AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

November 16, 2018

VIA ELECTRONIC MAIL
ASPEImpactStudy@hhs.gov

Brenda Destro
Deputy Assistant Secretary
The Office of the Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Social Risk Factors and Medicare's Value-Based Purchasing Programs Request For Information

Dear Ms. Destro,

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Social Risk Factors and Medicare's Value-Based Purchasing Programs Request for Information (RFI) by the Assistant Secretary for Planning and Evaluation (ASPE). Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 83 hospitals and more than 300 other health facilities in 17 states and the District of Columbia.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographical locations, we strive to provide an objective and sound policy voice that works across health care providers.

AHPA applauds the efforts that the Department of Health and Human Services (HHS) is taking to study how social risk factors influence patient outcomes and hospitals' performance under value-based payment models. To ensure that hospitals are not unfairly penalized for serving vulnerable populations, we believe that it is important to address social risk factors and work collaboratively to achieve health equity. Not every community faces the same social risk factors, and some are limited in their ability to be healthy because they have fewer social and economic opportunities. For example, in the bottom performing counties in the nation, one out of five children do not graduate from high school in four years.[1] These

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[1] County Health Rankings and Roadmaps. 2018 County Health Rankings Key Findings Report.

social and economic factors can account for up to 40 percent of health outcomes, while clinical interventions only account for 20 percent.[2] Therefore, to improve the health of individuals, social risk factors must be addressed. Below are the responses to the questions posed in the Social Risk Factors and Medicare's Value-Based Purchasing Programs RFI.

Responses to the RFI

Are social risk data being used to target services or provide outreach? If so, how?

In the discharge planning process, Care Managers collect social risk data—such as living situation, emotional factors and environmental barriers—on each patient. This data is also collected in the outpatient setting at physician practices and emergency departments. Based on the information collected, interventions are made when social needs are identified. The method and social risk factors collected can vary across health systems. Care Managers, supported by a multidisciplinary team (e.g. Clinical Social Workers, nurses) generally collect social risk data during the patient's discharge planning assessment, which happens within 48 hours of a patient being admitted to the hospital. The Care Manager then connects the patient with community partners that can address the identified social needs. Community partners can include Federally Qualified Health Clinics (FQHCs), churches, shelters or universities. For example, Adventist Health System has a transitional care program that coordinates care with local community partners to ensure that there is continuity of care for patients when transitioning from the hospital to their homes.

How are beneficiaries with social risk factors identified?

Patients with social risk factors are generally identified and supported through a discharge planning assessment, including a readmission risk evaluation, when they are received into the acute care hospital setting. The factors collected through these assessments vary across hospitals. Below is an example of the social risk factors collected by our AHPA facilities.

- Age
- Gender
- Marital status

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[2] County Health Rankings and Roadmaps. What is Health?

- Living Situation (e.g. Alone, Assisted Living Facility, Incarcerated, Homeless, Traveler, Lives with Friend, Domestic Violence Shelter)

- Support System (e.g. None, Friends, Organization, Church/Spiritual Life, Extended Family, Community, Cares for Self, Spouse/Family, Private Caregiver)

- Socio-economic History (e.g. Employed, Parent/Guardian is Employed, Spouse/Significant Other is Employed, Food Stamp Recipient, Women Infants and Children, Temporary Assistance for Needy Families, Unemployed)

- Environmental Barriers (e.g. No Barriers in Home, Inadequate Heating and Cooling, Lack of Transportation, No electricity in Home, No Running Water)

- Emotional Factors (e.g. Difficulty Managing Stress, Psych Consult Pending, Identified Psychiatric Diagnosis, Irritable/Agitated, Isolated/Lack of Social Interaction, Somatic Complaints/Chronic Fatigue)

- Major Stresses (e.g. Caring for Elderly Parent, Death in Family, Death of Spouse, Disability, Divorce, Marriage, Trauma, Unemployed, Work Problems, Homeless, Financial)

- Complex Needs (e.g. Domestic Violence in Family, Premature Infant, Behavioral Health Placements, Financial or Insurance Issues, Scarce Resources, Chemical Abuse)

What are promising strategies or best practices for improving care for patients with social risk?

The recognition of social risk factors and their impact on patient outcomes has spurred nationwide efforts to improve care for patients with social risk. Some promising strategies include social risk screenings, connecting patients with community resources, care navigation services and investments in community-based initiatives.

Social Risk Screenings

The push to address social determinants of health has led to an increase in the number of screening tools that have been developed to identify individuals with social risk factors.[3] The use of these tools are an emerging trend, as they can help health systems to identify patients that may need additional support. For example, a two-question screening tool developed by the U.S. Department of Agriculture can be used to determine whether an individual is food insecure.[4] This information, depending on the capability of the

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[4] American Academy of Pediatrics Publications. Promoting Food Security for All Children.

hospital's Electronic Health Record (EHR), can be documented in the patient's EHR to facilitate care coordination.

Connecting Patients with Community Resources

Once a patient's social risk factors are identified, a common best practice is for a Care Manager to connect the patient to community resources that meet such needs. This includes connecting patients with a local clinic for primary care services or with Meals on Wheels and food banks for food assistance. Researchers at the Yale Global Health Leadership Institute found that partnerships that provide access to resources such as housing and nutrition programs improve health outcomes and lower health care costs among low-income and vulnerable populations.[5]

Care Navigation Services

Providing care navigation services is an emerging strategy to reduce barriers to care. This includes providing home visits, phone calls, prescription assistance, arranging for follow-up appointments and securing transportation to appointments for patients. Offering and providing this assistance to individuals with social risk factors is crucial to ensure that they are receiving needed resources and completing their medical treatment. Care navigation roles are generally occupied by a Care Manager or Social Worker.

Investments in Community-Based Initiatives

Many of our AHPA hospitals have invested in community-based initiatives designed to ensure that patients with social risk factors receive the necessary resources to have healthy lives. For example, one of our member hospitals, Florida Hospital Orlando, provided a $6 million donation to the region's Housing First initiative to end chronic homelessness. This initiative has housed 555 individuals who were chronically homeless and housed another 168 people suffering from serious physical or mental illness, totaling 723 people. Housing the chronically homeless has helped saved the community millions of dollars in jail and police costs and has reduced their utilization of the emergency department by more than half.[6] Similarly, Adventist Health in California partnered with community stakeholders to develop "Project Restoration," an initiative to provide housing and intensive care management services to the homeless. This has resulted in average cost savings of over $5,000 per patient, per month. Community-

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[5] Yale Global Health Leadership Institute. Leveraging the Social Determinants of Health. What Works?
[6] Orlando Sentinel. Central Florida Leaders Mark Milestone in Housing Homeless.

based initiatives have proven to be effective in addressing social risk factors and improving clinical outcomes.

What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

In order to successfully refer a beneficiary to a social service organization, AHPA suggests that a best practice is to identify the social needs early. This can be done through the discharge planning assessment at the point of a patient's entry to the hospital. As soon as the needs are identified, the Care Manager or Social Worker can connect the patient to community resources. Follow-up phone calls or visits are also recommended to ensure that the patient receives the needed assistance.

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

There are many barriers that hospitals face when tailoring services to patients with social risk factors. These include:

- **The lack of access to health care services for behavioral health patients.** Since the deinstitutionalization of psychiatric services, there has been a growing shortage of psychiatric beds. Individuals that require intensive psychiatric care usually end up homeless or in prison.[7] A recent report by Merritt Hawkins found that around 13.6 million Americans live with a serious mental illness, but 60 percent received no mental health services in the past year.[8] Due to the shortage of behavioral health beds, hospitals often struggle to find behavioral health facilities and resources to connect patients in need after discharge. In addition to the lack of services, rehab centers or primary care providers sometimes refuse to take patients that have behavioral health issues for follow up services.

- **The lack of adequate community resources**. Finding enough resources to meet the needs of patients facing social risk factors is a major barrier to addressing those factors. AHPA hospitals

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[7] Health Affairs. The Changing Role of the State Psychiatric Hospital.
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have taken part in several initiatives to address social risk factors for vulnerable populations. These initiatives include partnering with food pantries or helping to staff free clinics, but there remain situations where there are not enough resources. For example, one of AHPA's member hospitals, Florida Hospital Orlando, contributed $6 million to the Housing First initiative in the City of Orlando which has helped 723 chronically homeless individuals receive housing.[9] Despite these efforts, there are still many individuals with disabilities and mental illness that are waiting to find housing.

- **The higher costs associated with coordinating care for social risk patients.** The costs associated with tailoring services for social risk patients can be significant because these patients require more resources, such as wraparound services and transportation. While some hospitals may have the ability to invest in such resources adequately, others may find it more challenging. The lack of sufficient funding, coupled with scarce community resources, can make it difficult to tailor services for patients with social risk factors.

- **The lack of interoperability and lack of ability to document social risk factors in EHRs.** To address a patient's social needs, it is crucial to gain historical information that identifies referral needs and examine previous failures that resulted in a patient not being able to remain healthy outside of the hospital setting. Due to the lack of interoperability among EHRs, hospitals often find it difficult to access information regarding services or resources received by a patient outside of the hospital walls. This includes data sharing with other hospitals as well as with organizations providing social services. The inability to access such data hampers the ability of hospitals to coordinate care for patients with social risk. Additionally, the majority of EHRs do not support the documentation of social risk factors. While many of our member hospitals document social risk factors in the medical record, it is usually not in fields that would make it conducive to data collection. Epic is one of the few EHR companies that has tried to standardize social determinants of health data into the medical record.

- **The separation of substance use data from the medical record.** Currently, 42 CFR Part 2 requires a patient's Substance Use Disorder (SUD) records to be separated from the medical record. As a result, clinicians are often unaware of the behavioral health needs of an individual.

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[9] Orlando Sentinel. Central Florida Leaders Mark Milestone in Housing Homeless.

> This limits the ability of providers to coordinate care for patients with behavioral health issues and tailor services appropriately.

In order to address these barriers, AHPA recommends that policymakers:

- Increase the community resources and services available for patients with social risk factors, particularly for those facing behavioral health issues.
- Increase the number of alternative payment models that account for the clinical and social needs of vulnerable populations.
- Engage in efforts to advance interoperability. This may include designating, through the Office of the National Coordinator for Health IT (ONC), an open Application Programming Interface (API).
- Incentivize the standardization of social risk data collection in EHR systems.
- Align 42 CFR Part 2, which governs the confidentiality of SUD patient records, with HIPAA.

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

The greatest lesson is that the presence of social risk factors is a major contributor to patient noncompliance. For example, a patient facing diabetes or other comorbid conditions can easily be labeled as noncompliant if they are not following a prescribed diet. However, that patient may be faced with food insecurity and can only afford to buy cheap, processed foods. Literature has also found that social factors play a role in patients' noncompliance to treatment plans. One study found that 13 percent of Medicare patients reported cost-related noncompliance. This rose to 29 percent for disabled Medicare patients.[10] To ensure patients can comply with their treatment, hospitals must proactively identify a patient's social needs. Patients with social risk factors also experience difficulty navigating the health care system due to many issues, such as not having a permanent address or phone number. This makes it more difficult to track those patients and ensure that they are getting the services they need. Therefore, a major lesson is that even after connecting patients with clinical or social services, it is necessary to follow-up with the patient or health provider to ensure compliance.

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How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)?

The costs for targeting and providing services to individuals with social risk factors vary across AHPA hospitals. Hospitals generally have charity and care management budgets that contain dedicated funds for addressing issues such as transportation and medication costs. Facilities have additional staff, such as Care Navigators, Transitional Care Coordinators and outreach clinics, that help patients with social risk factors.

<div align="center">

<u>Conclusion</u>

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AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@AHSS.org.

Sincerely,

Carlyle Walton
President
Adventist Health Policy Association

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AHS applauds the efforts that the Department of Health and Human Services (HHS) is taking to study how social risk factors influence patient outcomes and hospitals' performance under value-based payment models. To ensure that hospitals are not unfairly penalized for serving vulnerable populations, we believe that it is important to address social risk factors and work collaboratively to achieve health equity. Not every community faces the same social risk factors, and some are limited in their ability to be healthy because they have fewer social and economic opportunities. For example, in the bottom performing counties in the nation, one out of five children do not graduate from high school in four years.[1] These social and economic factors can account for up to 40 percent of health outcomes, while clinical interventions only account for 20 percent.[2] Therefore, to improve the health of individuals, social risk factors must be addressed. Below are the responses to the questions posed in the Social Risk Factors and Medicare's Value-Based Purchasing Programs RFI.

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What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

In order to successfully refer a beneficiary to a social service organization, AHS suggests that a best practice is to identify the social needs early. This can be done through the discharge planning assessment

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

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- **The lack of adequate community resources**. Finding enough resources to meet the needs of patients facing social risk factors is a major barrier to addressing those factors. AHS hospitals have taken part in several initiatives to address social risk factors for vulnerable populations. These initiatives include partnering with food pantries or helping to staff free clinics, but there remain situations where there are not enough resources. For example, one of AHS's member hospitals, Florida Hospital Orlando, contributed $6 million to the Housing First initiative in the City of Orlando which has helped 723 chronically homeless individuals receive housing.[9] Despite these efforts, there are still many individuals with disabilities and mental illness that are waiting to find housing.

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- **The higher costs associated with coordinating care for social risk patients.** The costs associated with tailoring services for social risk patients can be significant because these patients require more resources, such as wraparound services and transportation. While some hospitals may have the ability to invest in such resources adequately, others may find it more challenging. The lack of sufficient funding, coupled with scarce community resources, can make it difficult to tailor services for patients with social risk factors.

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In order to address these barriers, AHS recommends that policymakers:

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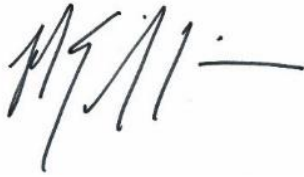
Conclusion

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AHS welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@AHSS.org.

Sincerely,

Michael E. Griffin
Vice President of Advocacy and Public Policy
Adventist Health System

ALTARUM

SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

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March 18, 2019

To: The ASPE Impact Study at ASPEImpactStudy@hhs.gov

Re: RFI on Social Risk Factors

On behalf of the Program to Improve Eldercare at Altarum, we appreciate the opportunity to provide comments on this RFI to improve Medicare for those living with serious disabilities associated with aging.

<u>How do plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors?</u>

Our team is actively involved in improving care for persons living with serious disabilities in old age. We are finding that clinical teams are using a variety of ways to identify social risk factors, including putting screening questions into their EMRs, requiring close inquiry when an elderly person has dependencies in Activities of Daily Living (ADLs), and having someone in the office or clinic who is charged with working with patients and caregivers to identify and secure community services. These are variably implemented, often not supported well in records or service delivery processes, and poorly documented, on the whole. Of course, PACE and some SNP plans do better, and CMS could use their performance as a benchmark.

