



November 22, 2018

*Submitted by email to ASPEImpactStudy@hhs.gov*

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

Dear ASPE Impact Study Team:

Commonwealth Care Alliance (CCA) appreciates this opportunity to respond to your Request for Information (RFI) regarding the *IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors*. From our beginnings, CCA has recognized how social risk factors impact health and has been among the first health care organizations in the United States to create interventions to address these needs. As an organization dedicated to providing the highest quality care for Medicare-Medicaid beneficiaries, we are in a unique position to comment on serving this population.

Established in 2003, CCA is a community-based, not-for-profit health care organization dedicated to improving care for people with complex chronic conditions, including multiple disabilities. For individuals who are dually eligible for MassHealth, the Medicaid program in Massachusetts, and Medicare, our unique, nationally recognized health plans provide and coordinate the full spectrum of care – medical, behavioral health, dental, durable medical equipment and social services – to eliminate gaps in care and reduce costs. Disability-competent, direct primary care is provided by our wholly owned clinical affiliate, Commonwealth Community Care, an organization with more than 30 years of experience supporting adults and elders with complex physical, developmental, intellectual and mental health disabilities, as well as through over 27,000 providers in our contracted provider network.

CCA serves more than 30,000 beneficiaries statewide in Massachusetts through our Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) and our Medicare-Medicaid Plan (MMP), through the Financial Alignment Initiative demonstration. Our FIDE SNP, Senior Care Options (SCO), serves over 10,000 beneficiaries, the vast majority of whom are dually eligible for both Medicare and Medicaid age 65 and above. Our MMP, One Care, serves more than 20,000 dual eligible members between the ages of 21 and 64. CCA has longstanding experience in providing and managing care across the continuum, including integrating primary care, behavioral health, and other long-term care needs for complex populations, and employing alternative payment models to better align payer and provider incentives to improve quality of care outcomes and achieve cost savings.

CCA's ability to engage in close clinical and therapeutic relationships with members and families and to develop individual care plans based on a high level of member engagement are key factors in changing lives and improving health outcomes despite the negative impacts that social risk is known to cause. CCA invests significant time and resources to find, engage, stabilize, and maintain members in the community. More than half of our workforce is dedicated to clinical care and care management.

Our comments below are divided into the following sections:

- Serving Medicare Beneficiaries with Social Risk Factors
- Investing in Non-Traditional Services and Innovative Programs
- Data through Each Member Touch Point and Beyond
- Impact on Quality Outcomes and Cost of Care
- Barriers and Opportunities

### **Serving Medicare Beneficiaries with Social Risk Factors**

Medicare beneficiaries with social risk factors face many barriers in their daily lives, including lack of affordable housing, unreliable transportation, food insecurity, access to the outdoors and safe neighborhoods, and adverse childhood events. Many of these individuals have experienced distrust in the health care system, significant gaps in their care, and stigma due to various factors related to behavioral health conditions or housing insecurity. They also navigate care between traditional siloes of support which have historically been established assuming individuals need help with just one medical or social risk factor, when in reality they need support with a variety of risks and co-morbidities. In addition, disability, functional limitations, and frailty make the need for addressing social needs more immediate because if social needs are not met, medical risk increases much more rapidly, with potential for more serious medical problems.

For the many dual eligibles CCA serves, social risk factors have a direct and immediate impact on medical needs. Often members prioritize housing, food, and other social risk needs over medical goals like losing weight or better managing chronic disease. Our experience has shown that only once social needs are fully addressed and members are stable, can they turn to addressing medical goals. On both the front and back ends of this dynamic, social and medical risk needs seem to be unrelated; but in between, social and medical risks are more intertwined. For example, members may move into housing but still have to work on other needs like regular access to healthy food. There is a tipping point when members start to see better medical outcomes because of decreased social risk and the trusting relationship developed with CCA care partners and interprofessional teams. At this point and beyond, members will call CCA when they have concerns instead of going straight to the emergency department (ED). We believe CCA's comprehensive model of care allows this tipping point to occur earlier than models that do not center around building relationships and holistic person-centered care. Our approach of including social risk factors and meeting members' more traditional medical needs as part of one comprehensive approach has proven to be successful

