Unfortunately, such codes are still under-utilized by physicians.

Some plans that have a contract with their state for managed long-term services and supports under Medicaid will also receive state Medicaid data, including LTSS assessment data, which contains demographic, functional, and SDOH information. There are limitations of using State derived LTSS assessment data and the Nursing Home Level of Care Certification (NHLOC). States differ widely in the scope, survey instrument, and methods of administration for conducting these assessments. The content, item wording, scales, and comprehensiveness of the assessments are substantially different from one state to another. The way that the instruments are scored to determine eligibility is also different. This lack of standardization in content and data definitions as well as scoring would restrict the ability to create consistent typology of population subgroups around SDOH risk factors or other care complexity issues across states. However, for plans with MLTSS, this can be a useful data set to mine for SDOH risk factors.

To promote more effective use of State Medicaid data, we recommend the following that CMS set a guideline for states to regularly update and distribute current information on beneficiary coverage from state agencies to health plans, and that states develop data collection mechanisms with certain minimum capabilities around the data collected, methods, data audits, and dissemination to allow health plans serving these Medicaid beneficiaries to have a defined, consistent, and timely set of information. This would include having historic data on Medicaid claims (e.g., past 3 to 5 years) so that plans with new enrollees would have a more complete picture of the needs of these new members. Such information would aggregate claims across carriers.

Additional member plan comments on identifying and using SDOH information:

- *We use population-based logic that is incorporated into risk strategy. The risk strategy identifies who are the members most in need of outreach. Factors such as chronic disease burden, care cost, diagnoses, are tied in. Our plan also conducts a comprehensive assessment that includes Social, Economic, Environmental, Physical/Behavioral Health and other social factors that impact members. That assessment drives our response.*

- *At a population level, we get information back from the state that informs us about vaccines, lead screenings, and other metrics that we can aggregate together. Using both claims and government data creates this powerful combination to help us maximize our intervention tactics to reach members and drive quality improvement.*

- *During the annual Health Risk Assessment, Care Coordinators identify functional status, social risk factors and social determinant of health needs using a standardized assessment tool. We do this for all of our FIDE-SNP members. Care Coordinators then address these needs by*

connecting members to social services and senior/elder services. We do not currently systematically analyze this information on a population level.

What are emerging effective practices for improving care for patients with social risk?

Care plan as part of enhanced Care Management - Efforts to address SDOH issues are usually part of a care plan. A coordinated care plan with involvement of multiple parties can yield results for specific high-risk individuals when targeted and sustained. Such efforts often require involvement and resources beyond what the managed care organization typically provides—that is, they involve working with and across medical, mental health, home/community resource providers and non-traditional service organizations, as well as across service sectors in the community.

Depending on the characteristics of the social risk subgroup targeted (e.g. younger people with physical disabilities, behavioral health needs and primary social risk factors such as housing instability, or low income frail elderly persons who live alone and have functional impairment and no social supports), different strategies are being deployed—although all start with identification, personal outreach, and more intensive care management.

Referral to or Contracted Service Provision with Community Services - The connection to specific community resources and ongoing touchpoints with the member/person through care managers is considered a proven strategy to address *some* of the needs of targeted high risk/high need, complex care individuals.

Some plans refer to services, some are paying for community services for high risk beneficiaries when tied to health/medical goals, and some plans are even providing services directly. Care managers spend considerable time learning about and working with community services providers. We see increasing examples of plans setting up contracts with aging service provider collaboratives, housing providers, transportation and food service agencies, or other types of service providers—for defined sub-groups of enrollees under high risk care management. Such services are tied to medical treatment/health care and are deemed at highest risk. These individuals receive the most intensive level of care management.

Individual, member focused efforts & strategies

Proactive Care Manager to Member Assignment – Some kinds of special needs plans (e.g., FIDE-SNPs), proactively assign a care manager (we will use the term care manager to also refer to plan care coordinator or delegated care coordinator) to each member as standard practice. This is because all of the plan's enrolled members are identified as "high risk." The plan proactively makes an assignment, and the care manager discusses SDOH issues with the member. Through one-on-one interactions between the care manager and the member/beneficiary, the manager gathers information about the individual's unique culture, health beliefs, ethnicity, language, religion, priorities as well as other characteristics, such as living arrangements, social supports, sexual orientation. Care manager/coordinator guidelines and protocols set up by the plan support consistency and comprehensiveness in the approach. Care managers recognize the need to identify barriers (including SDOH barriers) to access and to following through on treatment, care plans, and self-care goals. They work to create the communication pathways and relationship with the member to encourage the member to share challenges around financial assistance, food/meals, housing, legal assistance, transportation, and other social risk issues. The greatest asset in this

approach (according to the plans) is the trusted and ongoing relationship between care manager and individual member. To develop this relationship, plans must invest heavily in care management resources to allow for face-to-face interactions which includes sometimes extensive "dashboard time" getting to the member's residence, particularly in rural areas.

Other promising strategies

Community Health Workers and Extenders - Many special needs health plans report working with and/or employing Community Health Workers, particularly in ethnically diverse and low-income neighborhoods where they have substantial number of enrolled members. Other community-embedded workers being deployed successfully include peer navigators who work as an extension of the care managers serving people with mental health and behavioral health needs. Some plans have other kinds of care management "extenders" in the community, such as community social workers with Area Agencies on Aging, social service organizations, and disability services organizations.

Specific Issues, e.g. Nutrition - Other promising practices include attention to specific SDOH issues with special services. Plans proactively set up additional support services with the member's permission, e.g., around nutritional needs. The nutritional need is identified as part of a current assessment of the individual's condition and situation. It may be triggered by a recent event, such as a discharge to home. For example, some plans are offering medically-tailored meal programs to members with nutritional needs discharged from hospital, rehab, or nursing facility to home, or to individuals diagnosed with specific chronic conditions and identified as having a period where meal supplements are needed. These efforts are supported with dietitians offering nutritional health education tailored to individual needs and preferences. The care manager or care coordinator will then work with the member to seek out and set up extended nutritional/meal delivery services that are available in the area for meeting long-term nutritional needs. Other examples include assistance with applying for SNAP benefits, food delivery partnerships with meals on wheels, and vouchers or other help to access food pantries or grocery delivery services.