Recommendation: That a suitable screening for social risk factors, with follow-up for more intensive inquiry and support, be adopted for all Medicare beneficiaries with advanced illness or disability, and that the needed records be added to the requirements for certified EHRs.

<u>What approaches have plans and providers used to address the needs of beneficiaries with social risk factors?</u>

Unfortunately, health plans and providers nearly universally rely upon referral and navigation in response to identifying a social risk factor. Exceedingly few are involved in assuring the adequacy of the supply and quality of social supports. Most just advise the patient and family to contact one or more of the potentially available suppliers, and most do not follow up to see if the need was met. For the plans and providers who focus more on these issues, they usually find themselves up against limited supply and long waiting lists. Housing that is affordable and available for persons living with disabilities is virtually unknown, forcing many elderly persons into nursing homes (or assisted living, if they can afford the private payment). More elders are ending up homeless. Transportation is usually a predominant issue, leading to many no-shows at physician appointments and increasing isolation for the elderly person. Many elders need door-to-door support, and many local governments and providers are proud if they can provide curb-to-curb support, which is not enough. The undersupply of home-delivered meals is a national scandal. Many cities have multi-month waiting lists and find that the elderly person has died or moved into a nursing home before they make it through the waiting list. There are even widespread waiting lists for investigating elder abuse and neglect. And the lack of support for family caregivers or funding for paid caregivers is just accepted as a fixed element of our social environment.

So, we have been encouraging health plans and providers to get involved in adjusting the supply and quality of the services needed to mitigate social risk factors. A few are doing that. We are worried about health plans and providers directly providing community supportive services because those will mostly be targeted to elders who otherwise would use substantial medical care, rather than to the larger group who are hungry or homeless or otherwise in a vulnerable condition. It would be better to address the needs of the geographic community and be sure that frail and disabled elderly people can get the

basics of support when they cannot provide for themselves.

Plans have used referral (handing the patient or caregiver a list of community services that probably can meet the need, sometimes the Eldercare Locator or the Area Agency on Aging), navigation (helping the person to find a potential or actual source of the service in the community), and compromising (helping the person find a next-best way to cope when referral and navigation don't work well, such as entering a nursing home). A few plans have paid for some of the services directly – e.g., paying for a couple weeks of home-delivered meals after hospital discharge, paying for a "tuck in" service to settle at home a newly discharged person who has no family or volunteer help, paying for transportation to appointments, etc. Sometimes these payments have been worked into supplemental benefits, but sometimes they are actually paid from profits, e.g., through a foundation tied to the health plan.

All of this largely misses the critical point. In general, these services depend upon the supply and quality of services available in the geographic community where the person lives. The availability of home-delivered food, disability-adapted and affordable housing, a workforce skilled in the appropriate ways, employers that provide flexibility for family caregivers, and so on – these are all characteristics of the community, not of the health plan. It is inefficient and morally repugnant to provide the ways to mitigate social risks only to people who otherwise would be high utilizers of health care services. It is much more efficient to figure out how to mitigate social risks for frail and disabled elderly people in a town, city, or county. The health plans and providers have been slow to understand the functioning of the social supports in the communities where they provide services. Health plans and providers should participate in setting the priorities and mitigating the shortcomings in the areas where they work. They should know whether the local home-delivered meals service is developing a waiting list

and act to reduce or eliminate it. They should be speaking up at housing hearings to advocate for universal design. They should be participating with their community-based services and community colleges to enhance the workforce and should be helping to encourage employers to enable more family caregiving (without losing the family member's income). In short, health care providers need to develop corporate citizenship in the communities where they are making their living. This is the key. It is a good thing to get one patient into supported housing or to have reliable food or personal care. It is much more important to have the confidence that one lives in a community where these issues are monitored and managed so you can count on the basic supports if you need them.

Recommendations

1. That Medicare move to encourage and then require comprehensive care plans including social and family supports based on the personal situation and priorities for Medicare beneficiaries with substantial social risk factors.

2. That health plans and providers engage with their communities and participate in measuring, monitoring, and improving the social risk factors that affect their patients.

3. That health plans and providers screen and navigate – and follow up to see that the need has been met.

What is the evidence regarding the impact of these approaches on quality outcomes and the total cost of care?

The literature is now very consistent that targeted efforts to address social risk factors are reliably effective in improving beneficiary experience and reducing health care costs. We reviewed the literature for the July National Academy meeting on social risk factors for persons with advanced illness, and the array of proven interventions numbered more than 30. However, to achieve

beneficiary improvement and lower health care costs, the provider must target the intervention to persons who otherwise would use medical services (usually, as evidenced by their past history of high utilization). Therefore, the persons who would simply suffer and die would not be among those targeted.

How does one disentangle beneficiaries' social and medical risks and address each?

Here, we agree with the C-TAC response, as follows. With all due respect, this is the wrong approach. It is impossible to disentangle beneficiaries' social and medical risks and address them separately since they are inherently intertwined. For example, poor health literacy leads to difficulty managing medications and care instructions, which leads to poorer health. Lack of adequate nutrition works against medical treatment as it undermines peoples' ability to heal, maintain function, and avoid health crises. Our health care system has tried for decades to just address peoples' medical needs and the gap between what they truly need and receive is growing, along with unsustainable costs.

Recommendation– That instead of separating social and medical risk, Medicare take a more holistic care approach for elderly beneficiaries with serious disabilities associated with aging that is focused on quality of life for them and their family caregivers. An additional benefit of this approach is that it will address any social risk factors affecting their quality of life and, therefore, health.

Is value-based purchasing a tool to address social risk factors?

We agree that beneficiaries with social risk factors could benefit from such alternate payment models but only if providers in such financial arrangements are rewarded for gathering the right information on them, e.g. functionality, quality of life, family caregiver burden, etc., providing holistic

care, and are not penalized for caring for people with high needs and historically high cost.

For instance, a recent Government Accountability Office (GAO) report[i] confirmed that the current Medicare Advantage (MA) risk adjustment calculation understates the effort and cost of caring for those with poor functionality. This is problematic, as it makes it financially undesirable to care for such patients, many of whom also have social risk factors. Yet functional information is not gathered as part of MA risk adjustment methodologies, and is therefore unable to be factored into such calculations.

Recommendations

1. That functional assessment be added to all Medicare programs. We suggest exploring third party assessors, as per GAO report, should this be too administratively burdensome on providers.
2. That Medicare explore adding additional assessments of quality of life and family caregiver burden for those beneficiaries with advanced illness.
3. That value-based purchasing formulas be adjusted so as to promote the care of beneficiaries with poor function, high social needs, risk factors, etc.

What are barriers to collecting data about social risk? How can these barriers be overcome?

The most substantial barrier is that most providers have learned that they have little capacity to affect the social risk factors by referral and navigation. The waiting lists for services are too long, the administrative barriers are too hard for frail elderly people, and so many people have just a little too much income to get help from Medicaid. Providers do not want to

learn about the patient's situation when they can do nothing to make it better.

Furthermore, the existing requirements for EHRs do not support good care for this population. There is no place identified for social risk factors, indeed, there is no place identified for such obvious elements as functional status, mental status, and caregiver identification.

With so many providers beginning to pay attention to social risk factors, there is an urgent need for standardization of the key questions, so that improvement activities can be guided by data. If the Area Agencies on Aging and the hospitals use different screening protocols, there will be no ready way to examine the efficacy of the efforts to refer and secure services.

Recommendations

1. Shift payment incentives to promote capturing and acting upon social risk factors.
2. Require that federal EHR certification include key social and family caregiver issues.
3. Provide some incentives for plans and providers to be engaged in community action to address social risk factors.

In closing, we would like to comment on the perspective that is apparent in the ASPE RFI. ASPE, like many providers and payers, is falling into the commonplace trap of seeing "social risk factors" as factors that characterize a particular beneficiary — and not ALSO as factors that characterize the locality in which that beneficiary lives. Thus they note that RAND found (page 3) a list of four items in the taxonomy for MA plans addressing social needs. What's missing is any action to enhance the community's provision of supportive services, including adequate workforce (paid and voluntary). To illustrate — a beneficiary who lives alone without volunteer support and

who can no longer prepare food has a "social risk factor" in a town with a long waiting list for home-delivered food, but that same beneficiary living in a town with readily available home-delivered food has no such risk factor. So, the risk factor is not merely a characteristic of the patient but also of the mismatch between the patient's need and community's service provision arrangements.

Furthermore – the country has not come to terms concerning what families (and, for that matter, neighbors) should be expected to do to provide unpaid support. This ends up being negotiated and re-negotiated with potentially available people without any overall sense of what we expect. Most direct care is given for free by family – but that's the most stressful point in the upcoming demographics. Small and dispersed – and older – families will not be able to "take care of great-grandma" in small apartments with all adults working. We do not have large families living on the farm who can readily take in a disabled elderly person. So, putting into the EHR that the person has two children tells you almost nothing. Figuring out whether they are willing and able to do the personal care – and then seeing if they can actually deliver – is a complicated endeavor. What should be the response if the elderly beneficiary was a child abuser, or the adult child is hooked on drugs? These kinds of situations are all too common and very hard to verify or document. Even in the "usual" family, there will be real needs and limitations that limit caregiving. There needs to be a focused endeavor to sort out how to deal with family capability and willingness in the record, and the solutions are not likely to be simple.

Thank you for the opportunity to provide these recommendations. If you have any questions, please contact Joanne Lynn at Joanne.Lynn@Altarum.org .

Sincerely,

Joanne Lynn

Joanne Lynn, MD, MA, MS

Director, Program to Improve Eldercare

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i https://www.gao.gov/products/GAO-18-588

<u>Social Risk Factor Questions – Allina Health</u>

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

Allina Health completes a screen that addresses potential social risk factor concerns for all Medicare beneficiaries in the following locations:

- All Allina Health primary care clinics
- Outpatient mental health clinics
- OBGYN Clinics
- Three emergency departments (78 total care delivery sites to screen),
- Inpatient mental health

Across our system, this represents 78 care delivery sites where Medicare beneficiaries are screened. We utilize the CMS approved screening form that is part of the Accountable Health Communities model. This screening includes questions on food insecurity, housing, transportation, difficulty paying utility bills and interpersonal safety. Our experience should that approximately 28% of beneficiaries completing the screen identify at least one need.

Additionally, our home health program completes a screen for every beneficiary that has 112 elements, which all may focus on social risk to some degree. Comprehensive assessments are done in our inpatient rehabilitation & skilled nursing facilities, which address social topics that could be impactful to discharge, or the receipt of follow up care. These responses are then incorporated into the discharge planning process for each beneficiary. For all of our post-acute care sites, if a social risk were identified that warrants further assistance, the beneficiary would be referred to a social worker to follow up.

We have found that knowing whether a patient is enrolled in public programs can be a good indicator as to an individual's potential risk factors. However, typically it is quite challenging to identify patients who are enrolled in such programs. Thus, many of the resources that may be available to patients often go undiscussed.

2) **Are there especially promising strategies for improving care for patients with social risk?**

One population Allina health serves is patients that have a disability. There are several support programs offered through the Minnesota Department of Human Services (MN DHS) that operate at home or in the community in order to support this population. We try to enroll beneficiaries in support programs that fit with their particular need. Additionally, Allina participates in the Medical Home model for a population of individuals with disabilities and complex health conditions, certified by MN DHS. While this is a limited population, it has allowed us to better tailor strategies for addressing all aspects associated with care of the patient's needs.

Allina also offers care coordination services, which address medical needs, however social risk factors are considered as part of this service as well. Through this service, there is continued access to a social worker as a resource to patients. For patients that are identified as having a potential risk through our Accountable Health Communities screening, we offer a referral to community resources that could help

address their need. At this time, we continue to follow the patient for up to one year to see whether they are able to obtain the services they need.

Finally, Allina Health has focused on how to better engage staff in the awareness of what social risk factors are, and how they are impactful to our patients. Ensuring that all staff understand why addressing social risk factors is impactful to total health is an important step in our work to improve health outcomes. In order to address the social risk factors of our patients, staff first need to be able to recognize what a social risk factor is and why it is important.

3) **How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?**

As part of the Accountable Health Communities model, we are working on how best to evaluate the cost of services meant to affect social risk factors. Our care coordination model (referenced above), has actually increased outpatient costs, but likely reduced ED visits and possible readmission. The care coordinators assist patients in following up doctor visits or outpatient therapy. While we see that there is a decrease in revenue associated with employing a care coordinator, we believe that we are actually increasing value and quality care for both the patient and the organization.

4) **What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?**

We believe that engaging community service providers is critical. Aside from social services, developing partnerships with organizations such as Metro Transit could prove to be impactful in addressing social risk factors. In our view, there are aligned incentives for healthcare and social/community services to work together to address social risk factors.

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

The biggest lesson Allina Health has taken away is that the establishment of trust of key. In all of our post-acute care settings, we have found that the patient needs to feel comfortable with their care provider in order to open up regarding what challenges they may be facing. The opportunities for our care providers to establish a repoire with even one person can be very impactful in the identification of additional resources that may be available to the patient.

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

In our skilled nursing and inpatient rehabilitation facilities, our experience is that it can be very difficult to find a safe and appropriate discharge destination for a patient. With the combination of needing

accessible housing, the need for physical assistance, and potentially the need to move to Medicaid or Medicare payment, patients may not be admitted, or their discharge may be delayed because of anticipated problems at discharge. At this time, we are unable to consistently consider and identify the social risk factors outlined in this RFI, when discharge planning. Absent this information, it is very possible that once discharged, a patient will not be able to either care for himself or herself or receive adequate care once they have left our facilities. This increases the chance for readmission and poor outcomes.

Our experience in the home health population is that this service is often not the provider's first choice for additional care. Patients may be better suited to be admitted to a transitional care unit, however cost or insufficient access may prohibit them from going that route. Home health then becomes second choice, but is not the best/safest option for the needs of that patient. Allowing beneficiaries to be able to receive follow up care in the healthcare environment that is best suited to their particular needs is one barrier we would like to see addressed.

Finally, we have seen that many of our Medicaid population is unable to receive care as their spend-down limits is challenging to reach. We continue to encourage MN DHS to address the Medicaid spend down limits, as we believe this is an unwarranted obstacle to patients receiving needed care.

7) **For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?**

For patients that are disabled, adequate housing, transportation and follow-up with a provider all become more challenging. While there are many resources available to patients that are disabled, frail or have limited functional status, often times these services are counterproductive to what the health system is trying to accomplish. For example, a disabled patient may have to rely on community-based transportation in order to attend health appointments. In many cases, transportation is only available on a routine schedule. For a patient that is unable to sit, stand or wait until the community vehicle can pick them up and drop them off, the choice often becomes to skip the appointment rather than go in for the follow up care they need. Further, we have seen that for patients who have limited food access, community resources that are available to them are often unable to be utilized due to scheduling limits. Limited schedules or pick up locations make it challenging beneficiaries to access the resources they need.

