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November 16, 2018

Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 415F
Washington, D.C. 20201

Submitted via: ASPEImpactStudy@hhs.gov

RE: IMPACT ACT Research Study: Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Assistant Secretary:

UnitedHealth Group (UHG) is pleased to resubmit comments to the Department of Health and Human Services (HHS) regarding the IMPACT ACT Research Study: Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors. Specifically, we focus on how providers and health plans serving Medicare beneficiaries are working to improve health outcomes for beneficiaries, especially those with social risk factors. UHG is dedicated to helping people live healthier lives and making our nation's health care system work better for everyone through two distinct business platforms – UnitedHealthcare, our health benefits business, and Optum, our health services business. Our workforce of 285,000 people serves the health care needs of 140 million people worldwide, funding and arranging health care on behalf of individuals, employers, and the government. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, but we are also the nation's largest Medicare health plan – serving nearly one in five seniors nationwide – and one of the largest Medicaid health plans, supporting underserved communities in 30 States and the District of Columbia.

Through this study, HHS is requesting information on how providers and health plans capture Medicare beneficiaries' social risk factors to improve health outcomes. Additionally, HHS is requesting information on how providers and health plans are collecting and using data on Medicare beneficiaries' social risk factors. UHG has supported efforts to make the health system work better for everyone for more than a decade through our continuous work to identify, address and monitor health-related needs associated with age, gender, address, race and ethnicity, language and disability.

In May 2010, the UHG commitment to this effort was strengthened by founding the Health Equity Services (HES) Program. This cross-functional, enterprise wide program leads collaboration with UHG Commercial, Medicare and Medicaid leaders from our clinical, network, operations, data and informatics, customer service and marketing departments to foster a holistic approach in reducing health disparities and enhancing the end to end consumer experience.

HES program priorities include:

- Multicultural population stratification
- Understanding gaps in health and health care to develop interventions
- Refining the patient-centered approach based on member demographics, including race, ethnicity and language preferences; and
- Growing multicultural capabilities to enhance the member experience

The biennial survey from the Physicians Foundation shows 88% of physicians have at least "some" patients impacted by social determinants of health and more than half of physicians said that "many or all of their patients have such an impediment." The survey, which includes responses from more than 9,000 physicians, is conducted by physician staffing and recruitment firm MerrittHawkins. "In this [value based care] model, healthcare providers go beyond the maladies presented by particular patients to address their underlying causes," The Physicians Foundation report says. "It is an emerging strategy being used to integrate the social determinants of health into the traditional, individual approach to patient care. It is an approach that aims to improve the health of an entire human population."[1]

The Chronic Care Act of 2018 seeks to provide Medicare consumers more integrated care by integrating medical and non-medical care. Yet, the health care industry lacks the ability to consistently collect these social aspects, which impact care, in a standard way. By collecting this data though ICD-10-CM codes, policy makers, payers and providers will be in a better position to: meet consumers' needs, have better visibility into chronic diseases, have more accurate Star Rating measures, monitor, plan for the provision of support services, and ultimately improve consumers' outcomes.

CMS issued regulatory guidance in April 2018 (2019 Call Letter and 2019 Part C and D Final Rule) to be effective in 2019 permitting Medicare Advantage (MA) plans to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for consumers who meet specific medical criteria, provided similarly situated enrollees are treated the same. CMS also expanded its definition of "primarily health-related" benefits. We support CMS expanding the "primarily health-related" definition in 2019, and thus believe that the additions of the proposed ICD-10-CM codes are needed to capture situations that would include SDOH.

While there are a number of ICD-10-CM codes that identify a variety of "SDOH," there are few unique ICD-10-CM codes that identify "Social Diagnoses or barriers to care." As such, UHG is recommending the addition of several new ICD-10-CM codes that support the existing SDOH codes, thereby benefiting the industry as a whole in the management of patient care. The new, expanded ICD-10-CM codes would capture these "Social Diagnosis and barrier situations" to assist providers and consumers in obtaining routine care, medications, and preventive services that are not captured today.

Physician diagnosis and inclusion of SDOH codes in Plan of Care development is critical to enhancing clinical outcomes, as noted by The Robert Wood Johnson Foundation: only 20% of health outcomes can be attributed to clinical care. Upstream social determinants of health account for the other 80%, including social and economic factors (40%), physical environment (10%), and health behaviors (30%).[2]

[1] Social Determinants Impede Care of 88% of Patients, Doctors Say, by Bruce Japsen, September 18, 2018.
[2] Robert Wood Johnson Foundation's County Health Rankings Model, 2014.