Upon enrollment, CCA conducts comprehensive assessments to identify medical, behavioral, social, and long-term services and supports (LTSS) needs. Some new members, especially those

with social risk needs, are hard to reach due to many factors including homelessness, lack of access to a cell phone or email, or incorrect address and phone numbers. CCA has created specialized teams dedicated to finding and engaging these members, many of whom need an initial face-to-face meeting to begin to engage. Using data and knowledge of community resources, these teams reach out to past providers and pharmacies and set out into the community to places where members might regularly visit. They also coordinate with providers to meet members at scheduled appointments. Other times, we first engage with these members when they present to the ED for medical or psychiatric support.

Extensive care coordination, central to CCA's work with members, has been shown to lower longitudinal medical costs, particularly evidenced through a substantial reduction in ED and behavioral health inpatient admissions. After comprehensive assessments with members, CCA utilizes a stratification process to optimize the intensity and type of care with members' diverse and evolving needs and make efficient use of resources. Members with lower levels of need may be assigned to a primarily telephonic care model with in-home supports provided as necessary. Members with more complex care needs, including those related to disability, functional status, and frailty, are typically partnered with a mobile care partner who can provide care delivery, management, and coordination in members' homes or community. It is vital to the success of the CCA care model that the right mix of services is determined at the individual member level through a balance of both clinical and social determinants of health factors – aligned through comprehensive care plans. Members with particularly complex needs may be served by one of our intensive care coordination teams described below:

- **Behavioral Health Intensive:** Members with multiple psychiatric admissions or have had difficulty engaging in treatment, but with strong connections with their primary care providers, may be assigned to CCA's Behavioral Health Intensive (BHI) care model.
- **Full-Spectrum Primary Care:** Members with quadriplegia, bipolar disorder, past suicide attempts, limited mobility and/or a history of frequently missing medical appointments may be assigned to CCA's in-house clinic for enhanced primary care, Commonwealth Community Care (CCC).

Between 20 and 25 percent of CCA's One Care members receive care coordination through delegated care management sites called Health Homes. CCA has established deeply integrated, collaborative partnerships with these carefully selected experienced community partner organizations, such as community health centers and behavioral health providers, to provide high-quality care coordination aligned with CCA's model of care, mostly for CCA members with whom these organizations have an existing relationship (e.g., through a staffed residential facility, outpatient mental health services, or primary care). Members are assigned a care management resource from these delegated entities, thus benefiting from colocation, service integration, and the member's existing engagement with the provider, while CCA provides oversight and access to occasional specialized services (e.g. from our in-house diabetes specialist or admission to our Crisis Stabilization Unit) working collaboratively with the delegated entity's interprofessional team.

One example of this delegated arrangement is through Boston Health Care for the Homeless Program (BHCHP). A nationally recognized health care leader, BHCHP serves people experiencing chronic homelessness and those unstably housed. BHCHP offers clinics and programs at shelters and many other sites around the city, along with street outreach teams, suboxone/methadone clinics, and specialized care for certain chronic conditions. CCA has also funded BHCHP to conduct a cell phone pilot study, which provided cell phones to CCA members to improve access to care and increase engagement with the Health Home team.

Built into our care model, CCA care management staff have the flexibility of time and space to work with members on their most pressing needs, which are often related to social risk. Care partners travel to where members prefer to meet and can spend more time with members who need it. They develop trusting relationships by consistently showing up, meeting members without judgement, and demonstrating they are accountable to them. This allows care partners to dig in more deeply to understand more details regarding barriers and risk factors. Care partners support members in prioritizing their goals and creating a person-centered care plan, and offer incremental action steps towards progress. Invaluable to this work are nonclinical staff like Health Outreach Workers (HOWs) who immediately begin addressing the identified social risk factors and help members connect with other programs and benefits in the community, like day programs, addiction services, and workforce and education opportunities. Clinical supervision supervises HOWs where appropriate. Our model is designed to broaden members' circles of support, beyond the initial trusted relationship built with care partners, and translate that trust to the health care system as a whole.