Focus on Function and/or Frailty - Another frequent focus is on functional ability at home—particularly among plans serving dually eligible beneficiaries who have both Medicaid long-term services and supports coverage and Medicare coverage under one health plan product. These plans coordinate such as an occupational therapy assessment of the home for safety/falls hazards and bathroom safety devices and other home safety adaptations—for example to support health and functional needs of community-dwelling frail elderly individuals. A functional assessment combined with SDOH information on vulnerability around home, social supports, health literacy, and informal caregiver capability can be the starting point to initiate this home adaptation and environmental support. Plans also report explicitly screening for frailty, especially after a hospitalization—or even prior to discharge.

Housing - Assistance with applying for housing support, guidance and referral to subsidized housing, application for supportive housing and Section 8, assistance with application for transitional housing or family shelter programs, and other temporary or longer-term housing programs. Some plans work with community providers to obtain rental assistance and direct rental payments, e.g., through partnerships with nonprofit housing providers, city, county and state housing services programs or others. A few plans have even participated in a partnership to purchase housing units directly for high risk members.

Transportation – Many member SNPs provide or refer to transportation services. This may include authorizing a substantial number of rides with vouchers provided per month, accessing adapted van transport to medical appointments, contracted ride service programs, county-operated regional bus services, disabled/elderly transport via specially adapted vans, volunteer driver programs and other ride services (e.g., medical Lyft). A particular focus is on getting members to medical and mental health, dental or related appointments.

Mental health – We hear frequently from member SNP and MMPs that attention to mental health issues is very important—and that many SDOH vulnerabilities are connected to poor mental health status and/or behavioral conditions which are not consistently managed. Many health plans have invested in training such as Motivational Interviewing for staff positions (e.g., care management, customer service, navigators, etc.) who have direct interaction with consumers/members. The skills and techniques for active listening, coaching, and responding to members in a way that builds the member's capacity and confidence are part of an overall strategy to deepen understanding of the issues, preferences, current coping behavior or actions, and barriers to self-care.

Telehealth, Mobile units – Plans and providers are working together around key vulnerable populations or communities to address SDOH and other factors that restrict a person's ability to get necessary care. The use of telehealth including virtual visits and remote monitoring is one strategy, where plan care managers work with providers who have such capability within their clinic or health organization. Plans also collaborate with community agencies, clinics, and other organizations to support the use of mobile units for screening, prevention, and treatment (e.g., dental, vision, diagnostic, and preventive care) is very promising. Mobile units have also been used for delivery of fresh produce and other nutritional needs.

Linguistic Diversity – Plans offer interpreter services and translators and increasingly employ multi-lingual staff. They also work with ethnic and cultural community service agencies who are embedded in the neighborhoods and can serve very effectively to share information about access, services available, and how to get the help individuals need.

> *Our plan offers several benefits and targeted quality improvement interventions designed to address the social risk factor profile of our SNP population.*
>
> *As examples, to overcome transportation barriers and improve access to preventive care, SNP members are provided transportation to medical appointments, transportation to a health club participating in the Silver& Fit Exercise and Healthy Aging Program, in-home fitness kits, live video physician or psychologist visits via Doctor on Demand, and the option to receive at-home preventive care screening kits (e.g., colorectal cancer, A1c, bone scan).*
>
> *To overcome low health literacy and to decrease social isolation, we focus on delivering face-to-face care in the home, when possible. For example, SNP members recently discharged from a hospital or nursing facility may receive in-home medication-reconciliation and home-delivered meals.*
> *To overcome financial barriers to using in-home safety equipment, our plan offers additional funding for specific non-Medicare covered bathroom safety devices.*

Finally, we have partnered with an organization that is integrating Community Health Workers into the clinical setting and utilizing mobile care to address social determinants of health and treat and close identified gaps in care.

Community level strategies

Experts almost uniformly point to the need for a cross-sectional, collaborative approach to achieve greater impact and long-term viability at the community level for reducing the prevalence of SDOH risk factors. This is because the challenges are at a societal level and accountability is diffuse.

Health, housing, food, and transportation are basic needs. These sectors are encouraged to work together. Partners with shared interest around one or more social risk factors are finding ways to join forces around specific initiatives and within specific communities. There is consensus that no single organization or sector will be able to fund or deploy the "solutions" alone. Greater awareness of the interdependence of these issues and technical support to build robust approaches for cross-section stakeholder collaboration are needed.

Examples of such collaboration at the national and regional levels are growing. For example, the US Dept of Housing and Urban Development is working to incorporate health considerations into housing policy. Private philanthropic organizations and foundations such as The Robert Wood Johnson Foundation are working with others to support non-medical initiatives to reduce disparities and increase access to prevention programs and basic necessities, particularly focusing on intervening early in the life course (e.g., early child-care programs). Even later in life for people who are already living with the effects of life exposure to poor environmental factors and other social risks, there are effective collaborative initiatives underway across sectors with focus on a defined group or defined social risk area (e.g. housing instability, food insecurity) to help maintain stability in health status and function for a set group of people, neighborhood, or community.

SNP Alliance Collaborations - Plans may participate in or lead community efforts as well. At the community level, in the 2017 *SNP Alliance Annual Member Survey*, a high number of health plans (14 out of 19 reporting on this question) said they had a collaborative partnership underway or planned addressing one or more social risk areas (this would be efforts at the community level which are intended to also benefit some of the health plan members). The responses were:

Area of Focus for Partnerships:

- Food insecurity/nutrition (71%)
- Transportation (57%)
- Social support (57%)
- Health Literacy (50%)
- Housing (36%)

   (Source: *SNP Alliance Annual Member Survey 2017*, unpublished data).