Additionally, several of the Healthcare Effectiveness Data and Information Set (HEDIS) measures require outpatient visits that may be difficult to complete due to social barriers unrelated to consumers' health. For example, breast cancer screening must be completed in a location with mammography equipment. If consumers have no means of transportation, or cannot afford to pay for transportation to a breast cancer screening center, the probability is high that this screening will not occur. The standardization of data collection through the expansion of ICD-10-CM code sets the stage for consumer SDOH data capture for the industry to manage these types of situations to drive better consumer engagement, care, and outcomes.

Expanding this code set would allow for population health improvement, along with the opportunity for NCQA to expand HEDIS measurements around social barrier identification and assistance in the future. NCQA is supportive of this approach and has provided a letter of endorsement to UHG for the expansion of the ICD-10 codes.

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Rationale for Expanding SDOH Code Set

The following are further thoughts we would like to share with HHS on the importance of furthering the SDOH code set.

- SDOH are paramount in the complete determination of healthcare needs and are highly impactful in the accurate assessment and creation of care plans.
- The physician is key in the identification, coding, and Plan of Care development.
- All professionals participating in the healthcare continuum need to have access to, and assist in, the assignment of appropriate SDOH to accurately capture this information across the industry.
- Tracking specific SDOH allows for tailoring of care plans due to those codes that will improve overall health outcomes. Using the expanded SDOH ICD-10-CM codes would be similar to using other codes providers use in their care planning, as they alter a care plan based on this additional knowledge. Examples of other codes are:
    - Z88 = allergy to medications
    - Z72 = tobacco
- Specific SDOH are more impactful in certain settings. The more specific the SDOH, the more targeted the adjustment to a members' care plan. Examples are:
    - Housing instability or social isolation impacts discharge plans from an acute care setting
    - Economic factors (such as inability to afford the drug or copay) play a role in medication adherence
    - Food insecurity plays a significant role in treatment of diabetics
    - Transportation needs are critical for consumers with treatment plans that require frequent face-to-face contact, dialysis, cancer treatment, rehabilitation services, etc.
    - Illiteracy drives the care plan/treatment method communication mode and health literacy is a large part of a transplant success, as it requires adherence with complex medication schedules, dietary recommendations, management of co-morbid conditions, etc.
- Providers need input from all professionals across all care settings because this information may not otherwise be shared. Examples of current challenges:

    - Notes from hospital social workers, therapists and dieticians are often times not sent to outpatient providers
    - Consumers' income and education are not a standard part of outpatient health intake forms
- In order to be utilized regularly, this information needs to be shared with treating providers in a standard, easily accessible format. Examples are:
    - Facility discharge summary problem list
    - Specialist notes problem list
    - Health plan list of chronic conditions
    - Electronically via Care Continuity Document's, which is the common industry approach of transmitting hospitalization and transition services.

How SDOH Barriers are Captured Today

Today, capturing SDOH barriers appears to vary widely throughout the overall industry, rendering it a fragmented, inconsistent way of both capturing and using this information. In addition to using the current Z55-Z65 ICD-10-CM codes, SDOH is captured today through mechanisms such as Systematized Nomenclature of Medicine– Clinical Terms (SNOMED-CT), Logical Observation Identifiers Names and Codes (LOINC), NACHC's Protocol for Responding to and Assessing Consumers' Assets, Risks, and Experiences (PRAPARE) assessment tool, disparate home grown manual processes, etc.

UHG strongly encourages HHS to engage in industry conversations with all impacted stakeholders to reach an agreement on the best practice(s) to collect SDOH, and through the use of ICD-10 coding an existing standard could be utilized, which is a critical window into the health and wellbeing of a patient. Additionally, we request HHS to investigate options to educate and incentivize providers to participate in the collection of SDOH. It is critical, regardless of the best practice selected for the collection of SDOH that it be operational and widely adopted. The Promoting Interoperability Program may be one option to consider as a way to incentivize provider use of the ICD-10 coding. Other options could be to leverage risk adjustment methodologies and HEDIS measures.

Social Diagnoses or Barriers to Care Data Capture Value
Providers and Delivery of Care

Awareness about the social determinants of disease and environmental barriers to care is critical knowledge that can aid providers. First, a better understanding of the challenges and support systems available to their consumers would promise better outcomes because treatment regimens would be selected based on consumers' ability to comprehend and adhere to care regimens. Second, awareness of these consumer specific challenges documented in a consistent fashion can be better shared among the entire integrated care team keeping all involved mindful of the specific needs of the individual. Finally, this data provides an opportunity to better assess relative clinical risks so vital for population health, using analytic models that not only incorporate demographic and clinical data, but also the unique risks to health status introduced by these barriers. In this way, providers would have a better sense of the consumers in their practice with exceptional needs for management of their overall health.