By broadening the members' circle of support, CCA often makes referrals to outside community based agencies based on member ability to navigate complicated care systems. For members able to reach out to agencies on their own, we provide information and any needed education and then follow up with the member to ensure connections were made. If the member needs more support, we can make the phone call or warm hand-off with the member to the agency. Where appropriate, we contact the agency directly, provide helpful background on the member, including our assessment or clinical review as needed, and explain that we will authorize the service as the payer. We also provide support to alleviate administrative burden on the agency so they can focus on the provision of services to the member; and most importantly, we ensure coordination and follow up with both the member and the agency.

### **Investing in Non-Traditional Services and Innovative Programs**

CCA care partners work closely with our members to collaboratively identify goals and develop individualized care plans, resulting in a person-centered tailored set of services. The most appropriate care for members with social risk needs often involves non-traditional services like clean bedding, air conditioners, and home modifications which positively impact health outcomes. High utilizing members tend to use more non-traditional services than the average CCA member. We have found that One Care members with behavioral health conditions account for a majority of non-traditional services in the One Care program. For example, 79 percent of the CCA members who received non-emergency medical transportation; 79 percent of those receiving housing support services; and 74 percent of those receiving legal aid or credit counseling services have at least one underlying behavioral health diagnosis. In a 12-month

period between 2017 and 2018, CCA spent \$25 million on home modifications and environmental controls. In this same period, CCA clinical staff recorded 2,100 encounters for housing support and 11 percent of members received nutritional support through medically or non-medically tailored meal delivery.

While the identification of all social risk factors is important, we have found that the need to assess housing risk has been most important. We estimate between 7 to 10 percent of all CCA members have been homeless at one point in time during their enrollment with CCA. In addition, about 21 percent of One Care members and almost 11 percent of SCO members have moved at least once in the previous 20 months – a clear indication of being underhoused. For One Care, this means that nearly one third of members – or 18,000 individuals - have been homeless and/or underhoused. Approximately eighty percent of referrals to HOWs are housing related and as much as 50 percent of a HOW's time is spent on assisting CCA members with housing.

CCA understands that it is extremely difficult to prioritize health when housing is uncertain, often housing decisions lead to sacrifices with food, medications, or health care treatment as members are faced with difficult choices. Housing also becomes more complicated when a member has a spouse or children, because solving the member's social risk need means solving the need of the larger family or social unit. To address this, anytime a member mentions a concern with housing, a HOW reaches out to conduct a supplemental housing assessment, described in greater detail in the section on data below. The assessment identifies different levels of need, including (i) members experiencing homelessness, emergencies, safety risk, or eviction; (ii) members who spend a majority if not all of their income on housing; and (iii) members in a housing program they do not prefer. With this information, HOWs offer the following appropriate resources:

- **Appointments and Documentation:** Across the various systems related to securing and/or maintaining housing, CCA helps members fill out applications, manage required paperwork, and make action plans for obtaining each document. The process is often laborious as many members lack appropriate and required documentation such as drivers license and other state-issued identification. We also ensure members know what they can expect and what is required at various appointments and we accompany members to appointments to advocate on their behalf, assist with communications, and identify necessary follow-up action.
- **Housing Workshops:** CCA offers workshops to members during which HOWs present information on the housing programs available to members and assist with the completion of housing applications. CCA coordinates transportation to these workshops and prepares folders for each member with applications to housing programs in the geographic area for which they may qualify. Members and staff complete the applications together, CCA provides stamped envelopes, and mails the applications out to the appropriate agencies. These workshops mitigate the opportunities for members who fail to see the application through to completion.
- **Home Preservation:** HOWs work closely with resident coordinators and other housing agency staff to build relationships and prevent evictions. In addition, CCA's rehabilitation teams perform home safety evaluations to identify what DME items will appropriately support the member's independence. We help members file reasonable

accommodation requests where necessary and obtain paperwork from providers, for example, if a member needs a certain shower installed due to physical needs.