For example, several plans reported working with specific clinics and mental health providers or hospitals in partnership around specific vulnerable or at-risk individuals. A licensed social worker and two nurses were added in a particular clinic/hospital/ER that serves many low-income and at-risk members. The nurses work on health literacy/education and clinical/medical follow-up and

the social worker connects individuals to community resources, particularly around housing, social support, and food. The plan contracts for these services.

Plans told us that they are evaluating collaborative partnerships using several qualitative and quantitative methods including member satisfaction surveys, analysis of member participation, achievement of goals and objectives identified as the intended outcomes of the project, and achievement of benchmarks/targets set as program evaluation criteria. The partnership may set metrics for defining success that focus on community-wide indicators. The plans examine how individual high risk/high need members of their plan experienced and benefited from the effort. Another common measure is the impact on utilization – particularly hospital acute care admissions, re-admissions, and Emergency Room visits.

Evaluation measures for programs focusing on SDOH risk factors (examples) include:

- *Program for SNAP Recipients was evaluated based on the percentage of farmers market sales made with an EBT card that were from fruit and vegetable vendors and the percent of vouchers redeemed from fruit and vegetable vendors. Participants were also surveyed to learn if the Program increased the amount of fruits and vegetables they purchased.*

- *Transportation – monitored usage of the transportation vouchers/ride service offered*

- *Social and Community Health Worker Support (to pregnant women)– measured prenatal and post-partum care visits before and after program*

- *Health Literacy – Conducted pre and post assessment to measure confidence with using the health education program; also measured re-admissions around the specific diseases targeted for improved condition management.*

What evidence is available regarding costs and benefits of addressing social risk issues?

The plan-provider partnerships and SDOH collaborative efforts require significant structure, processes, and communication investments to establish and sustain. On top of this foundation, the resources required to address specific SDOH needs on the individual level can be substantial. Often multiple face to face and personal touch points are needed, together with coordinated communication outside of and in addition to regular information sharing (across information platforms and independent organizations) with additional Release of Information permissions and privacy regulations to consider. The most promising efforts suggest that interventions need to be targeted and sustained over multiple years to yield measurable results. A within-the-year expected "return on investment" is unlikely.

How are costs for targeting and providing those services evaluated?

We do not have detailed information from our member SNPs and MMPs on costs of targeting and providing enhanced services to people with high social risk issues. We do have some information about types of costs. From this and other information several models on costs could be derived (direct, indirect costs and expected payer sources, if any).

It is difficult to separate SDOH "costs" from everything else—this needs to be recognized. For many of the health plans involved in the work of the SNP Alliance most of their enrolled members have high social risk issues on top of care complexity due to medical and behavioral health conditions. The identification, care management strategies, outreach, medical, behavioral health and community services integration, member engagement, and plan-initiated service provision are all part of an enhanced approach for addressing the multidimensional needs of complex chronic populations. So SDOH isn't an "add-on," it is one of several areas assessed.

In terms of Potential "Added Costs" – We have descriptive information about some of the "additional" types of costs to identify needs and coordinate efforts to address the SDOH needs (or provide services directly) for a high SDOH population such as those served by SNPs that may be different than a general Medicare Advantage plan.

These additional/extra costs around SDOH include the following:

- Staff/labor -e.g., for all aspects of the care model – need more staff all along the pathway from identification and data analytics to outreach, care management staff/contracts, HRA costs, community services and home support, collaborative cross-sector partnerships and contracts, and member support, member education, etc. SDOH adds to the sum total of areas on which to focus, skills to develop (e.g., Motivational Interviewing, staff training, cultural and interpreter resources, etc.), and services with which to connect (or develop)

- I.T./data integration/exchange and legal issues within and across network, including working on data exchange, Release of Information, HIPAA and state law constraints, etc. – involves additional work with external organizations, e.g., education, technical support, BAA and other agreements, contractual requirements.

- Costs from State regulatory or policy – regarding working with State(s) on SDOH vulnerable populations there are additional regulatory and policy provisions that must be met, particularly if wishing to access and share necessary SDOH data. Often involves working with others within the state where SDOH data may be held by the county as well as the state, or with the Department of Health rather than Human Services. So, there is complexity around health data exchange. This may also require special attention around mental and behavioral health information, as state rules are usually different when dealing with these areas of information and the specialty providers.

- Direct service costs of SDOH focused services, e.g. transportation, housing, food, etc. – the health plan may refer to community services or in some cases pay for services related to health conditions and when authorized by the care plan and the care manager. The costs will generally be based on contracted rate and volume (e.g., # of units) for individual based on his/her needs. There are authorizations, processes, and other reporting requirements, such as quality review of service delivered. Processes, even when streamlined, add costs and must be covered under the capitation, together with the direct service.

Evaluation Factors to Consider

Evaluation approaches by Medicare and Medicaid will need to consider how it can wrap in a 360 view as much as possible with costs, benefits, and value comprehensively defined to address the perspectives of different stakeholders. Current opinion is that the evaluation timeframe should be a minimum of 3 years. This is particularly challenging for health plans who must contract and negotiate terms annually and whose members can disenroll, move, and elect other health insurance annually.

Timeframe - When calculating costs or benefits, an important consideration for the evaluation is timeframe. It is generally understood that many efforts take time to produce benefits. Some short-term benefits (within the year) are possible, such as reduction in ER visits or readmissions. These are more often shown when the SDOH issues are impacting the individual's ability to receive necessary care and treatment for complex chronic conditions. Cost savings from ER and inpatient visits avoided may offset costs of enhanced services, but this is not always the case.