Data:

1) **Which social risk factors are most important to capture?**

   Income and whether or not the patient is currently on Medical Assistance.

2) **Do you routinely and systematically collect data about social risk?** Yes, for all beneficiaries of government programs.

   • **Who collects this data?** A clinical assistant collects this information on a paper form, and is entered into a flowsheet in the electronic health record (EHR).

- **When is it collected?** In the outpatient setting, information is collected when patient comes in for visit. In the inpatient or emergency department setting, information is collected at discharge. Home health collects information at admission, every 60 days while receiving home care services and again at discharge.

- **Is it collected only once or multiple times for a beneficiary?** Information is collected every six months.

- **Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)?** Yes, Medicare, Medicaid, Dual Eligible.

- **What are the burdens of this data collection on plans, providers, and beneficiaries?** Data collection is time intensive, not only to actually collect but to also get into the EHR. Technology always presents a challenge, as systems have limitations and change frequently. We want to ensure that the data we are entering is correct, and is entered in a consistent manner for all patients, which requires staff training. On top of that, routine quality monitoring/auditing is needed to assess areas for improvement within our process.

3) **Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?**

As part of the Accountable Health Communities model, we have standardized data elements collected. Our experience thus far leads us to believe that it is beneficial.

4) **What are barriers to collecting data about social risk? How can these barriers be overcome?**

No response at this time.

5) **What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**

Allina Health has been in conversation regarding how to engage patients through their own personal devices, such as a cell phone. We believe that patients may be more willing to share information about social risks/concerns electronically than they would in the health care setting. In our experience, allowing people to utilize their own devices often achieves better response rates than requiring an actual computer to log in. We continually encourage patients to sign up for our online patient portal, however many patients to not have access to a computer & the internet. We find that this can actually lead to patients becoming non-responsive because they do not have the means to review information available to them. Developing a way for patients to utilize their phone for these communications could potentially address some of that divide.

Allina Health 🎗️

Department of Organizational Integrity and Regulatory Affairs
P.O. Box 43
Minneapolis, MN 55440-0043

November 16, 2018

Office of the Assistant Secretary for Planning and Evaluation
Submitted electronically to: ASPEImpactStudy@hhs.gov

Request for Information: IMPACT Act Research Study: Provider and health plan approaches
to improve care for Medicare beneficiaries with social risk factors

To Whom It May Concern;

On behalf of Allina Health, I appreciate the opportunity to comment on the Request for
Information: IMPACT Act Research Study: Provider and health plan approaches to improve care
for Medicare beneficiaries with social risk factors. We applaud the agencies for continuing to
reach out to providers on this important topic. While we do have home health, as well as an
inpatient rehabilitation and skilled nursing facility that are affected by the IMPACT Act, we also
participate in the Accountable Health Communities initiative. As such, we have drawn from our
experience across the care continuum in order to help identify what we believe could be useful
strategies and best practices in working to address social risk factors.

Allina Health is a family of hospitals, clinics and care services that believes the most valuable
asset people can have is their good health. We provide a continuum of care, from disease
prevention programs, to technically advanced inpatient and outpatient care, medical
transportation, pharmacy, home care, hospice and palliative care services. Allina Health serves
communities around Minnesota and western Wisconsin.

Our responses (attachment) to this RFI has been organized to respond to the questions that are
most relevant to our interest and experience. We understand a response to every question is not
required for our comment(s) to be considered. Please review the attachment with our responses
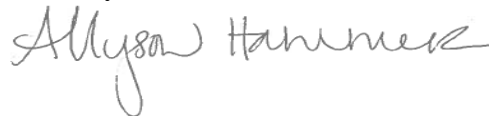to the questions.

While we believe that addressing social risk factors should occur, there are some barriers we
perceive that are worth consideration. First, how entities pose questions to beneficiaries could
impact the response they receive. In order to gather information that is meaningful and can be
acted upon, it is important to ensure that information is gathered and shared in a clear, consistent
manner across the care continuum. Second, identifying information is only the first step. Whose
accountability should it be to work with the patient to connect them to resources, as well as to
follow them through their journey outside of the healthcare need to ensure that they continue to
receive needed services? Coordination in this manner could be costly and time intensive. As

such, appropriate reimbursement would also need to be factored in for the provider that manages this process. Finally, even though a provider may offer resources to a patient, there is no guarantee that the patient will accept and take action to address existing risks. Our experience is that while we can recommend services outside of healthcare that may improve a patient's health status, they often are resistant to taking the steps to receive the needed services.

Allina Health is very interested in considering how to incorporate social risk factors into value based healthcare. As part of that model, we encourage the agencies to share real time information related to social risk factors with providers. We further believe one promising way to address social risk factors is to design beneficiary plans that incentivize implementation of the strategies we have laid out in the RFI.

Thank you for your consideration of our comments as part of this Request for Information. If you have any questions, please feel free to contact me at (612) 262-4908. I look forward to your responses in future rulemaking.

Sincerely,

Allyson Hammer,
Manager Organizational Integrity, Compliance & Regulatory Affairs
Allina Health

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

November 14, 2018

John O'Brien, Deputy Assistant Secretary
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 415F
Washington, DC 20201

Dear Deputy Assistant Secretary O'Brien:

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write in response to the request for information (RFI) titled "*Improving Medicare Post-Acute Care Transformation (IMPACT) Act (IMPACT) ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors*" as posted by the Assistant Secretary for Planning and Evaluation (ASPE) on October 16, 2018.

It is the mission of the AAFP to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity. In their patient-centered practices, family physicians identify and address the social determinants of health for individuals and families, incorporating this information in the bio-psychosocial model to promote continuous healing relationships, whole-person orientation, family and community context, and comprehensive care.

It is AAFP policy that social determinants of health (SDoH) are the conditions under which people are born, grow, live, work, and age. The AAFP believes policymaking should be based on research and evidence to identify and address the social determinants of health to improve the health of populations. Research conducted on SDoH should focus on effective interventions to reduce health inequities, including family physicians' roles in ameliorating social determinants of health.

The AAFP supports the assertion that physicians need to know how to identify and address SDoH to be successful in promoting positive health outcomes for individuals and populations. Family physicians take a leading role in addressing SDoH by partnering and collaborating with public health departments, social service agencies, and other community resources. Family physicians are integral within the continuum of care and use their skills and expertise to care for patients across the lifespan. Family physicians reach out to their communities, bridge health care gaps, and strive for better health for all. Given the role they play in their communities and in the delivery of patient-centered care, the AAFP supports policies that provide physicians with data and knowledge on how to identify and address SDoH to be successful in promoting good health outcomes for individuals and populations.

Our response to this RFI offers data and experiences from our members, outlines the AAFP's principles for incorporating SDoH into new payment models, and highlights strategies the AAFP has undertaken to integrate SDoH adjustments into AAFP's advanced primary care model. Our comments are organized into three main sections:
1) AAFP Member Survey and Experiences Assessing and Addressing SDoH;
2) Advancing Health Equity: Principles to Address SDoH in Alternative Payment Models; and,
3) AAFP's Advanced Primary Care Alternative Payment Model.

AAFP Member Survey and Experiences Assessing and Addressing SDoH;
The AAFP fields an AAFP member Social Determinants of Health (SDoH) Survey annually. This survey, as well as member experiences, and AAFP tools and resources to support family physicians' ability to screen for SDoH needs form the basis of the response below.

1. How plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors.
> The AAFP's 2017 Social Determinants of Health (SDoH) survey established that nearly 60% of family physicians already screen their patients for SDoH. There are several validated screening tools currently in use that screen for certain conditions (Adverse Childhood Experiences, hunger vital signs, etc.) or screen within certain populations (women, children, etc.). The AAFP developed the SDoH screening tool based on this work, and we promote it to our members as the EveryONE Project.

2. Approaches health plans and providers have used to address the needs of beneficiaries with social risk factors.
> According to the AAFP SDoH survey, 52% of family physicians are following up on SDoH needs identified in screenings by referring patients to community based social services. The AAFP's Neighborhood Navigator is a nationwide referral network, available in over 100+ languages that can connect patients to food, housing, employment, etc. based on their unique needs.

3. Evidence regarding the impact of these approaches on quality outcomes and the total cost of care.
> The Social Interventions Research & Evaluation Network (SIREN), led by family physician Dr. Laura Gottlieb, conducted a systematic review of SDoH screenings in 2017. This review concluded that research evaluating the effectiveness of screening has largely focused on process outcomes and feasibility. High-quality evidence does not yet suggest these approaches have any effect on an individual's health outcomes (short or long term), health care cost, utilization, or quality.
>
> The healthcare system needs to work towards generating more evidence on which approaches are successful – and how they affect individual and population health outcomes and costs. The AAFP is focusing on tools to help calculate a practice's return on investment related to its SDoH activities. At this time, it is impossible to calculate a return on investment on total cost of care for SDoH work at the practice level as physicians are most often paid to address an individual's health needs as opposed to the health of a practice population. While improving individual health needs may have an overall impact on population health, there are far too many inputs addressing population health to effectively calculate the return on investment from practice level interventions.

4. Ways in which health plans and providers disentangle beneficiaries' social and medical risks and address each.

It is very challenging for health plans and providers to "disentangle" social and medical risks. AAFP goals in developing principles for incorporating SDoH into APMs is to support holistic, integrated approaches to addressing patients' psychosocial needs. A patient's social and medical risks are inherently connected.

Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models

The AAFP welcomes the opportunity to offer our members' perspectives as ASPE undertakes a study to evaluate the effect of individuals' socioeconomic status (SES) on quality measures and measures of resource use under the Medicare program. As health care continues to transition to a value-based environment, there has been a growing call for the inclusion of SDoH as a criterion in advanced primary care delivery and value-based payment arrangements. Academic literature is beginning to show how significantly social determinants affect the health and well-being of patients.

As more AAFP members participate in APMs, key issues for the AAFP include data on the role of social risk factors in health outcomes, the impact of such data in assessing physician performance, and policy opportunities to improve payment and measurement methodologies.

The AAFP developed principles to address social determinants of health (SDoH) in alternative payment models (APMs) that we urge ASPE to consult and utilize. Outlined below, these principles ensure that SDoH are appropriately accounted for in the payment and measurement design of APMs, so practices have adequate support to improve quality and outcomes for all patients, eliminate health disparities, and reduce costs for the health care system.

1. APMs should support practice-level efforts to identify and address social determinants that are shown to impact health outcomes.
2. The incorporation of variables representing SDoH in APMs should be founded on evidence-based research methods.
3. Health information technology platforms should facilitate SDoH data collection from medical records and other sources to support improved clinical decision making, care coordination, quality measurement, and population health management.
4. To minimize administrative burden on providers and patients, SDoH data should be collected by leveraging existing mechanisms. Public and private payers should share data with clinicians to further enhance coordinated and comprehensive primary care since this data is challenging to collect. The AAFP encourages increased data sharing to improve its timeliness and clinical actionability.
5. To ensure APMs improve access, quality, and health equity, practices should receive appropriate resources and support to identify, monitor, and assess SDoH.

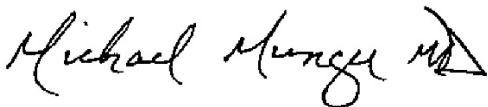Advanced Primary Care Alternative Payment Model

The AAFP welcomes the continued opportunity to work with ASPE to identify and implement policies that improve the Medicare program, especially as it relates to SDoH. The AAFP has been working the past two years to develop the Advanced Primary Care Alternative Payment Model (APC-APM), a next generation, advanced primary care model. The APC-APM would empower family physicians—especially those in small, independent practices—to move away from fee-for-service payment systems and into population-based, predictable revenue streams. These revenue streams will be risk-adjusted in part based on SDoH, and will support comprehensive, longitudinal, and high-quality primary care.

The APC-APM includes a SDoH adjustment to payments to participating advanced primary care practices using the Robert Graham Center's Social Deprivation Index (SDI). The SDI is comprised of variables of social deprivation (e.g. lack of access to good housing, employment, income, transportation and access to health facilities) that are readily available and easily updated on a national level. The SDI provides a single index at many different geographic levels, including zip code. The strength of the relationship between SDI and poor health outcomes has been verified at these levels of geography. In the APC-APM model, attributed patients would be assigned an SDI based on the zip code of their home address and a monthly payment adjustment would be made for attributed patients at or above the 85th percentile on the SDI. This is one example of how new payment models and approaches can begin to incorporate SDoH simply and efficiently.

The AAFP believes that investment in physician-led models that support advanced primary care practices is necessary to strengthen the long-term solvency of the Medicare program and to improve patient-centered care for beneficiaries. AAFP members offer a unique and important perspective as family physicians. They provide care in more than 90 percent of U.S. counties working in diverse settings as employed physicians, in large practices, and as owners of small independent practices. Family physicians participate in preventive and wellness services, chronic disease management, and leading care teams that also offer linkages to services that address SDoH. We are committed to working with ASPE to further develop and implement physician-led, primary care focused models that increase participation in value-based care and payment models that promote population health.

We appreciate the opportunity to comment. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org with any questions or concerns.

Sincerely,

Michael L. Munger, MD, FAAFP
Board Chair

About Family Medicine
Family physicians conduct approximately one in five of the total medical office visits in the United States per year—more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families, and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.

November 15, 2018

Brenda Destro, PhD
Deputy Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via email

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

Dear Dr. Destro,

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we would like to share comments on the recent 'Request for Information' (RFI) on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

The AAOS is committed to improving musculoskeletal care for patients, especially those who are vulnerable with socio-economic risk factors. In response to an RFI on the new direction for the Innovation Center at the Centers for Medicare and Medicaid Services (CMS) dated November 20, 2017[1], AAOS urged CMS to include important patient characteristics such as age, socio-economic status (SES), marital status, clinical co-morbidities, functional status, social and familial support in their evaluation of Medicare and Medicaid payment models. Medicare beneficiaries with such risk factors should be factored into the target price used in many Innovation Center models. AAOS also asked CMS to incorporate the risk stratification

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[1] AAOS comments on Centers for Medicare & Medicaid Services: Innovation Center New Direction. Available: https://www.aaos.org/uploadedFiles/PreProduction/Advocacy/Federal/Issues/medicare/AAOS%20comments_RFI%20on%20CMMI%20new%20direction_final.pdf

recommendations that the Assistant Secretary for Planning and Evaluation (ASPE) made to Congress in your 2016 report.[2]

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

It is heartening to note that CMS launched the Accountable Health Communities (AHC) Model in 2016 that addresses a critical gap among clinical care, community services and family support in the health care delivery system "by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization." Such effort is essential to address the social and economic risk factors experienced by certain racial and ethnic groups and within certain geographical areas. We hope that the AHC participants include support specialists (such as orthopaedic surgeons) in their patients' care plans as they assess unmet needs in their communities.