While these facts may be captured in other data sets, the establishment of a series of codes within ICD-10-CM would make these facts more immediately available, in proximity to the clinical diagnoses, without the need to query multiple data sets. It would be a practice enhancing approach to provide treating physicians with vital information without undue administrative burden.

Centers for Medicare and Medicaid Services

As the demographics of the Medicare population changes, this expanded profile of the consumers would provide CMS and its contracted payers a more comprehensive view of each Medicare consumer and their households resulting in improving the consumer experience along with better quality of care. UHG is serving as a leader in aggregating social determinants in order to provide a more comprehensive consumer risk profile, improved health outcomes, and improved population health data.

State Medicaid Agencies

As the state Medicaid agencies move toward integrating medical and behavioral health services, there is an opportunity to use encounter submission as a reporting mechanism to SAMHSA (Substance Abuse and Mental Health Services Administration), by using the ICD-10-CM SDOH and Member Attribution codes. The current reporting requirements to SAMHSA are cumbersome and being produced by outdated, disparate, state computer systems which, in many instances, are not integrated into the continuum of care. The Arizona State Medicaid System (Arizona Healthcare Cost Containment System-AHCCCS) requires and monitors Medicaid providers to ensure that they are coding all available ICD-10 Z codes and has also provided a letter of endorsement to UHG for the expansion of ICD-10-CM codes.

Why Use ICD-10-CM Codes Over Other Codes/Classifications

Utilizing the ICD-10-CM codes is a logical choice, as it is the standard language between care providers and payers. The existing SDOH range Z55 – Z65 in the ICD-10-CM has been labeled as "Persons with potential health hazards related to socioeconomics and psychosocial circumstances," validating that an expansion of these codes would be warranted within the ICD-10-CM classification.

Additionally, Chapter 21 of the International Classification of Diseases, Tenth Revision (ICD 10) covers factors influencing health status and contact with health services. Per the American Hospital Association (AHA), hospitals and health systems are already using codes in the Z55-Z65 categories to report socioeconomic and psychosocial circumstances. Additionally, it notes that hospitals and health systems should educate necessary individuals, including physicians, non-physician health care providers, and coding professionals of the important need to collect data on the social determinants of health. Utilizing these codes will allow hospitals and health systems to better track consumer needs and identify solutions to improve the health of their communities. As coding professionals review a consumer's medical record to identify the appropriate ICD-10-CM codes to include, they should be aware of and begin utilizing the ICD-10-CM codes included in categories Z55-Z65.[3]

While other coding standards have also identified some SDOH codes, there are varying reasons why they would be a substandard solution to wide usage by the industry:

- Systematized Nomenclature of Medicine – Clinical Terms (SNOMED-CT) is a large, comprehensive computerized clinical terminology covering clinical data for diseases, clinical findings, and procedures. SNOMED-CT codes are embedded in providers' electronic health record (EHR) systems to find ICD-10-CM codes in real-time - the I-MAGIC (Interactive Map-Assisted Generation of ICD Codes) use case to assist coding professionals by suggesting ICD

[3] American Hospital Association, ICD-10-CM Coding for Social Determinants of Health, April 2018

codes based on SNOMED CT-encoded problems.[4] It is only through this mapping to ICD-10-CM codes that allows the data to be pushed downstream to the health plans and population health and statistical data utilizers and researchers. In researching the current SDOH codes, UHG collects and reports on (either Z55-Z65 or UHG's Member Attribution codes) against the SNOMED-CT codes, there are less than ten SNOMED codes that could be utilized.

- Logical Observation Identifiers Names and Codes (LOINC) represent the "question" for a test or measurement; these codes are useful for ordering/reporting test results. LOINC's goal is to create different codes for each test, measurement, or observation that has a clinically different meaning. To do that, LOINC codes distinguish a given observation (test ordered/reported, survey question, clinical document) across six dimensions (component, property, time, system/specimen, scale and method) that we call Parts.[5] LOINC has been widely recognized and recommended for transmitting laboratory and clinical observations, but not for SDOH. Additionally, these codes are not tied to the physician's problem lists, diagnosis, or Plan of Care development.