Stability of Population - For health plans, a key concern for continuity of effort, effectiveness, and evaluation, is beneficiary enrollment stability. An individual who: loses state Medicaid eligibility, disenrolls from the plan voluntarily, moves without forwarding address, or disengages from the multi-pronged effort—is likely to be "lost in the system." Thus, benefits from individual or partnership efforts around SDOH risk factors can be quickly lost. The health plan and medical, community, mental health, and other resource providers involved will be hard-pressed to follow through unless the individual maintains connection with one or more of these stakeholders. The person who is already vulnerable and who loses coverage may find himself starting over again with new plan/providers, and care managers. This can be a defeating cycle of fits and starts where the person loses hope and disengages from future well-intentioned attempts at addressing risk issues.

Tracing Costs and Benefits - In studies of effective programs that have been designed to help address some social risk factor issues, the full direct costs of the program, who bears that cost, and where the benefit accrues is rarely well-described. More studies are needed that capture the total of costs across organizations and track the what happens to people over time—with some kind of matched comparison group of people who did not participate or receive help. Admittedly, this is very hard to do. A start is to create a repository of examples, that include at least descriptive and qualitative information on results. Providing guidance on evaluation approaches, with technical assistance around measures, instruments, and methods would help plans, providers, and communities to more consistently capture costs and benefits of efforts expended.

Comparative populations - When considering what strategies to study and what costs to include in modeling effect, a comparative approach would be best. This would include several sets of matched populations with similar medical and behavioral health/mental health conditions, demographic characteristics and within the same marketplace. These populations would be segmented into groups according to different functional abilities, SDOH factors, disabilities, and frailty characteristics. We could then study different care complexity strategies as they were deployed— some with greater or fewer components and level of intensity. The total costs of care, health outcomes, and other measures for effective care management and member experience could be obtained to determine what factors are most strongly associated with each other, whether there is a hierarchy of SDOH and other factors, and how various strategies are most effective with which

population subgroups. Such research would go a long way toward gathering the necessary information to guide effective practice, policy, and payment.

Measures - Evaluations will need to consider the total costs of care as well as measures of impact/benefit in tandem. Benefit might be measured using relevant and meaningful quality indicators, health outcome measures, individual or population level reported changes in health/condition status, or might include counts of people participating, units delivered, or other utilization indicators. Often increase in use of primary care, mental health visits, preventive services, or home health visits is a goal. Costs and benefits are not likely to accrue in the same year. For the SNP member population serving dually eligible populations, the most appropriate evaluation around costs should probably be the impact of a sustained approach on the total of costs of care across services and sectors. This would include pharmacy, medicine, behavioral/mental health, and long-term services and supports.

Other researchers in public health argue for including larger impact and cost measures, e.g., in housing, food, corrections) with measures around crime, recidivism, EMT costs, etc. This may be beyond the scope of many collaborative partnership efforts under Medicare and Medicaid, but it is important to have a multi-dimensional view on what results were observed. Evaluating impact through addressing just one SDOH factor with a narrow focus (e.g., utilization or cost only) will miss important information for determining results. The best SDOH approaches are multidimensional and integrated. Evaluation needs to be as well.

Self-reports - Patient/member self-reports or other consumer-derived information must be included. Evaluators should adjust methods to accommodate people with social risk and other issues affecting response. Race/ethnicity, language, health literacy, age/frailty are several factors to consider in conducting self-reports. The perspective of the person is critically important—better testing of instruments and methods for high SDOH populations with various characteristics (such as advanced age, cultural/ethnic/linguistic diversity, disability) is sorely needed. We have to do a better job at gathering relevant and timely information from people who are have unique characteristics which impact participation, methods should recognize and accommodate limitations. For example, a recent study of non-response bias in the CAHPS self-report survey among 695,197 Medicare beneficiaries found a 49% response rate. Asians, African-Americans, and Hispanics responded at an adjusted rate that was 7 to 17 percentage points lower than Whites (p <.001 for each group). Older age was the strongest predictor of missing responses. African-Americans were most likely to break off of the telephone survey (Klein, 2011). The authors note that administrative indicators of race/ethnicity are primarily derived from SSA files and typically under-count certain ethnic groups. They posit that those with limited English proficiency may prefer phone vs. mail formats. Non-White and older beneficiaries especially those 85 and older consistently have low response rates and higher missing items and therefore may need oversampling.

Analysis should control or correct for sub-population differences - In evaluation, comparison of cost and quality results should account for sub-population differences. We have ample evidence by ASPE, the National Academies for Sciences, Engineering, and Medicine and researchers studying Medicare Advantage quality outcomes that population differences impact how, when, what care can be delivered. CMS notes that MA contracts tend to have either a very high percentage of duals and low-income individuals (e.g., SNPs) or a very low percentage. Given this, the sample of individuals

from general Medicare Advantage plans are likely to be markedly different from the sample of individuals from Special Needs Plans. Any bias in responses arising from characteristics of the two populations (e.g., presence of social risk factors) would be embedded in the results. There is evidence of such bias in responses based on population characteristics. These known biases have not been adequately adjusted in the scoring, weighting, or composite ratings for quality measures. Therefore, comparison of the two groups on quality measures does not appear to methodologically sound. Such a serious issue must be taken into consideration when considering both quality measurement and value-based payment using these instruments and methods and in conducting any evaluation of efforts around addressing social determinants of health.

Resources required to address SDOH - considerations

Heavy level of investment/significant resources - From discussions and anecdotal information provided, it appears that health services resources available do not cover all the components needed to address social risk factors presented by members among many SNPs and MMPs. Plans are finding ways to stretch resources, improve targeting, and work with community groups, but there are limitations on how much health insurers and medical, behavioral health, and long-term services providers can do.

Not surprisingly, greater attention and identification to SDOH reveals more and more need. Needs may be intermittent or (more likely) ongoing—for example housing and nutritional needs. The plans are stretched. They must consider their obligation to cover medical, mental health, and LTSS services. They must consider the parameters set around Medicare and Medicaid coverage.