There is increased awareness among payers that chronic illnesses (such as diabetes, obesity, stroke, heart disease, and cancer) disproportionately impact low-income individuals and minorities.[3] Hence both CMS and commercial insurance companies have launched episodic payment models, accountable care organizations and other innovations to treat co-morbid chronic conditions so that the patients' emergent and predictable acute care needs are optimized.

Today, most Medicare beneficiaries are covered by CMMI payment models. Hence, it is important that the new value-based payment models in Medicare identify and address social economic risk factors. Lower extremity joint replacement (LEJR) procedures is one of the most common procedures in this population. The ASPE's finding that safety-net providers were more likely to receive penalties have been corroborated in studies focusing on musculoskeletal care.

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[2] REPORT TO CONGRESS: SOCIAL RISK FACTORS AND PERFORMANCE UNDER MEDICARE'S VALUE-BASED PURCHASING PROGRAMS. Available: https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs
[3] "The United States Can Reduce Socioeconomic Disparities by Focusing on Chronic Diseases, " Health Affairs Blog, August 17, 2017. DOI: 10.1377/hblog20170817.061561.

For example, a recent analysis[4] of Medicare claims for patients in Michigan who underwent lower extremity joint replacement LEJR during the period 2011–13 concluded that hospitals treating medically complex patients experienced unintentional penalties when proper risk adjustment is not accounted. Reconciliation payments were found to be reduced by $827 per episode for each standard-deviation increase in a hospital's patient complexity. These unintentional penalties for safety net hospitals must be addressed. This study also estimated that risk adjustment could increase reconciliation payments to some hospitals up to $114,184 annually. Thus, the Comprehensive Care for Joint Replacement (CJR) model in the study, referenced above, requires financial, clinical, and socio-economic risk adjustment to address treatment of these more complex patients. Another important point raised by this study is that the CJR model uses a novel calculation of the target price (a blend of a hospital's historical episode spending and the average spending of other hospitals in the same region). Predictably, the regional benchmark, increasing over time, will drive increasing financial pressures on hospitals treating more medically complex patients.

Which social risks are most important to capture?

The mechanism for disparities in musculoskeletal care is not well understood. Racial and ethnic minorities have a greater incidence of arthritis and chronic disability than the population in general.[5] For example, African-Americans have a lower utilization of total joint arthroplasty for a variety of reasons, including patient trust, perceived limited satisfaction with results by peers, varying knowledge about total joint arthroplasty, and concerns about pain associated with these procedures. However, not enough emphasis is laid on these concerns across the profession. Hence, national professional organizations (such as AAOS) are championing new research and designing collective physician education on these topics.

For an orthopaedic surgeon, language barriers with patients is a key issue. It is a major difficulty to find medically trained translators leading to delays in care, additional cost, miscommunication and in proper informed consent. It is accurate to state that such translation services may cost the system as much as the patient visit reimbursements. Active

[4] Ellimoottil, C., Ryan, A. M., Hou, H., Dupree, J., Hallstrom, B., & Miller, D. C. (2016). Medicare's New Bundled Payment for Joint Replacement May Penalize Hospitals That Treat Medically Complex Patients. Health Affairs,35(9), 1651-1657.
[5] Morgan, R. C., & Slover, J. (2011). Breakout session: ethnic and racial disparities in joint arthroplasty. Clinical Orthopaedics and Related Research, 469(7), 1886.

communication at hospital discharge is necessary for an optimal transition and to avoid post-acute adverse events. Understanding of medications and the type of follow-up care needed is low among patients with limited English proficiency and medical literacy.[6] Given that language concordance improves outcomes, there must be systematic identification of patients with limited English proficiency and reimbursement mechanisms that are reliable.

As for issues related to poverty, our surgeons find that unmet medical transportation needs and environmental hurdles in neighborhoods and homes present challenges for post-acute recovery. There is a rich body of literature that argues that provision and payment of social services under Medicare is a major necessity in our communities. Certainly, paying for transportation to and from appointments or care facilities would significantly enhance access to care as public transportation can be challenging for orthopaedic patients with limited mobility. In addition, greater access to home safety assessments and the ability to pay for a ramp to enter the home or make other mobility enhancements are frequently necessary to avoid lengthy institutional post-acute care. Unfortunately, there are not enough resources and incentives for screening for these issues routinely. The AAOS believes that physicians and other health care providers would be more likely to do such screenings if they knew where to direct vulnerable patients locally. Social workers are not so common in orthopaedic practices, and this is a specialized skill and service that is required if our surgeons are to effectively help their patients with issues beyond their clinical expertise that affect care outcomes. It usually only happens when the patient sees the social worker prior to discharge after a procedure and would be more effective and more widely utilized if there was better connectivity to local government and nonprofit human service organizations.

Lastly, the most difficult social risk factor to identify is the existence of 'implicit bias' among clinicians. [7] Racial/ethnic concordance among physicians and their patients lead to improved communication and thus improved outcomes. There is a rich body of literature that has found that implicit or unconscious bias is alive and thriving among all of us. Medical training should
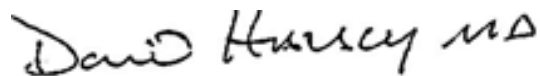
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[6] Karliner, L. S., Kim, S. E., Meltzer, D. O., & Auerbach, A. D. (2010). Influence of language barriers on outcomes of hospital care for general medicine inpatients. Journal of Hospital Medicine, 5(5), 276-282.
[7] "Examining Provider Bias in Health Care Through Implicit Bias Rounds, " Health Affairs Blog, July 17, 2017. DOI: 10.1377/hblog20170717.060993

actively involve awareness of socio-cultural factors that impact care and practical steps to mitigate implicit bias. Recognition of our own implicit bias is the first stepping stone.

The AAOS appreciates your request for information on this important issue and hope that HHS and the Congress will be able to develop practical policies that address some of the social risk factors that impact our patients. Our comments are simply indicative of deep-rooted issues in this area, and we look forward to working with you in improving the quality of musculoskeletal care for all of our patients. If you have any questions on our comments, please do not hesitate to contact William Shaffer, MD, AAOS Medical Director by email at shaffer@aaos.org.

Sincerely,

David A. Halsey, MD
President, American Association of Orthopaedic Surgeons

cc: Kristy L. Weber, MD, AAOS First Vice-President
        Joseph A. Bosco, III, MD, AAOS Second Vice-President
         Thomas E. Arend, Jr., Esq., CAE, AAOS Chief Executive Officer
        William O. Shaffer, MD, AAOS Medical Director

November 16, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health & Human Services
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
200 Independence Avenue, SW, Room 415F
Washington, DC 20201

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

Dear Deputy Assistant Secretary Destro,

The American Association of Nurse Practitioners (AANP), representing more than 248,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment on ASPE's request for information on improving care for Medicare beneficiaries with social risk factors. We thank ASPE for their focus on improving the health of Medicare beneficiaries with social risk factors and we look forward to continuing to work together to achieve these goals.

NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. They are experts in the provision of care to patients with social risk factors.

NPs practice in nearly every health care setting including clinics, hospitals, Veterans Affairs and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia. It is important to note that 86.6% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually.

ASPE has requested feedback on how providers are working to improve health outcomes for Medicare beneficiaries, specifically those with social risk factors. Nurse practitioners are invested in improving community health and have answered the call of our nation's most pressing health care needs for beneficiaries with social risk factors, including fighting the opioid epidemic. As you are aware, with the passage of the Comprehensive Addiction and Recovery Act (CARA) in 2016, NPs were authorized to provide medication-assisted treatment (MAT) after taking the necessary training and obtaining a DEA waiver. Since CARA passed, over 7,000 NPS have obtained their MAT waiver in order to provide much needed treatment to patients suffering from opioid use disorder. Based on the strength of the response from the NP and PA communities to this crisis, and the ongoing need for health care providers to provide MAT, this authorization was made permanent in the SUPPORT for Patients and Communities Act (H.R.

6). NPs are committed to improving the health and welfare of Medicare and Medicaid beneficiaries with social risk factors.

One of the primary issues impacting beneficiaries with social risk factors is a clinician shortage, particularly in primary care, that is being exacerbated by an aging population.[1] Nurse practitioners are currently providing a substantial portion of the high-quality[2], cost-effective[3] care that our communities require, and will continue to do so to meet the needs of their communities. They are the fastest growing provider specialty in the Medicare program and are on pace to be the largest provider specialty within a year.[4] "Eighty-four point nine percent" of NPs are accepting Medicare patients and 82.9% are accepting Medicaid patients.[5] This will have a particularly large impact on primary care as approximately 85% of all NP graduates go into primary care.[6] NPs comprise approximately one quarter of our primary care workforce, with that percentage growing annually.[7] Early access to high-quality primary care is essential for Medicare and Medicaid beneficiaries with social risk factors. Nurse practitioners are well-positioned to meet their healthcare needs.

Nurse practitioners are educationally prepared to take a wholistic and patient-centered approach to health care which is grounded in their nursing roots. This approach addresses the social and environmental needs of these patients. This emphasis is essential when treating patients with social risk factors who have complicated needs that go beyond a medical evaluation and treatment. Nurse practitioners not only evaluate, diagnose and treat their patients, but also educate and empower patients to improve their self-care. They work with patients and their support systems to ensure that the patients' needs are met by coordinating with social services resources, families and other health care providers. These concepts are ingrained in nurse practitioner preparation and are the backbone of care delivery models such as the patient-centered medical home, which deliver the comprehensive and coordinated care required for patients with social risk factors.

ASPE requested feedback on how to improve the collection and utilization of data on social risk factors. In their practice, NPs routinely identify and target the needs of their patients, provide care management and coordination, directly address their patient's social needs, and integrate Medicare and Medicaid into their practices. However, the current structure of electronic health records often does not accommodate the incorporation of social risk factors documentation into the record. In addition, barriers continue to exist within federal programs that restrict care coordination and delay access to care for nurse practitioners' patients.

Despite the need for nurse practitioners in our communities, and decades of evidence showing that NPs provide high-quality, cost-effective health care, NPs continue to be constrained in their ability to practice by outdated State and Federal statutes and regulations. Limiting the ability of qualified practitioners to practice to the full extent of their education and clinical training prevents our communities from meeting the needs of their at-risk patients. These unnecessary barriers deprive patients of their provider of choice, reduce access to needed treatments and services and lead to delays in care. These delays and barriers are particularly problematic for patients with social risk factors. We request that as a component of this study, ASPE recognize the importance of nurse practitioners in treating patients with social risk factors, and the

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[1] Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners, Final Report, page 4. https://aspe.hhs.gov/system/files/pdf/167396/NP_SOP.pdf.

[2] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.

[3] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.

[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2016/Downloads/PROVIDERS/2016_CPS_MDCR_PROVIDERS_6.pdf

[5] 2016 AANP National Nurse Practitioner Sample Survey.

[6] https://www.aanp.org/images/documents/about-nps/npfacts.pdf.

[7] Rural And Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners, Hilary Barnes, Michael R. Richards, Matthew D. McHugh, and Grant Martsolf, Health Affairs 2018 37:6, 908-914.

need to ensure that they are not constrained in meeting the health care needs of our most complex patients due to unnecessary statutory and regulatory barriers.

Barriers for NPs' patients within the Medicare and Medicaid programs that delay access to care and inhibit care coordination include: the Medicare and Medicaid home health benefit; patient access to diabetic shoes; hospice certifications; conditions of participations for skilled nursing facilities, hospitals, and rehabilitation facilities; and ordering and supervising cardiac and pulmonary rehabilitation. We have attached an addendum with detailed descriptions of these issues.

HHS has several tools at its disposal to enact these necessary changes, for instance:
- **many regulations are more restrictive than required under statute, such as skilled nursing facility (SNF) admissions that can be alleviated by HHS through rulemaking;**
- **HHS can issue enforcement moratoriums, such as that applied to supervision of outpatient therapy in critical access hospitals;**
- **it can use its regulatory authority to expand the definition of physician to include nurse practitioners, similar to the diabetes outpatient self-management training program, recognizing that much of the statutory language is outdated and not reflective of how care is currently delivered in the Medicare and Medicaid programs;**
- **it can ensure that any state waivers or future care models allow clinicians, including nurse practitioners, to practice to the full extent of their education and clinical training; and**
- **in those areas that are strictly defined by statute, such as hospice, HHS can highlight the negative impact of these restrictions so lawmakers are aware of the changes that need to be made.**

We thank you for the opportunity to comment on this request for information to improve health care for Medicare beneficiaries with social risk factors. We look forward to continued work ASPE to improve the health for patients with social risk factors. We would welcome an opportunity to engage in further discussions regarding the role of nurse practitioners in this initiative. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

David Hebert
Chief Executive Officer

ADDENDUM

Below are some of the specific barriers that exist for nurse practitioners, their patients and their communities, and suggestions on how the Department of Health and Human Services (HHS) can relieve these barriers. Removing these barriers is necessary to increase patient access to care and improve the efficiency of our health care system by removing duplicative treatment, maximizing the efficiency of the health care workforce and reducing health care costs. We encourage HHS to implement these proposals to provide greater access to care for Medicare beneficiaries and improve community health. Following are barriers that need to be removed for NPs and their patients:

- **Decrease Administrative Burdens Within Medicare Home Health Services:**

Currently, NPs with patients who need home health care services must locate a physician who will document the nurse practitioner's assessment and provide a plan of care. Further, while NPs are authorized to perform a required face-to-face assessment of the patient's needs, the PPACA also requires that a physician document that the encounter has taken place. These delays in treatment jeopardize patient health, limit provider choice and the ability of NPs to compete in the marketplace, causing the Medicare program to incur additional costs by requiring the participation of additional providers. These delays are especially problematic for home health care patients who suffer from more chronic conditions and report more limitations on activities of daily living than the non-home health care Medicare beneficiary population.[8]

We suggest that HHS either broaden the definition of "physician" to include nurse practitioners or add "nurse practitioner" after "physician" in the regulatory language covering home health services for Medicare and Medicaid beneficiaries. The statutes governing home health services for Medicare beneficiaries do not define the word "physician" as it relates to those services. Thus, the Secretary has the discretion to revise the existing regulations to include NPs in that definition. Changes in definitions within the Medicare home health care regulatory framework would also apply to the Medicaid program.