- **Moving Costs:** First and last month's rent and security deposit are a significant burden for our members. CCA connects members with a variety of community resources that sometimes can help defray these costs. In addition, many members experiencing homelessness have little or no personal belongings, and CCA connects them to community resources that provide donated furniture and household items.
- **Wellness Workshops:** CCA's Health Education Team delivers wellness workshops, often in conjunction with Outreach and Marketing throughout the year. The team is currently partnering with a local housing organization to integrate workshops into their larger wellness program. We are also developing a proposal to this same organization to provide a wellness nurse to provide care coordination to residents.
- **Credit Scores:** CCA connects members with their local community Legal Aid offices to determine if credit counseling or filing bankruptcy would be beneficial to a member. We also connect our members to resources to assist with the payment of past-due utility bills, help set up payment plans with representative payee organizations to help lower a member's credit risk.

These non-traditional support services have improved outcomes to our members. CCA's One Care and SCO programs have been recognized as incubators to test innovative health care models for dual eligibles and complex populations. CCA has realized the potential offered by both programs to pioneer clinical innovations, many of which have become national models for providing high quality and cost-effective care for the populations with complex medical, behavioral health, and LTSS needs. CCA's payment model of monthly fully capitated blended payments allows for innovation and creativity to develop effective approaches to flexible spending across medical, behavioral health, and social risk needs. These innovations include:

- The development of **Crisis Stabilization Units (CSUs):** To provide effective, compassionate care for those with behavioral health diagnoses, CCA worked in partnership with the Massachusetts Department of Mental Health to create specialized CSUs, providing respite care for members with acute behavioral health needs as an alternative to psychiatric hospitalization. These units operate based on a continuum of care, not an episode of care. These units offer members a structured setting where our clinical teams focus on maintaining member safety, improving recovery, and promoting a safe return to the community. Peer support groups, ED diversion, and longitudinal behavioral health and medical care are the cornerstones of these two units. Because we are a payer and provider, we have the flexibility to allow for longer stays in these units where appropriate and necessary to stabilize these individuals and avoid ED visits. For example, members with clinical acuity may stay one more week until they are able to get into a sober house, where they can maintain sobriety for another sixty days, instead of risking relapse in between.
- **Mobile Integrated Health (MIH):** CCA's MIH program partners with ambulance companies to assist our members with non-life-threatening acute and subacute issues. MIH paramedics have been specially trained in home-based evaluation and treatment and have diagnostic and care skills that exceed those of standard ambulance services. They work in close communication and collaboration with CCA primary care teams which

allows for experienced physicians familiar with our members to offer continuity of care. The program has been a success by any measurable standard. Eighty-two percent of members were able to stay home after a MIH visit and over 99 percent of members reported satisfaction with the care received in their home by a paramedic. Due to this success, the program has been expanded statewide to reach more needy individuals. We look forward to continuing this program, which has become an integral component of our care model.

- **Inpatient Care Model at Boston Medical Center:** Hospitalization is particularly challenging for CCA members with physical, behavioral health, and intellectual disabilities. In collaboration with Boston Medical Center (BMC), CCA provides inpatient care at BMC focused on understanding and meeting the needs of these special inpatient populations. Staffed by experienced CCA hospitalist clinicians, CCA members are provided with unmatched longitudinal care which allows seamless integration with outpatient teams. Members and families experience a better inpatient care delivery system – one that recognizes and meets their unique needs and provides continuity to ensure success upon discharge.
- **Life Choices Palliative Care:** CCA has employed an alternative to traditional hospice with a broader range of in-home services available throughout the course of serious illness, not just at end of life. Led by board certified palliative care physicians, CCA nurse and nurse practitioner palliative care clinicians work closely with care partners to improve the quality of life of members facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other physical, psychological, and spiritual challenges.
- **Tele-Psychiatry:** CCA utilizes tele-psychiatry to improve access to psychiatric care and offers on-demand support to members in the community. Our field-based care managers can leverage tele-psychiatry to conduct joint consultations over the phone with an off-site CCA psychiatrist while the care manager is in the home with the member. This technological innovation has improved efficiency and availability of limited psychiatric resources for members in need.