In identifying SDOH issues, how can a plan or provider determine what elements of that need (e.g, safe housing, steady job) fall into their role and require a plan or provider driven intervention? Even with higher intensity care management and pro-active connection to social services, the needs are great and increasing. This is particularly true in low-income, poor neighborhoods, with public hospital and safety net clinics, and in rural/remote areas where resources are already stretched. All avenues and resources are explored such as community nonprofit aging and disability organizations, housing, food, and care/service organizations, faith communities, advocacy organizations, clubs, and volunteer groups. Many of the non-healthcare service providers are not set up to contract with a managed care organization, nor can they meet the information, reporting, and quality management requirements to serve as a vendor. Some have only manual or stand-alone databases maintained on single computers. Even if health care definitions were expanded to include social care, there is evidence of scarcity within communities that would impact what a person can access and when.

Bringing to Scale - The high intensity care management with community follow-up can be very effective, but it would be difficult to scale this approach for large population groups. This is a labor-intensive approach. Even with established care pathways, there is significant one-on-one assistance still required. Coordinating health services, legal, financial, housing, food, and transportation assistance, for example, is very resource-intensive and has to be titrated to the most high risk individuals currently experiencing crisis. Doing this across large population groups for addressing basic needs for food and shelter is not supported under the current policy, payment, and structural environment under Medicare and Medicaid.

What SDOH data challenges and promising practices are observed?

What lessons have been learned about providing care for patients with social risk factors?

The information we've obtained thus far offers insights into what it takes to be successful in addressing complex care populations and achieving quality performance. Factors include: sustained attention and commitment to complex chronic populations with high social risk factors (the two tend to go hand in hand) as well as extensive investment and trial of various methods for outreach, integration, care management, and provider network development over many years.

At the organizational/macro level, we find support for the following:

- Have organizations and collaboratives proactively consider and identify their purposes as well as clarify the structural, organizational, and operating characteristics of each partner or stakeholder involved;
- Individual organizational efforts as well as collaborative efforts must be clear on roles, authorities, commitment and expected return. To learn about success and barriers a strong implementation evaluation is required;
- Sustained commitment is needed. Organizations must be ready to fund capacity over multiple years;
- Policy, payment, and the community environment greatly influence effectiveness.
- Medicare and Medicaid programs will need to change scope and definition for what is covered health services and change payment in order to address SDOH issues.

At the individual (person) level, effective strategies for addressing SDOH factors include the following "lessons learned" (based on information from case examples, plan to plan discussions, and some peer review and grey literature reviewed):

- Meet people where they are;
- Expect/plan for the need to invest in and provide structure/process support for any approach undertaken (this is a long haul and will need structure/process to yield desired outcomes);
- Longer-term relationships to influence behavior change and provide ongoing coaching or care management support are more effective than episodic or person-to-person hand-offs – this goes for the individual member as well as the professional providers/clinicians involved. Where individual services are involved, an overall "one key contact" for the member to call can be extremely important to the individual— especially when setting up new services or when the individual's situation changes, or when there are health literacy or behavioral health issues;
- Cross-organizational stakeholder development of the approach and cross-organizational information sharing with near real-time information is very important; effective SDOH interventions will require cross-organizational commitment from leadership to the people directly involved with the individual;
- A peer-to-peer approach (e.g., incorporating CHWs or other peer workers) seems to be more effective for outreach and extended support to persons with chronic SDOH and care complexity issues (especially mental/behavioral health) than an approach that rests solely on professional care managers;

- A data-directed algorithm to identify high risk individuals only goes so far – the best predictive models still fall short. This may be due to data timeliness, completeness, and gaps as well as limitations in the algorithms. Therefore, a combination of data risk stratification models together with human observation and ability to respond seems necessary.

Structural and Policy Constraints - Medicare and Medicaid have defined benefits and eligibility guidelines. They are health insurance programs. They are not social care programs. If the goal is to identify SDOH risk issues and address them, this should be explicitly directed as part of the parameters set for providers and plans. While SNPs are reaching far to consider the complexity characteristics and address these within beneficiary groups (including SDOH characteristics), SNPs must operate within existing laws and regulation for Medicare Advantage Organizations.

In considering how SNP care management and other strategies might apply across MAOs, there are a few additional structural and policy constraints.

General Medicare Advantage plans could work to embed these identification, outreach, care management and community services strategies in workflows, care models, and resource allocations for a subset of their population. These general MA plans would need to study effective ways to identify, target, and reach sub-populations within their general MA enrollment. Persons who have care complexity and social risk characteristics may be a small percentage of their total enrollment. If this is the case, investment in high intensity care management services with local/regional community services linkages, collaboratives, and SDOH partnerships might be difficult to support from an economic valuation.

There are also environmental constraints, such as the level of integration allowed across the Medicare and Medicaid programs, the comprehensiveness of benefits and the investment in care strategies that are resource intensive which will come into play. Some integration across medical, behavioral, and long-term services and supports is hampered by current rules for general MAOs as well as for SNPs.

Some of the following insights and lessons learned could help guide next stage efforts. The promising approaches show:
- Robust and proactive SDOH identification using multiple data sources, tied to care complexity issue identification and response;
- Attention to methods and consistent, standardized data sources, as well as shared information platforms that provide nearly real time information – so that plans and providers and community services coordinators can be aware of significant changes and make adjustments;
- Continued development of robust predictive modeling, population stratification, and creation of strong feedback loops; multiple data sources to be integrated and utilized in these models;
- Plans have tied their data-driven strategy to a human strategy and worked to increase capacity for outreach and effective care management;
- Increased investment in community resources tailored to population subgroups;
- Greater sophistication of collaborative partnerships and evaluation of these efforts;

How are beneficiaries' social determinant of health risks and care complexities intertwined (medical, behavioral/mental health, functional, frailty)?

What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?

All the barriers the individuals face around: mobility/transportation, isolation, mental health or behavioral health conditions, lack of social supports, housing and communication and food insecurity—can be barriers to tailoring response by a health plan, provider, and community. The SDOH issues impact all aspects of life.