- **Decrease Administrative Burdens for Medicare Patient Access to Diabetic Shoes:**

NPs treating a patient with diabetes must locate a physician to certify the patient's need for diabetic shoes. Currently, an NP's patient must undergo the following redundant multistep process to obtain their necessary treatment: the NP who is treating the patient with diabetes makes the initial determination that the patient needs diabetic shoes; then the NP must send the patient to a physician who then refers that patient to a podiatrist or other qualified individual to fit and furnish the shoes. NPs are authorized to be reimbursed for the treatment of patients with diabetes under the Part B program. They have demonstrated that they provide expert treatment and management of patients with diabetes without the need for physician supervision. Requiring a physician to certify that a patient requires diabetic shoes after the patient's NP has already made that determination leads to delays in treatment, inhibits the ability of NPs to compete in the marketplace, decreases patient choice, and increases costs to the Medicare program by requiring the participation of an additional provider.

We suggest that HHS broaden the definition of "physician" to include nurse practitioners or add "nurse practitioner" after "physician" in the regulatory language covering diabetic shoes for Medicare beneficiaries. The statute governing diabetic shoes for Medicare beneficiaries does not define the word "physician" as it relates to those services. Thus, the Secretary has the discretion to revise the existing regulations to include NPs in that definition.

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http://ahhqi.org/images/uploads/AHHQI_2018_Chartbook_09.21.2018.pdf.

- **Value-Based Reimbursement**

HHS and commercial insurers have made a commitment to shifting health care reimbursement from a volume-based system to a value-based system in an effort to improve both the quality and cost of care delivered in our communities. NPs have been actively involved in this transition and provide the high-quality, cost-effective health care incorporating social determinants of health that advanced payment models value, such as with the patient-centered medical home. However, barriers still exist within the claims-based assignment methodology of the Medicare Shared Savings Program and some commercial insurers still limit their value-based programs to physicians. It is essential that if we are going to continue the transition of our health care system to one that reimburses providers based on value, that these opportunities are available to nurse practitioners.

- **Hospice Certification:**

NPs are attending physicians under the hospice care statute, but despite this designation they are not authorized to provide the initial certification that a patient is terminally ill and in need of hospice care. The very nature of hospice care and the terminally ill state of hospice patients demands that this process take place as expeditiously as possible. This hospice certification requirement is an unnecessary restriction on NPs that does not benefit the patient and serves only to complicate the hospice selection process.

- **Skilled Nursing Facility (SNF) Admitting Examinations and Bi-Monthly Assessments:**

NPs are essential providers in SNFs. Studies have demonstrated that NP participation in SNFs has lowered overall costs and improved quality of care. Even though NPs provide high-quality care to SNF patients, they are still prevented from approving a SNF admission by not being authorized to perform the admitting examinations and every other monthly patient assessment. These are unnecessary restrictions on practice that go further than statutory requirements and inhibit access to care in SNFs. This diminishes a facility's ability to utilize available clinicians to the full extent of their education and clinical training.

It is important for HHS to recognize that many of these patients may be under the care of an NP, thus making them the most appropriate provider to direct that patient's care. We encourage HHS to explore options that would modernize SNF regulations to authorize providers, such as NPs, to admit and perform the admitting assessment and all monthly patient assessments.

- **Inpatient Rehabilitation Facilities (IRFs) and Comprehensive Outpatient Rehabilitation Facilities (CORFs):**

As is the case in SNFs, NPs are important providers in IRFs and CORFs, yet they are still prevented from practicing to the fullest capacity of their license. In IRFs and CORFs, there are unnecessary restrictions that inhibit access to care and create additional administrative burdens within the setting. These restrictions include physician supervision, certification and establishing a patient's plan of care. We suggest that HHS recognize that many of these patients may be under the care of an NP, thus making them the most appropriate provider to document and direct that patient's care. Facilitating the full utilization of nurse practitioner skills in these facilities will contribute to the safety and well-being of their patients in an efficient and cost-effective manner.

- **Facility Conditions of Participation:**

In some hospitals and other facilities NPs are still not allowed to practice to the full extent of their education and clinical training. HHS should be sure that all the federal conditions of participation for hospitals and other facilities allow nurse practitioners to practice to the full extent of their license. This

includes serving as facility medical directors. HHS is the leader in the health care industry and such guarantees will have a significant impact on access and the provision of high quality cost effective care.

- **Cardiac and Pulmonary Rehabilitation (CR and PR):**

In 2018, Congress passed legislation which would authorize NPs to <u>supervise</u> cardiac and pulmonary rehab starting in 2024. However, NPs are still not authorized to <u>order</u> cardiac and pulmonary rehab for their Medicare patients. NPs are fully qualified based on their education and clinical training to order and supervise these services and this obsolete barrier to care harms patients by causing unnecessary delays in treatment. We request that HHS update the regulations for cardiac and pulmonary rehabilitation to authorize NPs to order these treatments for their patients, and also to expedite the implementation date of NPs being authorized to supervise these treatments through an enforcement moratorium.

- **Education:**

All nurse practitioners must complete a masters or doctoral nurse practitioner program and become nationally certified to become licensed to practice. Didactic and clinical courses prepare these advanced practice nurses with specialized knowledge and clinical competency to practice in primary care, acute care and chronic care settings, giving them advanced clinical preparation beyond their professional nursing education. For these reasons, nurse practitioners must continue to be an integral part of any policy development related to increased education and training opportunities for clinicians.

- **Combating the Opioid Epidemic:**

As mentioned above, with the passage of CARA in 2016, NPs were authorized to prescribe medication-assisted treatment (MATs) after taking the necessary training and obtaining the required DEA waiver to do so and this authorization was made permanent in the SUPPORT for Patients and Communities Act (H.R. 6).

However, current law stipulates that if a state requires an NP to maintain a collaborative or supervisory agreement with a physician in order to practice, that physician must also have a MAT waiver for the NP to provide MAT. This has proven to be a significant barrier, especially in rural and underserved areas, because very few physicians have obtained MAT waivers. NPs in these states, many of which are the most impacted by the opioid epidemic, have reported that despite going through the training and obtaining a MAT waiver they are still unable to provide MAT because they cannot locate a physician who also has a MAT waiver. This report should recommend revising this requirement, which the Secretary has the authority to do via regulation[9], so that NPs who have completed the training and obtained their waiver can provide this medically necessary treatment without having to also locate physicians who have obtained the waiver.

- **Collecting and Modifying Data:**

It is important that nurse practitioners be an integral part of any data collecting, research activities and trials developed and implemented by HHS moving forward. This includes examination of social determinants of health, evidence-based practice, health care quality and disparities, and barriers to access to name a few examples. We encourage HHS to study the best way to utilize the health care work force and remind you that there is already sufficient evidence to support the utilization of nurse practitioners to the highest extent of their education and clinical training.

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[9] Public Law NO: 114-198, Sec. 303.

- **Network Adequacy:**

Our members have expressed concerns regarding their inability to become paneled with some MA plans, and to date there has been little to no enforcement of the non-discrimination policies. This is also true for commercial plans covered by section 2706 of the ACA. Provider non-discrimination is an important component to ensuring that patients can select their provider of choice and that communities have an adequate network of providers to meet their health care needs.

- **State Practice Environment:**

Currently, twenty-two states and the District of Columbia are considered Full Practice Authority (FPA) states because their licensure laws allow full and direct access to nurse practitioners. In FPA states, NPs are authorized to evaluate patients, diagnose, order, and interpret diagnostic tests, and initiate and manage treatments, including prescribing medications, without a regulated relationship with a physician. NPs are authorized to perform these functions in the remaining states, but these states restrict patients' access to nurse practitioners by limiting the practice setting or scope of NP practice, or requiring collaboration, supervision, delegation or team-management with an outside health discipline.

States with a restrictive practice environment limit patient choice and decrease competition in the marketplace. For example, on January 3, 2018 the Federal Trade Commission (FTC) wrote a letter in support of FPA legislation in Pennsylvania which the FTC stated would "benefit competition and healthcare consumers in Pennsylvania."[10] The letter cited a 2014 FTC report on advanced practice registered nursing (APRN) which found that "[S]cope of practice restrictions may eliminate APRNs as an important source of safe, lower-cost competition. Such a reduction of competition may lead to a number of anticompetitive effects."[11]

States that adopt full practice authority for NPs have also shown beneficial health care workforce trends. For instance, Arizona retired its version of an attestation requirement and transitioned to full practice regulation for all elements of NP practice in 2001. Workforce trend data from the Arizona Rural Health Office (ARHO) looking at the first five years following this regulatory change demonstrated a significant increase in the number of NPs in the state and serving in underserved areas. According to the ARHO report, "the number of Arizona licensed NPs in the state increase 52% from 2002 to 2007", with the "largest percent increase of NPs occur[ing] in the rural-rural classified counties".[12]

In addition to recommending reducing federal burdens on NPs, the report should encourage State partners to take similar steps. Reducing restrictions on NP practice will increase choice and competition in the marketplace, leading to improved access to care for patients.

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[10] https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-pennsylvania-state-house-representatives-regarding-likely/v180002_ftc_staff_comment_to_pa_state_house_re_house_bill_100_and_aprn-cnps.pdf
[11] https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.
[12] http://azahec.uahs.arizona.edu/sites/default/files/u9/azworkforcetrendanalysis02-06.pdf.

November 15, 2018

ASPEImpactStudy@hhs.gov

The ABFM is pleased to respond to the Request For Information with the general question: *How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?*

Below we address your specific questions with references where available. We would be pleased to provide additional information, a demonstration of the mentioned tools, or to discuss.

• Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?
We are using the Social Deprivation Index at the census tract level to identify patients from neighborhoods with increased risk.

• Are there especially promising strategies for improving care for patients with social risk?
Hennepin Health System has several modalities for helping patients with social risk. Their ambulatory ICU provides a robust team of clinicians, social workers, nurses, community care workers, and substance use counselors to a small panel of patients with the highest social risks. They use clinical resources to assure housing stability, family counseling when a loved-one is released from prison, social prescriptions for food banks and farmers markets.[1] Wellmed, a Medicare Advantage plan in Texas filled medications for people who could not afford them, transported patients who had no vehicle, offered health coaches to patients with clinical and social risk factors and had social workers in each clinic.[2] There are many models but what most of them share is population-based payment, either capitation or supplemental funding above and beyond traditional fee-for-service. A notable emerging example is the North Carolina 1115 waiver, which includes systematic collection of social determinants data, connection through social services and promises statewide practice facilitation social determinants to support implication across all Medicaid recipients.

• How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?
Wellmed had 60% lower bed-days than matched comparisons and 50% lower age adjusted mortality after putting nearly 15% of total health spend into their model; both represent large

ROI. Addressing social risk is difficult to address in a randomized, controlled trial. Most models with enhance capacity to address social determinants also have other enhancements, most typically in primary care and population health functions.[3-6] The good news is that most of these have much larger returns than the investments needed.

• What are the best practices to refer beneficiaries to social service organizations that can address social risk factors? Best practices are warm handoffs and local resources. Relationships are key to providing good care—relationships between clinical and social services are just as important as those between patients and care-givers. Vermont realized this and used their Medicare waiver to put behavioral health and social workers in communities as shared clinical resources. Practices that can embed these resources or have them close by can better assure good referrals. Housing vouchers or transitions can be particularly difficult without clinical and community partnerships; it is not enough to refer someone.

• What lessons have been learned about providing care for patients with social risk factors? Caring for social risk factors is not easy. They are not isolated and are often intertwined with behavioral, substance use, and medical conditions. They are also not isolated—their family members often have related problems and household chaos is common. However, they can also be the most rewarding, both in terms of personal impact and in terms of financial savings. Financial savings come from reduced ED and hospital use, but also from reduced police resources, court costs, and incarceration.
Moving up from the clinic level to health systems and making response to social risk a component of the IRS-required Community Health Needs Assessment for non-profit hospitals are important strategies. Health systems are beginning to intervene systematically with CHNAs and interventions (Atrium Health Care, in Charlotte, NC and New Hanover Regional Hospital in Wilmington, North Carolina). Atrium has shown dramatic reduction of ED visits among frequent ED visitors with an intervention including transportation and tagging within a regional integrated EHR.

• What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?
There are special challenges in rural areas, which often have less infrastructure and less transportation options. They may need more resources in order to hire or build functions not available in their communities. For example, if you look at the Social Risk resource Aunt Bertha, rural areas are often devoid of any identified resources. Vermont's Blueprint for Health is a good example of building shared community resources for patients with social risk factors. Tailoring also means having updated tools for enabling targeted referrals or collaborations. Many of the tools that take stock of and update community-based resources are proprietary, and it would useful to have national (CMS?) support that provides access to them (Aunt Bertha, Community Rx, etc.)

• For patients with social risk factors, how does patients' disability, functional status, or frailty

affect the provision of services?

It complicates the provision of services because they often have family care-givers or rely on a complex network of support. Family care-givers are typically unpaid and need support of their own. Complex networks rely on community social cohesion which some practices are able to cultivate, but they take resources that are difficult to tie to patient care. For example, Wellmed turned a 100,000 square foot warehouse into the Cisneros Community Center where meals on wheels were provided and personal trainers were available for free, but also where mariachi bands played and pool and chess tables were available for patients to be social and get to know each other.

As part of the second Report to Congress, HHS is requesting information on how providers and health plans capture beneficiaries' social risk. HHS is requesting information on how providers and health plans are collecting and using data on Medicare beneficiaries' social risk factors:
• Which social risk factors are most important to capture?

The PRIME Registry currently serves more than 2500 clinicians in 900 practices in 49 states. The PRIME Registry Population Health Assessment Engine (PHATE) uses the Social Deprivation Index (SDI) to capture and characterize social risk factors for patients and Communities.[7,8] The SDI includes poverty, nonemployed, percent overcrowded, percent black, less than 12 years' education, rate of no car ownership, renter-occupied housing, high-need age group, and single-mother household. Similar to the Area Deprivation Index, the New Zealand Deprivation Index, and the UK Index of Multiple Deprivation, the SDI used factor analysis to test small-area SDOH measures against outcomes.[9-11] The results are indices predictive of increased cost, utilization, disease prevalence, and mortality. The UK and New Zealand have used their indices to adjust payments for clinical care and social services.[12-14]

• Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

We use data collected systematically and routinely by the US Census via the decennial census and the American Community Survey. The Robert Graham Center uses these data to refresh the SDI annually. There is no burden placed on clinicians or practices. The SDI is employed as a Community Vital Sign to convey risk for individual patients, and to evoke a conversation between clinician and patient about their particular risk factors.[15,16]

• Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

The NAM report series raised important concerns about using EHRs as a mechanism to collect social risk data. EHRs already put burden on clinicians to collect scores of other data, many of which have no utility or no direct utility. EHRs shifted work to clinicians that is a poor use of their time and training, and yet most clinics cannot afford to offload this work to people better

suited (and who can be trained to standardize data capture). To avoid offending patients, clinics may guess at patient's social risks rather than ask them for fear of offending or angering them.