### **Data through Each Member Touch Point and Beyond**

As health care has moved away from the hospital or clinic walls, we now expect engagement with members at home or in the community. With this transition also comes the expectation that data collection does not solely come from medical appointments within certain medical office buildings. Medical, administrative, and encounter/claims data are not well suited for capturing social risk factors and do not provide sufficient detail regarding level of need or the interplay of clinical need and social risk factors. We believe that health plans and providers must think more creatively about intentionally collecting more and better data, especially social risk data, through regular care management activities and member-reported data initiated by the member, care team, and/or technology.

CCA has used a variety of ways to collect data in many ways, including during comprehensive assessments at initial enrollment, with triggering changes of condition, and at the required annual or semiannual timeframes. These assessments provide a thorough snapshot of needs in a specific

point in time and help members create and update care plans alongside their care partners. These assessments also include some questions about social risk factors which might, for example, identify whether a member is unstably housed at that specific time of assessment. The cornerstone of data collection is communication with the member. Plans need to be consistently engaged with members to stay up to date and understand the sometimes rapidly changing needs of members. CCA collects data from regular care partner interactions and provider activities. Our 24/7 clinical triage line, which deploys a variety of clinical resources to engage with members, is also a key way that we quickly learn about important changes in a member's life.

CCA utilizes a care management platform with an embedded supplemental social determinants of health (SDOH) assessment. A care partner or other care team member can decide to conduct this SDOH assessment with a member at any time, at initial assessment or afterwards. The required assessments may capture a certain social risk need, like housing instability, and the platform automatically recommends that the supplemental SDOH assessment be conducted. Because of the high need for housing support, CCA created an additional housing supplemental assessment based on questions they typically ask members with housing risk.

Once the SDOH and housing assessments are completed, the care management platform provides recommended interventions based on the identified social risk needs. CCA tailors the intervention recommendations to give more specific direction about how to support such members according to member location or eligibility factors. Moving forward, any care team member can access the assessment within the electronic platform. The care management platform is also able to take assessment results and pre-populate the care plan with items which may be a priority to members. The care partner then shows the care plan to members as a starting point for discussing opportunities for improvement. Members make decisions about what matters most in their lives.

CCA also uses predictive analytics to identify members who are likely to visit the hospital or experience issues with certain chronic conditions. This allows us to target support and intervention instead of waiting for a crisis event to occur. Care partners can actively take steps to prevent or delay acute episodes. Publicly available data can also be used to identify a member's proximity to a grocery store or transportation options and to locate lease and mortgage records to better identify need and target key social risk interventions.

CCA has been at the forefront of emerging technology and leveraging the potential to improve care for members. From voice technology, innovative home-based monitoring platforms, medication adherence devices, and enhanced telemedicine, CCA has helped develop and pilot platforms and devices which revolutionize how care is provided. We see opportunity for such technology to regularly monitor whether a member has enough food to eat in a given week or whether a member experiencing homelessness is staying with a friend, in a shelter, or on the street. CCA continues to explore opportunities regarding the following technology which we believe will improve quality outcomes of these populations:

- Because sickness and acute cases do not follow a traditional 9-5 medical day, a **24/7 Virtual Care Environment** would leverage advances in telemedicine, home monitoring, and avatars to provide access at all hours and days of the year.



- **Individualized technology** can be provided to members and considered a part of their care plans. Assessments should include evaluation of Wi-Fi access, smart phones, and other technology devices, along with the potential to leverage such devices.
- **Voice and face-to-face communication** has the potential to address social isolation, which many of our members experience. This technology can be scaled to include populations not traditionally included in commercial markets.
- **Connected home monitoring technology** has the potential to supplement medical home visits and provide real-time data that allows for increased evidenced-based care decisions by utilizing more accurate and greater amounts of data.