Care complexity complicates everything. The presence of persistent and ongoing functional limitations, for example in ambulation, cognition, eating, can greatly complicate adherence to medical advice and treatment. For example, a low-income person with Diabetes and Congestive Heart Failure who has unstable housing, no family nearby, low health literacy, and lack of access to proper fresh fruits and vegetables would find it difficult conduct daily insulin testing, eat at the right times and the right foods, follow exercise regimens to manage heart disease, check on weight gain/loss and track changes in fluid retention daily. The care manager and community services providers would work with this person to address these SDOH needs, working together to help the person through subsidized housing application/advocacy, setting up a community health worker or volunteers, initiating a home delivered grocery or meal service, buying a scale with remote telehealth access to the clinic EHR for the person's daily weights, and setting up voice mail or email or text reminders. Both the coordination and these additional services add extra costs to the total costs of care for this person. The plan is making an investment in such accommodations and supports to help the person achieve better self-care practices at home to support the medical treatment regimen. The longer-term goal is that the person achieves better success in self-care, meets Diabetes and CHF management guidelines, and accomplishes either improvement or maintenance in heath status.

A similar diagnosis in a person who has a stable home, family members to help, sufficient income, and a higher level of health literacy might not require such extensive support--even though both individuals are of a similar age, weight, gender. We know that medical expenditures for a similar condition differ substantially, and this variation is due in part to SDOH and other characteristics (e.g., dementia/moderate to severe cognitive impairment, presence of a chronic behavioral or mental health disorder, significant functional impairment, disability, and/or frailty status).

Which social risk factors are most important to capture?

The answer depends on enrollee/market characteristics and the beneficiary/enrolled/person characteristics as to what is considered "most important." The SNP Alliance has been examining peer-review studies, research and data analysis, expert committee reports, published case studies, and other resources/references on social determinants of health and the impact these risk factors have on health outcomes and quality of care measurement results. The priority factors that are most often reported in these references include:
- poverty status,
- living in a poor neighborhood,
- low health literacy,

- low education level,
- housing instability,
- lack of regular transportation,
- food insecurity,
- lack of social supports; social isolation including living alone,
- poor/unstable mental health status leading to disability or inability to work or maintain stable housing; closely tied to chemical dependency,
- living in an area with lack of mental health services/resources,
- living in an area with a lack of preventive/primary care services,
- non-English speaking, non-native born,
- unemployed, loss of job,
- lack of regular communication device (e.g., trac phone runs out of minutes; no landline or cell phone).

In the 2017 *SNP Alliance Annual Member Survey*, member health plans were asked about the top social determinant of health risk factors observed in their enrolled SNP and MMP populations. Plans were asked to involve their care managers and examine available internal data to respond to this question. The results corroborate many of the factors identified in other published studies.

The top SDOH factors reported by this sample of special needs plans were:
- low income/poverty status (80% reporting),
- low health literacy or education level (73%),
- lives alone or has few social supports (67%),
- lack of available mental health services and supports in the community (60%),
- housing instability/transience (53%),
- transportation challenges (47%), and
- food insecurity (40%).
- Additional SDOH factors mentioned included history of trauma, violence, and abuse.

(Source: *SNP Alliance Annual Member Survey 2017*, unpublished data).

Plans shared some examples and descriptive information about their special needs plan enrollment to provide additional illustration; these profiles reveal some of the complexity of their populations:

We have reviewed the characteristics of our special needs health plan enrolled members, and found they live with many social determinant of health challenges in addition to their physical, medical and behavioral conditions. For example, 76% are non-English speaking, 44% did not graduate from high school, and 49% cannot read.

We have an average age of SNP members of 82 years, 76% have a high school degree or less, 7% speak a language other than English, 72% are single, 85% live in a rural area, and 41% have an income of $10,000/year or less.

Poverty is the primary social risk factor that impacts members' health as it contributes to other key risk factors, such as housing stability. Secondary risk factors include: [low] *educational attainment, the* [lack of] *capacity to comprehend information and caregiver and caregiver quality and consistency (i.e. lack of regular family support). ADL functional status is also crucial in addressing care needs.*

All SDOH as well as clinical and other factors have a much bigger impact for members with mental/behavioral health and dementia co-morbidities.

The answer to "what social risk factors are most important" must take into account issues experienced at a point in time by the individual. For example, a current crisis experienced by a person (e.g., loss of job or housing), the severity of various medical/behavioral/social conditions (e.g., bi-polar disorder manic or depressive episode together with multiple chronic conditions such as liver disease, Diabetes, or COPD), the individual's preferences and beliefs (e.g., ethnic or culturally based belief in environmental or spiritual influences), and the individual's willingness to participate/engage—will impact the feasibility of any particular medical/health care solution or treatment offered.

Even if all practitioners and the individual are aligned in what is important, the resources available in the community to address that risk factor/issue will direct or greatly impact how/what can be done. Care management strategies to connect people to community resources can be very effective when there are resources available to which they can refer or with which they can contract. That said, the most sophisticated care management and information-linked systems crossing plan, medical, behavioral and social services providers will not solve the lack of affordable housing units in a region, solve underemployment/wage rate inequities, or mitigate the presence of lead in the drinking water.

As the number of people in need rises—elderly, disabled, low-income—and as the prevalence of social risk factors increases due to poor wage rates, underemployment, or adverse environmental conditions (e.g., natural disasters, food deserts, violence, decaying infrastructure)—community resources are increasingly stretched. Plan comments illuminate the issue of scarcity of resources:

MLTSS staffing shortages exist, especially within personal care attendant, companion and individual community living supports waivered services.

We see a lack of mental health and behavioral health services in our region.

What are barriers to collecting data about social risk?

There are many barriers—some already described. Standardizing data elements and definitions so that the same elements and definitions would be used by plans, providers and community organizations and within the Medicare and Medicaid programs would be an important and useful effort. This would require significant cross-sector stakeholder involvement but is needed for better identification, outreach, tracking, evaluating, and reporting.