• What are barriers to collecting data about social risk? How can these barriers be overcome? Increasing investment/payment so that clinicians can offer referrals or other resources when social risks are discovered makes them more likely to ask and capture those data. The NAM was also clear that providing data from other sources—Social Security, Census, American Community Survey—reduces burden and is often more reliable. They also discuss the role of Medicare in capturing social risk factors at enrollment.
A key issue is how to integrate into the training of clinicians. A collaborative of primary care residencies is implementing screening and interventions in their practices. How to do this optimally is still unknown.

• What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?
The Census Bureau's Center for Administrative Records Research and Administration (CARRA) efforts to link HIE and Registry data with Census/ACS data and improve small-area understanding of social risk and associated outcomes should enhance the availability of reliable data to clinicians and communities. It also increases the likelihood of the previous IOM report recommendations on common data platforms available to primary care and public health.[17]

Sincerely,

Robert L. Phillips, Jr MD MSPH
Executive Director, Center for Professionalism & Value in Health Care
American Board of Family Medicine Foundation
Member, National Academy of Medicine
Member, National Committee on Vital and Health Statistics

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November 16, 2018

Alex Azar
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

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

Dear Secretary Azar:

On behalf of over 39,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on a request for information (RFI) that seeks input on how health care providers and health plans are working to improve care for Medicare patients with social risk factors. As emergency physicians, we see patients from all social statuses, and both by law and by oath, we treat all patients that come through our doors. We intersect with many different type of providers across the health care sector, including primary care clinicians, behavioral health specialists, hospitalists and other specialists, social workers, and community workers—and routinely consult with these colleagues for the sake of our patients. Given the unique role we play as the healthcare system's safety net, we believe that we can be active partners in any policy effort that your Department engages in related to improving care for patients with social risk factors.

Before responding to your specific comments, we would like to note that we have long supported accounting for social risk factors in Medicare payment programs. Emergency department (ED) patients in rural parts of the country, as well as those in urban, medically underserved areas, often have many more social risk factors than those in geographic areas that are better served, with less access to the many resources and community services needed to ensure better health outcomes. Inadequate risk adjustments that do not account for these factors could result in unfair penalties for providers that care for the highest acuity low-income patients, creating a perverse incentive that could result in these patients over the long term being further underserved and having their access to care threatened.

As a College, ACEP is committed to improving the quality of care that is delivered to all our patients, and we are cognizant of the specific challenges facing patients that do not have access to adequate social support services. With this value and understanding in mind, we offer the following responses to the Department's major questions posed in the RFI.

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

In recent years, providers and health plans have begun to recognize the importance of social determinants of health to a patient's overall health. Many interventions help identify barriers to health such as transportation and access to food and housing. One such tool that ACEP supports to help manage care for patients with complex needs is the Collective Medical Technologies' (CMT) Edie™ (a.k.a. PreManage ED) software. Edie™ is an information exchange that provides critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their drug history, other providers who are involved with the patients, and finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It also lowers health care costs through a reduction in redundant tests and through better case management that reduces hospital readmissions. Through an alliance with CMT, ACEP has seen this system mature in approximately 17 states. Washington state, in the first year alone, experienced a 24 percent decrease in opioid prescriptions written from emergency departments, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than $32 million.[1]

Some EDs across the country are attempting to create care coordination and case management programs that help improve follow up appointment scheduling from the ED and target social interventions and primary medical care to high ED utilizers. One such program in Maryland applies mobile technology to use paramedics in a community health worker role to follow up on discharged patients at risk for readmission.[2] Many of these patients are Medicare beneficiaries. Another program in the East Bay, California has a help desk for health-related social needs with four integrated medical-legal partnerships, called Health Advocates, to help patients navigate housing and transportation challenges, immigration challenges, and benefit eligibility.[3]

ACEP is continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients, including through participation in alternative payment models. We have developed a physician-focused payment model (PFPM) called the Acute Unscheduled Care Model (AUCM), which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recently recommended to the HHS Secretary for full implementation. The AUCM provides incentives to participants to safely discharge Medicare beneficiaries from the ED by facilitating and rewarding post discharge care coordination. Under the model, a Medicare beneficiary who presents to the ED will undergo a safe discharge assessment (SDA) concurrent to receiving clinical care to identify socio-economic factors and potential barriers to safe discharge back to the home or community, needs related to care coordination, and additional assistance that may be necessary. If the participating emergency physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA will be used to generate unique patient discharge instructions including identifying symptoms that would require rapid reassessment and return to the ED. After the initial ED visit, the patient will receive appropriate follow-up care from the ED physician, his or her primary care physician, and other specialists as needed. ACEP is excited about the infinite possibility this model has in terms of improving care for Medicare beneficiaries, and is eager to work with HHS on implementation.

How do plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors?

Understanding the full significance that specific social determinants of health have on a patient requires comprehensive screening by trained professionals. While screening can be burdensome, it can help highlight those patients who may need additional services (such as nurse follow up calls, peer counseling, or a visiting

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[1] https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/

[2] For more information on the Maryland Mobile Integrated Health Care Programs, please go to https://www.miemss.org/home/LinkClick.aspx?fileticket=w-K7gG-8teo%3D&tabid=56&portalid=0&mid=1964

[3] For more information on the Health Advocates Program, please go to http://www.levittcenter.org/ed-social-welfare-in-collabor/.

dietitian) to prevent the next acute care episode. There are many screening techniques and tools that exist, and while ACEP supports the concept of screening, we have not endorsed a particular approach.

Beyond screening, another way to identify Medicare beneficiaries with social risk factors is to simply look at utilization, particularly in acute care settings such as emergency departments. Edie™, which is described above, can help identify individuals that have gone to the ED frequently. Once these beneficiaries are identified, ACEP believes that it is important to create targeted care coordination plans that can help get the appropriate care to each individual patient.

What approaches have plans and providers used to address the needs of beneficiaries with social risk factors?

ACEP believes that the approaches that are most effective include:
- Direct patient engagement in the community;
- Broad community resource engagement;
- Customized patient care plans;
- IT System that allows for common information exchange across all community electronic health records (such as CMT's EDIE/PreManage platform described above)
- Use of care managers and coordinators, social workers, and health educators,
- Transportation services after discharge;
- Peer and support groups; and
- Services that address needs such as housing and food insecurity, especially for the highest utilizers of acute care services.

What evidence is there regarding the impact of these approaches on quality outcomes and the total cost of care?

There are numerous articles that try to address the financial impact of care coordination and case management on patients with social risk factors. However, some of these studies are limited in generalizability, and randomized controlled trials are rare.

ACEP has convened a group of emergency physicians who are interested in examining how social factors impact emergency care. This group has identified the following resources that may be helpful to HHS as the Department continues examining this issue:

Resources

Patient Activation Changes as a Potential Signal for Changes in Health Care Costs: Cohort Study of US High-Cost Patients. J Gen Intern Med. 2018 Oct 5. doi: 10.1007/s11606-018-4657-6.

Evaluation of The Behavioral Health Integration and Complex Care Initiative In Medi-Cal. Health Aff (Millwood). 2018 Sep;37(9):1442-1449.

Community Health Workers as an Extension of Care Coordination in Primary Care: A Community-Based Cosupervisory Model. J Ambul Care Manage. 2018 Oct/Dec;41(4):333-340.

Cost-Effectiveness Analysis of a Capitated Patient Navigation Program for Medicare Beneficiaries with Lung Cancer. Health Serv Res. 2016 Apr;51(2):746-67.

Low-cost Transitional Care with Nurse Managers Making Mostly Phone Contact with Patients Cut Rehospitalization at a VA Hospital. Health Aff (Millwood). 2012 Dec;31(12):2659-68.

Cost-effective: Emergency Department Care Coordination with a Regional hospital information system. J Emerg Med. 2014 Aug;47(2):223-31.

Evaluation of Housing for Health Permanent Supportive Housing Program, Hunter SB, Harvey M, Briscombe B, Cefalu M.. Santa Monica, CA: RAND Corporation. [Available at https://www. rand. org/pubs/research reports/RR1694. html. 2017.](https://www.rand.org/pubs/research)

What are ways in which plans and providers disentangle beneficiaries' social and medical risks and address each?

ACEP believes that rather than focusing on disentangling these social and medical risks, we have to recognize that the two are intrinsically connected. Chronic medical illness may predispose a patient to have depression or decompensated mental illness. Homelessness impacts the ability of a patient with diabetes to have access to the insulin they may need. Patients with liver disease and encephalopathy may forget their follow up appointments and have poor adherence. Substance use disorder makes it less likely that a patient will follow a complicated medication regimen properly. The examples go on and on. In all, we think that a more prudent approach to treating patients is to address their social and medical risks together, not separately.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,

Vidor E. Friedman, MD, FACEP
ACEP President

November 15, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Avenue, S.W, Room 415F
Washington, DC 20201

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

Dear Ms. Destro:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the request for information (RFI) on provider and health plan approaches to improving care for Medicare beneficiaries with social risk factors.

The AHA commends the Office of the Assistant Secretary for Planning and Evaluation (ASPE) for adopting a holistic approach to examining the links between social risk factors, health care outcomes and value-based payment programs. America's hospitals and health systems are deeply committed to identifying and eliminating disparities in health care outcomes. We appreciate ASPE's interest in understanding how hospitals are using information about the social risk factors faced by their patients and communities to improve care for all patients. At the same time, we applaud ASPE's continued attention to the need to account for the impact of social risk factors beyond provider control in value-based payment programs. ASPE's December 2016 report to Congress showed the extent to which provider performance on outcomes such as readmissions, patient experience and cost are impacted by social risk factors, and laid out several policy approaches to appropriately adjust measures and program designs for them.

In short, the AHA believes that efforts to eliminate health care disparities must go hand in hand with efforts to account for social risk factors in value-based payment programs. To support this goal and inform ASPE's next report on addressing

social risk factors scheduled for 2019, we offer insights on how social risk factor information is captured and used in hospitals. **We also recommend that ASPE promote further work to create standards for capturing social risk data in electronic health records (EHRs), and examine approaches to adjusting measures in value-based payment programs that go beyond the approaches in current Centers for Medicare & Medicaid Services (CMS) programs**.

CAPTURING AND USING SOCIAL RISK FACTOR INFORMATION IS A DYNAMIC PROCESS

Social risk factor information often is integral to shaping a patient's care plan. Social risk factors can impede a person's ability to maintain or return to a state of health. Hospitals have reported that a number of social risk factors are particularly impactful to shaping the trajectory of patients' care. These include, but are not limited to:

- *Safe and stable housing,* including whether a patient can safely live alone, cope with any access challenges (e.g., stairs), maintain a clean environment, and afford housing (which affects stability).

- *Access to food,* including availability and affordability of nutritious foods in their communities and ability to prepare meals that support recovery.

- *Transportation*, including how individuals can access health providers, prescriptions and food.

- *Social interactions*, including whether a patient lives alone or has connections with family and friends.

- *Personal safety,* including whether there are any potential issues with abuse, or whether community violence affects the individual's activities.

Hospitals and health systems also have shared that they find value in capturing social risk factor information across the full breadth of their patient population, rather than just for those whom they suspect have a social risk factor**.**

However, collecting social risk factor information in the clinical record and using it to shape the care plan is a complex and dynamic process. Hospitals and health systems face an array of choices in determining at what point of care to capture the information. They could use admission interviews conducted by an intake nurse. They could capture the information during outpatient visits using clinicians or other non-clinical members of the care team. They could have patients fill out paper forms or use electronic mechanisms. In some cases, more sensitive information (e.g., issues around violence or abuse) may be best captured through conversations with a clinician the patient trusts rather than through forms. Hospitals generally make their choice of data

collection approach based on the needs of their patient population and their own processes. However, the choices do create some variability in what information is captured, its completeness and its accuracy.

The initial capture of social risk factor data is only the beginning of the challenge for hospitals. Social risk factors can change over time, adding to the complexity of keeping those data accurate and up to date as patient needs and circumstances evolve. **Furthermore, for the data to help shape care, they must be accessible to clinicians at the point of care.** Many hospitals have pointed to EHRs as a potential mechanism for not only capturing social risk factor data in a more standardized fashion, but also making it accessible to clinicians when delivering care. However, as detailed further below, much work remains before hospitals can accurately capture social risk factor data in EHRs.

ENHANCING STANDARDS FOR CAPTURING SOCIAL RISK FACTOR DATA IN EHRS

The EHR certification standards developed by the Office of the National Coordinator for Health IT (ONC) hold promise for promoting greater standardization of social risk factor data in EHRs. However, significant gaps in standards remain. ONC's EHR certification criteria, test procedures and test tools are used to confirm that an EHR can capture, incorporate and send data in accordance with standard codes. The certification criteria and the testing procedures for some data – such as demographics (as outlined in §170.315(a)(5)) – are specific.

However, for other data in the EHR certification standards – including many related to social risk factors – the testing approach is not prescribed. As a result, social risk data may be collected routinely but perhaps not consistently or in support of a patient population identified as needing particular services. For example, the social, psychological, and behavioral data certification criteria (§170.315(a)(15)) requires EHRs to be certified to capture data in eight domains: financial resource strain, education, stress, depression, physical activity, alcohol use, social connection and isolation, and exposure to violence. Certified EHRs are required to capture whether the individual provides a level of response to each domain but are not certified to indicate if the individual declined to respond to the question. The criteria also permit EHRs to capture information in text fields rather than structured codes. Furthermore, the testing approach for this certification criteria is self-declaration.

Additional work is needed to standardize the data collected in electronic form, test EHRs to confirm the consistent implementation of the standards, and crosswalk the standard data to social risk factor measures or well-established social risk factor screening tools. **The AHA recommends ASPE collaborate with CMS, ONC, providers, and EHR and health IT vendors to develop or refine standards, implementation requirements and guidelines to support the effective capture and use of social risk data in EHRs.**

The successful development of these EHR standards could enable further development of tools to help identify and address social risk factors at the patient and population level. At the patient level, a positive screen for a social risk factor could provide a clinical decision support tool linking clinicians to internal or community partner resources that may benefit a particular patient. At the population level, hospitals may be able to use mapping and visualization tools to help illuminate geographic areas of communities that are particularly at risk, or better detect associations between social risk factors and health outcomes. This could better target interventions and hospital population health strategies.