How the Industry is using this Data for Better Clinical Outcomes

In 2017, UHG began a national initiative to capture, code, and refer to social and governmental programs those members who self-identified a SDOH. The work began with data from UHG's MA members, but the model is applicable to data collection and use for any consumer. Based on the findings, UHG, along with the National Association of Community Health Centers (NACHC), is proposing to add specific new ICD-10-CM codes for healthcare industry adoption. Adding these specific codes would drive to a consistent and standard method to identify barriers to care, including an increased ability to track the codes as related to HEDIS measures, thus resulting in better member outcomes and quality of care. The addition of these proposed new codes will also provide value to the industry, as data will be available that can be utilized to recommend or refer consumers to get needed care that they may not otherwise be receiving due to encountering unidentified social barriers.

Many entities in the health care industry have adopted the usage of NACHC's Protocol for Responding to and Assessing Consumers' Assets, Risks, and Experiences (PRAPARE) assessment tool to document SDOH. The Health Information Technology, Evaluation, and Quality Center's (HITEQ) June 2017 article displays a tool that outlines existing ICD-10 Z codes that are a close match to the questions in the PRAPARE tool and they note: "While z-codes do not yet exist for all responses to PRAPARE domains and specific responses, systematically coding using a standardized dataset for domains that do have close matches will allow health centers to use such structured data for practice change and consumer care and to build the beginning of a robust SDOH dataset across health center populations for policy and evaluation."[6]

UHG started collection with 36 individual codes used so that very granular member issues can be identified and allow specific assistance to be provided. Half of those codes (18) are standard ICD-10 diagnosis codes, and the other half (18) are uniquely created "Member Attribution Codes." Collecting and using these codes together allows for improved care that better integrates member health and social factors into the holistic care of the member.

[4] How SNOMED-CT can help in the ICD-10-CM transition, National Library of Medicine/National Institutes of Health, Kin Wah Fung, MD, FRCSEd, MS, MA, 2010
[5] LOINC from Regenstrief webpages: https://loinc.org/get-started/what-loinc-is/ and https://loinc.org/get-started/loinc-term-basics/
[6] HITEQ, ICD-10 Z-Codes for Social Determinants of Health, June 2017

The process to collect the data is based on the creation of a standardized flat file layout, which could accommodate sources that ***identify*** member social determinants, sources that ***refer*** members to social services that assist them with their barriers to care, sources that ***fulfill*** a social need or sources that do more than one of those activities.

Each data source is mapped to the standardized layout by certified coding expert consultants to match the source's terminology to the established codes producing a file. The file is then provided on a regular schedule to a designated secure location for ingestion, storage, and provisioning to designated consumers of the data.

To illustrate a way UHG utilizes this data to reduce disparities in health and subsequently its determinants is as follows:

An organization contracted by UHG conducts at least 1.2 million home visits per year utilizing Nurse Practitioners. Starting in 2017, clinicians asked 19 social determinant, Veteran, and care giver questions as part of home visits. In less than a year, data collected shows that over 400,000 members have self-identified a need for social, financial, or community assistance affecting health. The identified social determinants are sent daily to a UHG vendor partner, who utilizes the information to reach out to members and assist them with applications for Medicare Savings Program/Low Income Subsidy (MSP/LIS) and/or ***refer*** them to social services.

Referrals are returned to UHG using the standard file layout, so that analysis can be conducted on outcomes.

UHG's mechanics for capturing SDOH data focus on the Medicare Advantage population including Group Retirees and Dual Special Needs members, with expansion planned for Medicaid, Medicare Supplemental, and Commercial members, include:

- Collection of SDOH data from 15 currently identified internal and external sources to leverage available government/community resources to improve care outcomes
- A permanent, secure location to transmit their files
- A transmission schedule of their choice; daily, weekly, or monthly
- An Interface Agreement document with details of the file transmission process
- Meetings for walkthrough and file testing
- Ongoing Production Operations monitoring, with feedback to submitters if any issues arise
- Consolidation and storage of the SDOH data for subsequent access
- Display the SDOH data in a Clinical Profile tool used by case managers that allows for identification/referrals and use in developing member plans of care
- Reporting and analytics on the consolidated data for population health management and programmatic improvements

Chronic Kidney Disease Research

Finally, OptumLabs, UHG's open collaborative research and innovation center, is working with NQCA on a CMS Office of Minority Health (OMH)-sponsored research project examining how Chronic Kidney Disease progression may vary due to social disparities. We expect results to be available in 2019.

Thank you for your thoughtful consideration of our comments. Please do not hesitate to contact us to discuss further.

Sincerely,

Richard J. Migliori, M.D.
Executive Vice President and Chief Medical Officer
UnitedHealth Group