Barriers to SDOH data collection include limitations and challenges in:
- Member outreach and engagement;
- Member concerns about privacy;
- Lack of standardized data elements, definitions, scales, scoring methods;
- SDOH data is captured by multiple organizations and across time periods, e.g. by the State for Medicaid eligibility assessment (may also include county data systems), by medical, behavioral health/mental health, and social services providers and agencies serving the

individual, by health plans, by non-health care service sectors, e.g., housing, legal, financial, and correctional services;

- SDOH data is held within multiple databases across organizations, on information platforms, and within record systems that are not easily searched (even if data elements and definitions were consistent/standardized);
- Data may not reflect the current conditions, therefore for targeted attention, additional information is often needed from the individual to tailor a response that reflects current priorities and issues to consider.

Utility of Standardized data elements for EHRs - Electronic Health Records would not be an ideal or primary source of SDOH data according to the SNPs and MMPs. Our member SNPs and MMPs explain why. They report challenges with accessing/using EHR data such as:

- There is variability in electronic health record platforms and data systems across providers;
- SDOH information is scattered throughout the patient chart/medical record and not easily searchable;
- Care coordinators, social workers and others who note SDOH risk factors may include observations in notes which means that terms and information varies by every person who records in the chart;
- During the medical office visit there are many items to cover including vital signs, update on the status of the person's disease/conditions, check-in on utility and effectiveness of procedures, treatment, medications, new symptoms or changes, treatment options, and other patient concerns—making attention to SDOH factors difficult;
- SDOH risk issues may be intermittently or only partially captured, even when queried by the physician or rooming nurse and included in an encounter visit (e.g., use of ICD-10 "Z" codes). Therefore, even if SDOH items were standard and EHRs were searchable through algorithms it is unlikely the information would fully reflect the patient's current situation;
- Providers are hesitant about asking questions when they do not have interventions or services to address the patient's needs;
- Plans and providers want more evidence on "what data, when, and how" to connect to effective strategies with measurable results;
- As attention on SDOH increases, state and federal agencies are already standardizing their required data elements and mandating use of specific assessment instruments. This is increasing the data collection burden on plans, providers, and consumers and may dampen the consumer/patient's willingness to answer similar questions on SDOH risk factors across providers and settings and raise concerns by patients about privacy.

Plans did remark that they would like to see standardized SDOH data elements and definitions, scales, and scoring, but that this goal is not specific to elements in EHRs.

Efforts to select specific domains and improve standard definitions would be helpful to encourage consistency across EHR platforms but this will not necessarily improve SDOH targeting. As part of our background examination of this issue we referred also to the Institute of Medicine of the National Academies of Sciences, Engineering and Medicine that issued a report from an expert committee in 2014 on issues around capturing social and behavioral health domains in electronic health records (NAP, 2014). This may offer further guidance to EHR developers and providers.

Additional comments include:

Standardizing the SDOH elements and capturing them in a systematic way would assist care teams in identifying and addressing the needs of the patient.

It can be a challenge for care teams to find SODH and ADL needs within an EHR as the information can be scattered throughout the chart. Capturing the data in a single location would also improve reporting capabilities as it would make it easier to extract the data to be captured on a population level.

Moving data elements from paper documents or free-standing electronic surveys into an EHR requires additional data entry and takes clinician's time that could be spent with patients/members. Integration of electronic survey data into an EHR/database would reduce data entry time but there are technology development costs.

Data about social risk in itself is fragmented. The challenge is how to produce a more straightforward narrative about the status of the member's health and wellbeing considering all the various data elements collected for each member. There is also the concern of collecting data without having a way to address the needs identified with meaningful interventions to support a member and/or membership population.

Our State Department of Human Services has provided an HRA form for non-MLTSS members as well as the assessment for LTSS members, so it is already standardized and comprehensive. We have initiatives in place to monitor and improve HRA completion rates. However, As CMS and DHS continue to expand regulatory elements and quality measures to be collected via the HRA tool, the assessment experience is becoming exhaustive for the frail elder and disability members. Please note this does not include time spent with members for care plan development.

Promising opportunities

Improving member engagement - Patient/member engagement and activation –that is how willing and ready the person is to be part of the ongoing care management is very important. This is the other component that is needed—the person himself must be willing to consider how his choices and actions are impacting health. He needs to get to the point where he wants to change and is willing act on advice. Motivational interviewing, health coaching, and other approaches show promise.

Plans are experimenting with various ways to improve reach, tailor and enhance member communication, and engage members in the way they prefer. Plans are also exploring ways to better understand current risk, past behaviors, and how to effectively intervene with targeted members.

One health plan describes their approach that they have been testing and fine-tuning over several years:

We implemented a technology solution that specializes in cost and quality management, revenue management, and customer engagement to assist in SDOH data collection. We experimented with a variety of communication tools such as phone calls, email, social media, and text messages to reach out to beneficiaries in need of additional management. We used the technology to record engagement rates and then survey members about

socioeconomic healthcare challenges. Some members pick up the phone and some don't--At the end of the day, we want the member to respond. Members are more likely to engage in their health when we are contacting them according to their preferences. Over time we started to record if members prefer text messaging and opt into text message engagement. Now we have data to determine how to apply the appropriate intervention tactic to engage each member, and to have the best response rate.

The engagement strategy incorporating SDOH information into the plan's risk stratification approach allowed for additional information gathering such as member surveys about SDOH challenges. This also facilitated better outreach. The plan believes that this has led to improvement in some of the chronic disease control measures, such as Diabetes, Managing High Blood Pressure, and Medication Adherence. There is higher member engagement and response to text message or other reminders and better follow-up. The plan attributes the improvement in chronic disease management measures to their concerted efforts around outreach to members regarding their communication preferences and plan follow-up that includes customized alerts and proactive attention to members' concerns.