ENHANCING APPROACHES TO SOCIAL RISK FACTOR ADJUSTMENT

The AHA applauds CMS's recent actions to begin accounting for social risk factors in a few of its value-based payment programs. However, we encourage ASPE to assist CMS and all stakeholders by continuing to explore alternatives to the current approach to inform future policymaking. For example, in the Hospital Readmissions Reduction Program (HRRP), CMS places hospitals into peer groups based on the proportion of dual-eligible patients they treat. And the physician Merit-based Incentive Payment System (MIPS) includes a complex patient bonus awarding clinicians and groups up to five points based, in part, on the proportion of dual eligible patients they treat.

The ideal data for use in adjusting for social risk factors should: 1) have a conceptual and statistical relationship to the outcomes being measured; 2) use a readily available data source; and 3) be collected in a consistent way using standardized definitions. Dual-eligible status has all three of these characteristics, which is why we believe it is appropriate to use in the HRRP and MIPS at this time.

Nevertheless, dual-eligible status also has important limitations as a risk adjustor. Most notably, there is variation in the generosity of state Medicaid program benefits, and, in the long run, the adjustor may be sensitive to differences in state-level decisions. Dual-eligible status also may not fully reflect the poverty in communities. For example, it would not fully reflect the proportion of homeless in communities.

The use of peer groups – such as in the HRRP – obviates the need to change the risk adjustment models for underlying quality measures. However, the use of peer groupings involves somewhat subjective choices about where to set the cut points of a particular group. Those hospitals at the upper end of one quintile and those at the lower end of the next quintile would have similar proportions of dual-eligible patients, but would be placed into different quintiles for performance comparison purposes. This is true regardless of the number of peer groups chosen to use to evaluate performance.

The science of quality measurement is dynamic, and there are a number of options that we encourage CMS to evaluate for improving the risk adjustment approach. One particularly promising set of data that could be used in the shorter term are census-tract data on poverty rates and income. Census variables like poverty rate and income are readily available, and could be mapped to a hospital's patient population using zip codes. Moreover, census data could be a more direct measurement of poverty than dual-eligible status, and would not be sensitive to differences in state Medicaid programs. Hospitals also are beginning to use ICD-10 CM codes to record patient-level information related to social risk factors, such as housing, literacy and education. The codes should bolster efforts to track trends at a population level. In the future, the codes also could be evaluated for their suitability in risk adjustment models. In the long-term, social risk factor data derived from EHRs may be superior to both claims-based and other administrative data as they may better align with the dynamic process of assessing and responding in real time to patients' changing social risk needs. However, as noted in the previous section, work remains to foster stronger standards around the EHR-based capture of social risk data.

The AHA appreciates your consideration of these recommendations. Please contact me if you have questions or feel free to have a member of your team contact Akin Demehin, director of policy, at ademehin@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

AMA
AMERICAN MEDICAL
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November 16, 2018

Brenda Destro, PhD
Deputy Assistant Secretary for Planning and Evaluation
Acting Assistant Secretary and Acting Principal Deputy
 Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Deputy Assistant Secretary Destro:

The American Medical Association (AMA) appreciates the opportunity to respond to the Assistant
Secretary for Planning and Evaluation's (ASPE) Request for Information on he IMPACT ACT Research
Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk
factors. Providing care to individuals and families that addresses both medical and social needs is integral
to optimal health.

Overarching Question and General Questions

The Department of Health and Human Services (HHS), private payers, physicians, hospitals and others
must work collectively to create a system that enables the collection and use of this information at the
point of care and for communities, regions and across the United States. We support efforts to accelerate
the consideration of social risk factors and associated social determinants of health (SDH) into the
provision of direct patient care and population health management, and for measurement purposes. Our
comments focus on the gaps in knowledge, resources, and/or data, particularly as those gaps impact
individuals receiving care in small practices and those physicians and groups who serve in rural areas or
underserved populations. The areas include:

- Delivery of services

    - Education on how to collect and document social risk factors and SDH including
      access to resources to address such factors in a manner that respects a patient's autonomy
      and privacy;
    - Toolkits and resources for all health care settings and providers integral to identify,
      appropriately select and refer patients with social risk factors;
    - Legal restrictions that may limit a physician's ability to successfully implement these
      practices; and

- Financial incentives or other investment and reimbursement methods to offset these costs for physicians.
- Data
    - Standardization of the required SDH data elements to enable consistent and reliable tracking of progress, integration into electronic health record systems (EHRs) and clinical registries, and for aggregation of the information for secondary uses such as measurement

Evidence and gaps in knowledge

The Deloitte Center for Health Solutions surveyed hospitals and health systems to assess current and future efforts around social risk factors.[1] More than 80% of the hospitals and health systems currently screen those individuals who were hospitalized or identified as higher users of the system at a minimum. Just over 40 percent have a clear pathway to connect patients with needed resources with most being the larger hospitals and disproportionate share hospitals; however, 25 percent indicated that they did not have that capability. Even with higher rates of screening, most hospitals or systems reported that processes were not standardized or consistent across their patient populations and approximately 40 percent of the respondents report that they are not able to track the impact on health outcomes, cost and patient experience. The lack of sustainable dollars to support these initiatives remained a challenge for most and often required cobbling together funding from multiple sources such as state and federal agencies. While there is broad interest in integrating this information at the point of care, doing so requires significant financial resources and partnerships to implement effective strategies.

While the Deloitte study provides a snapshot of current approaches to SDH adopted by hospitals and health systems, the degree to which these issues are being identified and addressed in physician practices is less clear. Research funded by the Robert Wood Johnson Foundation in 2011 found that 85 percent of physicians concur that addressing medical and social needs are equally important and poorer outcomes are directly linked to unmet social needs.[2] Regrettably, the majority reported that they did not feel adequately equipped to be responsive to these needs, limiting their ability to provide optimal quality care. This sentiment is further confirmed in a recent editorial by DeVoe and colleagues in which they concluded that integration of social determinants of health is not broadly implemented across primary care practices and there is little to no evidence to show how these data can be integrated into care effectively.[3] These findings demonstrate that currently the ability for primary care, specialists and small practices to address social risk factors is limited.

There is emerging evidence indicating that investment in programs and initiatives focused on effectively addressing social risk factors can drive improvements in patient outcomes, result in cost savings to the system and positively impact a physician's job satisfaction. A study by WellCare Health Plans and the University of South Florida found that health care spending was reduced for those patients with social

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[1] Deloitte Center for Health Solutions. Social determinants of health: how are hospitals and health systems investing in and addressing social needs? Available at: https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-addressing-social-determinants-of-health.pdf. Accessed October 28, 2018.

[2] Harris Interactive and The Robert Wood Johnson Foundation. 2011 Physicians' Daily Life Report. Available at: https://www.rwjf.org/content/dam/web-assets/2011/11/2011-physicians--daily-life-report. Accessed October 30, 2018.

[3] DeVoe JE, Bazemore AW, Cottrell EK, Likumahuwa-Ackman S, Grandmont J, Spach N, Gold R. Perspectives in primary care: a conceptual framework and path for integrating social determinants of health into primary care practice. Ann Fam Med. 2016;14:104-108.

needs by 10 percent compared to those whose needs were unmet.[4] Another study demonstrated that provision of resources that enable physicians to be responsive to their patient's social needs is associated with less levels of professional burnout.[5]

Standardized Terms and Definitions

We believe that it is important to also standardize the definitions and terms to facilitate broad understanding and communications across providers. For example, additional precision in terminologies and definitions related to "dual eligible" versus "dual covered" is needed. Standardizing these terms would enable accurate identification of patients at risk, particularly within EHRs, and prevent incomplete capture of the patient population for measurement. Specifically, we have determined that there are no clear definitions for "dual eligible" and "dual covered" due to state-to-state differences in Medicaid eligibility, as well as the level of coverage each beneficiary may receive within these programs. These nuances play an important role in understanding what services and treatments are covered versus those that will require referral to other resources. In addition, an individual's status can change over time and currently we are limited in our ability to capture these variances electronically and longitudinally.

Beyond eligibility and covered status, there have been efforts to classify and target beneficiaries by zip codes (and when available, zip+4 increases precision), but beneficiaries are transient and zip codes may be changed by the United States Postal Service. Some rural areas, particularly in the Mountain West, do not have assigned zip codes and it is unknown what percentage of the population is missed when we rely on zip codes to target or risk-adjust based on social risk factors. Therefore, there is a need for further understanding of the implications and stability of five plus four-digit zip codes as a marker of socioeconomic risk.

Delivery of Services

The environmental scan and evidence review we conducted to respond to the Request for Information (RFI) identified a key theme across the various national initiatives and regional collaborations targeting this topic. Many of these health systems or health plans were successful in creating sustainable models through partnerships with more than one organization within a community, and many established relationships with a data analytics or information technology vendor. We believe that there may be successful strategies, best practices and lessons to be learned from these entities to address the critical gaps on education, toolkits and resources.

National Initiatives and Programs

The following are organizations and projects that have focused on standardized data collection and provision of data at the point-of-care and for population health management from whom ASPE may gather useful information and data.

Atrium Health Community Resources Hub (https://chscommunityresourcehub.auntbertha.com/) -

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[4] Pruitt Z, Emechebe N, Quast T, Taylor P, and Bryant K. Expenditure reductions associated with a social service referral program. Popul Health Manag. April 17, 2018. ePub ahead of print. doi: 10.1089/pop.2017.0199

[5] Olayiwola JN, Willard-Grace R, Dubé K, Hessler D, Shunk R, Grumbach K, Gottlieb L. Higher perceived clinic capacity to address patients' social needs associated with lower burnout in primary care providers. J Health Care Poor Underserved. 2018;29:415-429. doi: 10.1353/hpu.2018.0028

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Region-based online tool that allows providers and patients to identify potential solutions available in the community to address resource needs such as transportation, food pantries, and housing.

City Health Dashboard (https://www.cityhealthdashboard.com/) - Provides data on social determinants of health, patient outcomes, clinical care, and other measures on 500 cities across the United States.

Healthify (https://www.healthify.us) - Software solution focused on linking patients' social risk factors with the necessary resources for health plans and health systems.

Health Leads (https://healthleadsusa.org/) - Organization that collaborates with hospitals and clinics to implement interventions at the point of care and within the community.

The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) (http://www.nachc.org/research-and-data/prapare/) - Initiative to assist health centers and providers collect the social risk factor data needed to improve patient outcomes, particularly using EHRs.

NowPow (http://www.nowpow.com/) - Using data integrated into EHRs, this startup assists health systems to identify community resources based on the patient's needs.

Selected Community and Regional Models

Geisinger's Fresh Food Farmacy (https://www.geisinger.org/freshfoodfarmacy) - Program targeted to patients with diabetes who are food insecure and have higher HbA1c levels (above 8.0 percent) than is considered optimal who are referred by their physician for clinical interventions, education, and access to healthy foods.

Utah Alliance for Determinants of Health - Partnership of city, county, and state agencies and community organizations that seeks to develop a model for providing resources and support to address social risk factors such as housing instability, food insecurity, and other needs and improve patient health and reduce costs. (https://intermountainhealth care.org/news/2018/06/new-alliance-seeks-to-promote-health-and-prevent-illness-by-addressing-social-determinants-of-health-in-ogden-st-george/)

UnitedHealth care - Awarded grants to several community-based organizations in Wisconsin to address food insecurity and provision of preventive health screenings such as dental and vision care. (https://newsroom.uhc.com/news-releases/unitedhealth care-awards - 1-95-million-in-grants-to-wisconsin-com.html)

States are also addressing social risk factors with just under 20 requiring Medicaid managed care plans to screen and refer patients with these factors. The majority of Medicaid managed care plans have initiatives to address social needs. The Center for Medicare and Medicaid Innovation State Innovation Models and the Delivery System Reform Incentive Payment initiatives also seek to leverage approaches for addressing the social needs of patients through partnerships and targeted projects within communities.[6]

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[6] https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Barriers/Restrictions

The anti-kickback statute, physician self-referral law (Stark), and the civil monetary penalty (CMP) law are potential barriers to tailoring and delivering services to patients with social risk factors. Significant changes in our understanding of the impact of SDH on health, health care payment and delivery have occurred since enactment of the existing fraud and abuse laws. Numerous initiatives are attempting to align payment and care coordination efforts to improve the quality and value of care delivered. In addition, the delivery of care is undergoing a digital transformation associated with adoption of innovative technology. However, the fraud and abuse laws have not commensurately changed. The laws can have a negative impact on Medicare beneficiaries with social risk factors by inhibiting collaborative partnerships, care continuity and the engagement of patients in their care.

As discussed in the RFI, continuity of care requires smooth transitions to prepare for patients' changing clinical and social needs. The Stark law may impede this continuity and these care transitions. Specifically, in certain circumstances, physicians are prohibited from employing promising care coordination strategies on behalf of their patients, e.g., an arrangement that pays for a nurse coordinator to coordinate a recently discharged patient's care among a hospital, physician specialists, or a primary care physician may induce future referrals to their own office to avoid an unnecessary readmission to the hospital. Instead, patients, in addition to dealing with the physical and emotional aspects of a disease or condition, often find themselves having to coordinate their own care in a fragmented and siloed system. Placing the obligation on the patient to know how to properly manage follow-up care without the assistance of their physician or care coordinator may have a negative impact on patient care, the physician-patient relationship, and on a physician's ability to achieve high levels of performance for beneficiaries with social risk factors. This barrier can be overcome through creating an anti-kickback safe harbor and Stark exception to facilitate coordinated care.

Engaging patients in their care involves designing individualized care to promote the health of individuals in the community setting. Under the CMP, this engagement can include providing certain incentives that promote access to care (e.g., providing childcare during an appointment). However, the AMA is concerned about potential anti-kickback statute liability for these arrangements. For example, provision to beneficiaries of a dedicated mobile treatment plan app that facilitates daily engagement with the physician and ensures greater compliance with evidence-based treatment plans fit within the exception from remuneration under the beneficiary inducement CMP because it helps beneficiaries access care by improved future care-planning by their physician. However, even though this tool provides early intervention to avoid unnecessary hospitalizations and emergency room visits, the arrangement is still subject to anti-kickback statute liability because it may induce future referrals to the physician to receive coordinated care. This barrier can be overcome through creating a new anti-kickback safe harbor to cover this conduct or by issuing a law enforcement policy statement from the Office of Inspector General that meeting the requirements of the promoting access to care exception from the definition of remuneration from the beneficiary inducement CMP poses a sufficiently low risk of fraud and abuse under the anti-kickback statute.

Another type of beneficiary engagement that implicates the anti-kickback statute and CMP is the provision of incentives for wellness and managing chronic diseases (e.g., adherence to treatment plans and management programs). There is no exception under the CMP or the anti-kickback statute for this type of incentive. Thus, physicians cannot provide incentives for adherence without facing treble fines and jail time. Rewarding adherence can help some patients understand the important interactions between

lifestyle, socioeconomic position, disease, and prescribed treatment. Ultimately, validated programs could substantially reduce the cost of health care over time and help patients achieve better health and health outcomes and physicians achieve high levels of performance for beneficiaries with social risk factors. This barrier can be overcome by creating a new exception from the definition of remuneration under the CMP to include adherence to treatment plans and management programs.