Data sharing is a barrier to providing and coordinating care. Sharing information between providers and community partners as appropriate is important for cohesive and aligned member care, but current electronic data sharing systems do not always support person-centered care plans that involve a team-based approach to care. CCA supports the standardization of a minimum set of social risk data for EHRs to increase the knowledge of and ability to compare social risk need across populations or geographies. Such a standardized set of data should not hinder face-to-face interactions between providers and patients or become a burden to providing the most appropriate care.

### **Impact on Quality Outcomes and Cost of Care**

Measuring the impact of social determinant interventions on the individual level is challenging, and quality measurement protocols must appreciate the long term nature of the results of these programs. Alignment on quality and total cost of care is critical. However, flexibility must remain in the system to allow for innovations in this emerging field. With some members, we see immediate quality and financial impacts. With other members, these results take one to two years. CCA's care model has demonstrated proven outcomes in quality, utilization, and cost and is regarded as a national model for complex care delivery to beneficiaries with high costs and high needs. CCA's SCO program has consistently achieved four stars or above in the Medicare Advantage Star Ratings program, achieving in 2019 five stars on 22 measures, including the four new measures (two for appeals management and two for the appropriate use of cholesterol-lowering medications in high-risk members with diabetes or heart disease) and four stars on another 9 measures. For 2018, CCA's One Care program is the highest rated MMP in the nation, based on the 2016 and 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys administered by the Centers for Medicare & Medicaid Services (CMS).

CCA often finds that new members have spent years in the fee-for-service system with significant unmet needs and very high acute care utilization, using EDs as their primary source of care for both psychiatric services and primary care. After joining CCA, members are connected to services and resources that result in lower utilization of high-cost services over time. While there are some examples of immediate impact on utilization, typical CCA members need well over a year to be stabilized and to make substantial progress toward meeting their health care goals. We recognize that sometimes costs for caring for complex populations can increase initially due to the cost of managing new member with such unmet needs, but believe that front investments in care coordination and community-based services lead to ultimately reduced utilization across a range of metrics, including ED visits and psychiatric inpatient admissions.

We have found that individuals with behavioral health and substance use complexity can experience the strongest improvement in utilization while at the same time experiencing an increase in their quality of life and improvements in their health care status.

It is often difficult to pinpoint return on investment (ROI) of specific non-traditional services because they are included in a comprehensive care plan approach. However, when total cost of care (including both traditional medical and non-tradition social risk focused services) is evaluated over a member's total tenure with CCA, our care model has proven that investing in community-based services does decrease the cost of acute care. In the three-year period from 2015 through 2017, medical costs Per Member Per Month (PMPM) decreased by 4 percent per year in SCO and 0.2 percent per year for One Care. In a recent analysis comparing established members to new members, medical costs PMPM for established One Care members was 5 percent lower, with 29 percent fewer inpatient admissions and 13 percent less ED visits. In SCO, while medical cost PMPM for established members was 9 percent higher, we observed a 23 percent decrease in inpatient admissions and 17 percent less ED visits.

In addition to the results that we have found across our care model related to medical spend, we have invested in studying specific programs to test their impact on health outcomes as well as cost of care. For example, CCA recently collaborated with Massachusetts General Hospital to find out if providing home delivered meals can result in fewer ED visits and hospital admissions and also save the health care system money.<sup>1</sup> In this pilot, a select group of patients received medically-tailored meals from our partner Community Services, whose meals are developed by a Registered Dietician and executive chef and are tailored for diabetes, HIV/AIDS, cancer, heart disease, kidney disease, and other life-threatening illnesses. Another group of patients received non-medically tailored meals, and a control group, with similar demographics and clinical profiles, did not receive tailored meals. Compared to the control group, medically tailored meal participants had a total care cost of \$843 per month vs. \$1,413 per month for the control group and were associated with fewer ED visits, inpatient admissions, and emergency transportation. After accounting for the cost of the meals provided, the program experienced an ROI of 63%.