Improving data mining and analytics – Plans are investing in better data system capabilities to do such things as increase HRA data integration, join independent care managers on a shared data platform, and connect or share data across providers and plans—this focuses on SDOH data elements as well as other key care complexity factors, such as frailty status, functional status, and other important markers or health indicators. In our most recent Annual Survey, 70% of plans said that having better data systems/capabilities was their most important priority around identifying, reaching, targeting, segmenting and serving specific sub-groups of members within their enrolled population to tailor and coordinate efforts. In the SNP Alliance Annual Member Survey, we asked plans about how they would use better, more complete SDOH data and what they already do to utilize this information. The responses are shown in Table 1.

Table 1. Strategies for using SDOH information		
N=15 plan organizations reporting	**Already use SDOH data for this purpose**	**Likely to pursue if had SDOH data**
To modify customer service/member services protocols	70%	30%
For member outreach	60%	40%
To modify the Model of Care (specific to SNPs)	60%	30%
To modify care management strategy/methods	60%	40%
To change algorithm/stratification for identifying high risk groups	50%	50%
To analyze quality reports/results	50%	50%
To modify member materials	40%	40%
To enhance analysis of other data, by social risk factor or sub-population	30%	70%
To change provider networks or modify provider requirements	30%	40%
Working with provider groups	20%	50%

(Source: *SNP Alliance Annual Member Survey 2017*, unpublished data)

Plan comments help illuminate the opportunities and challenges:

> *Our plan uses aggregate sociodemographic, or social risk factor, data to identify categories of need and develop interventions to address these needs. Through one-on-one interactions, Care Coordinators identify individual members' needs and refer them to appropriate resources and programs.*

> *We have primarily understood the population by reviewing social risk factor data from the census and other public data sources on the population. Internal care coordination assessments have also provided insight to member needs. More recently, we conducted deeper analysis of our internal data to understand the population risk-profile of our members. We conducted descriptive analysis of all available individual and social demographic data (such as urban v. rural residence, and race among other variables) to describe our SNP population compared a similar Medicare managed care population. To study additional social determinants of health, we matched our members' census tract to the American Community Survey (ACS) to obtain education, average income, poverty status, and home ownership at the neighborhood level. This comparison exposed the disparities faced by the SNP population.*

> *We have analyzed the social demographic data in multivariate regressions to predict gap closure* [for specific quality measures] *(of Colorectal Cancer Screening, Breast Cancer Screening, and the Comprehensive Diabetes Care measures of Eye Exam, and Kidney Disease Monitoring) within the SNP population, but did not find a relationship, potentially due to lack of variation in these census-tract level variables.*

Conclusion

Our analysis shows robust efforts across special needs health plans based among those participating in SNP Alliance discussions, shared learning and surveys. These plans are actively identifying SDOH and other care complexity issues in their SNP and MMP populations. They have identified multiple sources of data and are using these in a variety of ways (referred to by some as "layering information") to tailor response to individual members and to subgroups within their enrolled populations.

Many SNPs have significant resources invested in their care management and care coordination methods, with protocols, pathways, and information systems. They provided many examples on ways they are working to extend across medical, behavioral, and long-term services and supports providers to address care and support needs in a consistent and coordinated way. Many plans are regularly referring to and some are paying for these community services through contracts with aging service provider collaboratives, housing providers, transportation and food service agencies and others. The need is tied to health management and the connection to community resources is part of the care management work. SNPs attend to key risk factors (conditions and social risk triggers) with alerts to enable early proactive attention when there has been a change in status.

Plans point out that the persistent and ongoing social risk factors together with other health risk issues, such as presence of substantial functional limitations interact and can exponentially increase care complexity. The SDOH and health factors impact the person's daily functions and ability to maintain a quality of life (e.g., impacting sleep, mobility, eating, social isolation, self-care management, and cognition). Studies support this observation showing that total costs of care and

quality health outcomes, even for people with similar health conditions, can differ widely and that SDOH risk factors, functional limitations, care complexity, and level of cognitive impairment are strongly associated with higher costs and poorer outcomes.

Plans have described multiple challenges with finding and using SDOH data and linking this information to effective care strategies. More can certainly be done. There is opportunity and promise for identifying effective outreach and care integration strategies that crosses sectors and spreads within communities. For some services and in some communities, however, identification and information exchange and outreach cannot address the lack of services available. There is evidence of scarcity already, even without consistent identification or targeting.

Based on the knowledge gleaned from SNPs and MMPs, sustained commitment including time and resources dedicated to these population subgroups is bedrock. It is clear that medical, mental health, and social needs are deeply intertwined. Integrated approaches have demonstrated successes on which to build.

 SNPs have invested in chronic care expertise, internal structures and processes, innovation, member outreach, and communication connections to facilitate virtual interdisciplinary care management and accountability. This is extending beyond traditional medical and behavioral health settings. Plans are trying to make these connections across providers and with LTSS.

Plans have worked with their communities, states, and providers for years to achieve their current care models. All of these structures, processes, and resources invested rely on a deep attention to and understanding of members' characteristics and community resources. Finding multiple ways to proactively reach the member, establishing relationships, and connecting across settings, disciplines, and over time, are some of the ingredients of successful efforts. This happens only over time and with intentional sustained effort.

Special needs health plans and Medicare-Medicaid plans are at the forefront of efforts by Medicare Advantage plans in addressing vulnerable populations, as they have a long-standing and exclusive interest in chronic care. We hope that others build on these strategies developed over many years and shared in this response.

As mentioned in our introduction, while it is encouraging that providers and health plans are responding to social risk factors as important characteristics of their patients/members—we must recognize there are limits to what they can do. It seems apparent that the social determinant of health deficits experienced by people enrolled in Medicare and/or Medicaid will not be able to be addressed by the health care sector alone. Long-term community-wide solutions are needed for some of the most intractable social risk issues. Addressing SDOH factors will require greater multi-sector long-term investment by society.

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