## **Barriers and Opportunities**

A primary challenge to collecting social risk data is that some health care providers do not consider social risk factors as medical or in the scope of their work. Some medical professionals, especially those in medical settings without integration with behavioral health, LTSS, or social supports, avoid asking about social needs because they do not know how to support issues of housing, food insecurity, and domestic violence.

As Medicare and other programs move increasingly towards value-based or alternative payment models, there is great opportunity to incorporate the findings from this RFI into health plan programs and providers' knowledge base. Quality measures in these efforts, tied to financial incentives or penalties, should include those specifically related to social risk factors and metrics of high importance to such high need populations. This will increase the interest and ability of

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<sup>1</sup> Berkowitz, S. A., Terranova, J., Hill, C., Ajayi, T., Linsky, T., Tishler, L., DeWalt, D. A. (2018). Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries. *Health Affairs*, 37(4), 535-542. doi: <https://doi.org/10.1377/hlthaff.2017.0999>

plans and providers around the nation to focus resources and invest in addressing critical social risk factors. We particularly recommend that social risk and other factors that have been demonstrated to impact the results of population-based quality measure performance results be fully considered and case-mix adjustments and/or stratifications be implemented where appropriate to allow for valid performance comparisons across plans or providers.

Working within the current regulatory framework of existing Medicare and Medicaid systems is also a barrier to the provision of services outside the scope of what is considered traditional benefits. CCA is successful operating under a number of Federal waiver authorities (including 1115a and the Financial Alignment Demonstration) CCA firmly believes that any future programs or models that attempt to intergrate the challenge of addressing social risks for a publicly-funded beneficiary with the provision of their medical and behavioral health services must remain flexible and patient-centered in their application while at the same time allowing states, plans and providers the opportunity to “think outside the box” of what has been the standard practice of capitated payment systems.

Limited availability of affordable housing and long housing waitlists are among the biggest barriers to housing that our members experience. Public housing or private subsidized housing waiting lists are at best 6 months long and at worst 2-3 years long. Housing Choice Voucher waiting lists can be much longer, as much as 8-10 years in Boston, for example. HUD funding remains a critical component in funding for housing supports and we encourage broader efforts to increase investment in and access to affordable housing, along with initiatives to allow for increased and flexible funding so that plans and providers can better assist members with housing need.

Many communities in Massachusetts and across the nation experience a scarcity of mental health and substance use disorder providers. As discussed above, the majority of CCA members often have complex medical, behavioral health, and social risk needs, each of which can increase the acuity of the others. The intersection of these needs, along with trauma, high baseline costs of care, and the scarcity of clinical providers, supports the need for new innovations and greater provider capacity to ensure success in caring for members with behavioral health needs. CCA supports workforce development initiatives and increased education and training for providers, particularly on behavioral health conditions.

Risk-adjustment methodologies that give more meaningful consideration to social risk factors would ensure more appropriate payment allocation for high need members. For many people experiencing homelessness, rating categories and risk scores does not fully capture the often-associated elevated inpatient, ED, medical expense rates, and higher intensity management resources. Payment model adjustments may give plans the opportunity to keep pace with the expenses of members with significant social risk needs and continued investment in innovations tailored to their particular needs is strongly supported by CCA.

Finally, lack of formalized coding structures for non-traditional services is a significant barrier to the identification of important social risk factors affecting high need populations. This inflexibility can contribute to a lack of realizing the full benefit of fully integrated health plan service delivery models like CCA’s and the traditional physician practice model that, in the

current billing environment, is difficult to align. A broader array of allowable codes to recognize social risk factors would enable plans to capture and report this critical data through the encounter submissions.

## **Conclusion**

CCA applauds the work that ASPE is conducting regarding socioeconomic status and social risk, as required by the IMPACT Act. We welcomed the opportunity to contribute to the recently published *Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans* report and would be pleased to provide any additional information upon request. Please contact Ken Preede, Vice President, Government Relations, with any further questions via email at [kpreede@commonwealthcare.org](mailto:kpreede@commonwealthcare.org) or by phone at 617-426-0600.