Financial Incentives or Other Reimbursement Methods

Financial incentives or other vehicles by which physicians and other providers can offset these costs must be identified. Many of the activities, applications and other resources required are not currently reimbursed by Medicare or private payers. Alternative payment models are moving in the direction of addressing risk, but also largely do not cover activities and related services. Physicians are limited in their ability to provide free services unlike hospitals, which may apply the community benefit standard; yet, they are often well suited to identify and refer patients for these services during the course of routine care.

Data

There is growing evidence to support the integration of social risk factors and determinants of health into EHRs at the point-of-care, but challenges and barriers exist that must be addressed for successful and widespread implementation. The recent study by Gold and colleagues in three Pacific Northwest community health centers demonstrated that integration of these data into practice can be accomplished, but not without significant effort.[7] While three barriers were explicitly identified, all related to the lack of data integration into clinical workflows in an efficient, meaningful way. For example, capturing the information on paper to then be manually entered into the EHR increased the burden. Display of relevant data in disparate sections of the patient's record increased complexity and negatively impacted physicians and staff's overall experience. It was also difficult for staff to identify and document resources to which a patient could be referred and follow-up, due to increased positive screening rates and unmanageable workloads.

The AMA believes that the data collection and aggregation of SDH must be standardized to the greatest extent possible to enable use within practices for quality improvement and across populations to monitor progress toward our desired outcomes. Collaborations involving frontline physicians, hospitals, community leaders, EHR vendors and others are needed to enable this standardization without compromising clinical workflows and patients' privacy.

EHR and 2015 Edition Certified EHR Technology (CEHRT) Issues

These efforts will facilitate reliable and valid data that can be used for multiple purposes including performance measurement. All the factors mentioned previously are integral to the reliability and validity of the data for measurement and perhaps more importantly to enable us to develop the evidence needed to demonstrate a linkage between addressing these factors, improving outcomes and reducing costs.

Some larger EHR vendors have enabled social risk factor collection, often using electronic screening tools for data capture. However, there is no universal mechanism for collecting social risk factor data, nor

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[7] Gold R, Bunce A, Cowburn S, et al. Adoption of social determinants of health EHR tools by community health centers. Ann Fam Med. 2018;16:399-407. doi: 10.1370/afm.2275.

a definitive set of social risk factor data elements to collect. While the current landscape provides flexibility, and allows different individuals within the health care organization to capture social risk factor data, too much variation limits a delivery system's ability to analyze SDH and related data from EHRs and other sources, and may limit the use and usefulness of the collected data. Furthermore, in terms of user navigation and overall usability, inconsistencies in social risk factor collection throughout the clinical workflow and encounter contribute to clinicians' cognitive burden.[8]

Depending on an organization's internal policies and available resources, or the sensitivity of the information, social risk factor data could be captured by behavioral health workers, nurses, or medical assistants. Individuals may feel more comfortable using a kiosk or online portal to enter sensitive information, such as domestic violence or abuse. Additionally, there are situations where the applicability of social risk factor information differs based on the medical specialty. For instance, health care organizations may identify a standard set of social risk factor indicators for collection; however, physician specialists or subspecialists may request additional unique social risk factor data, e.g., mental health and social stressors.[9,10] Therefore, there is a need for customizable or "extendable" social risk factor tools to support patient care or health care operations.

Standards, such as Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), consists of a set of national core and optional measures. While there is a freely available PRAPARE toolkit, which includes EHR templates, workflow diagrams, and implementation strategies, only a small number of EHR vendors support PRAPARE's integration.[11] Even for the EHRs that support PRAPARE, questions remain around the total lifecycle costs for implementation—including long-term EHR support, data analysis, and reporting. There is further concern about the cost EHR vendors are charging physicians to enable even this basic level of functionality and the fees to connect third-party applications that support SDH.[12,13]

Significant emphasis has been placed on the expected data exchange capabilities of the next generation of EHRs—including the ability to better support social risk factor and social determinants of health data. While the 2015 Edition of CEHRT products are required to support application programing interfaces (APIs), overwhelmingly EHR vendors are implementing read-only APIs focused only on the information required in the Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health Information Technology's (ONC) common clinical data set (CCDS). Federal certification focuses on the EHR's ability to support individuals' access to only a small subset of patient information—acting

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[8] Ratwani, R., Savage, E., Will, A., et al, A usability and safety analysis of electronic health records: a multi-center study, Journal of the American Medical Informatics Association, Volume 25, Issue 9, 1 September 2018, Pages 1197–1201, available at https://doi.org/10.1093/jamia/ocy088

[9] Fisher, M., Baum, F., The social determinants of mental health: implications for research and health promotion, Australian and New Zealand Journal of Psychiatry, 2010, available at http://www.sdoha.org.au/SD%20of%20mental%20health-1.pdf

[10] World Health Organization, Social Determinants of Mental Health, 2014, available at http://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=C497BBEB41C474FA8BD0A2BA484989A6?sequence=1

[11] National Association of Community Health Centers, PRAPARE Implementation and Action Toolkit, accessed October 2018, available at http://www.nachc.org/research-and-data/prapare/toolkit/

[12] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Health Policy, Incorporating Social Determinants of Health in Electronic Health Records: A Qualitative Study of Perspectives on Current Practices among Top Vendors, October 2018, available at https://aspe.hhs.gov/system/files/pdf/259901/NORCSDHVendorFinalReport101218.pdf

[13] Allen, A., "Developers complain of high EHR fees for SMART apps", Politico, August 6, 2018, available at https://subscriber.politicopro.com/ehealth/article/2018/08/developers-complain-of-high-ehr-fees-for-smart-apps-721486

as an artificial high-water mark for EHR design. For example, the CCDS is a grouping of 20 data classes that is meant to act as a "floor" of data for certified EHRs. Yet, ONC has identified at least 50 additional data classes—including those considered social risk or SDH—that should be accessible electronically.[14] The ability for patients and physicians to have electronic access to the entire medical record is a core tenet in the Health Insurance Portability and Accountability Act (HIPAA) and the 21st Century Cures Act. However, the lack of read *and* write capability, coupled with vendors limiting data to only the CCDS, contributes to the inherent weakness in 2015 CEHRT Edition EHRs' APIs.

Cybersecurity Challenges

There is deep concern that our nation's health care providers and patients have been insufficiently prepared to meet the cybersecurity challenges of an increasingly digital health care system. This will continue to be a concern as the tide of information, including on social risk factors and determinants of health continues to rise. The health care community must recognize that cybersecurity is not only a technical issue, but also a patient safety issue. The AMA recently completed a first-of-its-kind cybersecurity survey of 1,300 physicians.[15] The top three cybersecurity concerns that physicians identified were interruption of access to an EHR, EHR security (including compromise of patient data), and general patient safety concerns. The survey results underscore the importance of considering the potential harm to patients and interruption to their care when conducting cost-benefit analyses of available approaches to data security, privacy, and interoperability. Cybersecurity is a national priority and physicians, other health care providers, and patients need tools to secure sensitive patient information in the digital sphere.

Standardized Data Elements

Due to a lack of standardization, there are challenges with the variability in coding social risk factor and determinants data. The multiplicity of data coding, beyond just social risk factors, contributes to the larger interoperability issue. Some of this can be attributed to health care organizations' desire for flexibility; however, even the codes and regulations are inconsistent. In some cases, individual data elements can be represented by multiple codes in one terminology or multiple codes across different terminologies. This becomes challenging for EHR vendors who then are required to support different value sets. There is wide recognition that greater standardization would allow health care organizations to better analyze and interpret social risk factor data in clinical decision-making and would reduce some pressure on EHR design and development. This is also a necessity to advance interoperability.

Further, not all social risk information can be coded and free text fields are frequently used despite efforts by the organizations that manage terminologies, e.g., the World Health Organization (ICD), Regenstrief (LOINC) and SNOMED International (SNOMED-CT). Much of the data that are collected cannot be characterized by a given code, necessitating capture in free text. This becomes especially challenging when screening tools or surveys combine codified or yes/no responses with free-text fields to provide context, description, or further detail.

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[14] The Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, Draft U.S. Core Data for Interoperability (USCDI) and Proposed Expansion Process, January 5, 2018, available at https://www.healthit.gov/sites/default/files/draft-uscdi.pdf

[15] American Medical Association, Medical Cybersecurity: A Patient Safety Issue, accessed October 2018, available at https://www.ama-assn.org/about/medical-cybersecurity-patient-safety-issue

One approach is to implement social risk factor and determinants data collection tools with a focus on a dimension of interest e.g., chronic disease or specific clinical domains like hypertension, diabetes and asthma. Starting with a priority set of patients or a smaller cohort allows both EHR vendors, health care organizations and the data standards and interoperability communities to work out technical difficulties, refine and improve clinical workflows, and facilitate scaling to larger populations.

Given the breadth and depth of these issues, multiple stakeholders including physicians and health care professionals, patients, vendors, standards-developing organizations and government agencies must work together in a collaborative fashion.

How AMA is contributing to a solution

The AMA's Integrated Health Model Initiative (IHMI) is working to improve the ability to share and use data to improve patient health outcomes. IHMI uses the best available science to define and model meaningful and clinically-valid data elements, including patient function, state, goals and SDH, in high-burden disease areas.[16] IHMI features three components:

- A digital community for hosting collaborative groups reflective of IHMI's current focus and work;
- A physician-led validation process to review clinical applicability; and
- A technology-agnostic clinical information model for organizing and exchanging data: The Integrated Health Model (IHM).

IHMI is a platform for developing data portability solutions. Data liquidity, also known as semantic interoperability, is the ability to exchange usable data. A requirement for liquidity is portability, which occurs when the exchanged data are defined in a semantically-harmonized, consistent manner down to the level of computability for automated information exchange. IHMI works by accepting clinical content submissions, which it evaluates for inclusion in the IHM. If a submission is accepted a clinical validation process is run to convert the submission into a business requirements specification. This specification is then used to model the data structures needed to create computable, structural representations of clinically meaningful data elements that can be used by any electronic system to capture, exchange, store, and analyze health data. The development and use of the IHM is anticipated to enable better outcomes analysis, empowering clinicians and patients with data that can be trusted for clinical decision making. *IHMI aims to model patient health state, functional status, SDH and patient health goals across high-burden diseases where needed data in these domains are not well-represented in current available data standards. Improved ability to capture these data in a clinically valid, structured, standardized manner is anticipated to have many benefits, including increased success in the execution of value-based payment models.*

IHMI as a benefit to provider organizations

The development in the IHM of clinically-valid information models for high-priority use cases e.g., the capture and use of SDH data to identify patients with social risk factors is expected to improve the quality and usability of health data. Increased availability and use of those data has the potential to improve health outcomes by reducing clinical variation in data from the extremely varied sources of SDH data.

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[16] https://www.ama-assn.org/integrated-health-model-initiative-ihmi

Reduction in the incidence of false signals and other interpretive errors may be a benefit to operational efficiency, helping clinicians and providers to perform more effective risk prediction, targeting patients who are truly at risk with the right care and resources they need.

Care plan effectiveness may benefit from the enablement of feedback loops between patients monitoring their health at home and the clinicians providing their care. For hypertension and other similar disease states, office visits may be better utilized reducing cost to patients and provider organizations. Facile incorporation of SDH data at the point of care is expected to improve shared decision making and health outcomes for patients with social risk factors.

How IHMI is working to help provider organization realize these benefits

IHMI has released Self-Measured Blood Pressure Monitoring, version 1.0 (SMBP1), modeling patient health state in hypertension. Future releases are expected to expand IHM's coverage of this disease state with the inclusion of an initial set of SDH that are relevant in hypertension but also to diabetes and asthma.
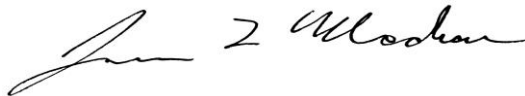
In high risk populations, access to resources is a common and significant SDH factor. Remote monitoring together with education about how to use remote monitoring can help address the issue of access to health care resources. Remote monitoring then can range from SMBP for patients who are assessed to be good candidates to using kiosk devices such as what can be found in their local pharmacies, to mobile clinics that bring services to the county/community.

IHMI is modeling SDH data beginning with five-digit zip code with optional plus four as a proxy for geographic location, which has been correlated with socioeconomic and sociodemographic status, along with dual eligible status. The initiative is working within its collaborative community to identify additional SDH factors for inclusion in future IHMI releases, depending on market demand. The AMA and its IHMI look forward to its efforts in this domain being further informed by the ASPE's report.

Conclusion

The AMA appreciates the opportunity to provide our comments on this important issue. If you should have any questions regarding this letter, please feel free to contact Koryn Rubin, Assistant Director for Federal Affairs, at koryn.rubin@ama-assn.org or 202-789-7408.

Sincerely,

James L. Madara, MD

November 16, 2018

The Honorable Brenda Destro
Acting Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Delivered electronically to: ASPEImpactStudy@hhs.gov

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

Dear Assistant Secretary Destro:

These comments are submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) with respect to the above captioned Request for Information.[1] We welcome the opportunity to offer input to the Department of Health and Human Services (HHS) to inform its second report to Congress on the effect of socioeconomic status on quality and resource use measures as mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. AMRPA supports the principles and objectives of the Act and remains committed to working with HHS and the Assistant Secretary for Planning and Evaluation (ASPE) to achieve them.

AMRPA is the national trade association representing more than 625 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (collectively referred to as inpatient rehabilitation facilities (IRFs) by Medicare), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs).

Inpatient rehabilitation hospitals and units (IRH/Us) provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from post-acute care (PAC) provided in non-hospital settings. AMRPA members help their patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement. The vast majority of our members are Medicare participating providers and, on average, Medicare Part A payments represent more than 60 percent of IRH/U revenues.[2] In 2016,

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[1] https://aspe.hhs.gov/system/files/pdf/259906/ImprovingCareMedicareBeneficiariesSocialRiskFactorsRFI.pdf

[2] Medicare Payment Advisory Commission, Report to Congress, Medicare Payment Policy, 267 (Mar. 2018).

IRH/Us served approximately 350,000 Medicare beneficiaries, representing more than 391,000 stays.[3]

AMRPA's responses to the questions posed in ASPE's Request for Information follow below.

1. **Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified? How is this data collected?**

IRH/Us use a multidisciplinary and comprehensive set of evaluative, diagnostic and therapeutic interventions focused on restoring functional capacity, activities of daily living and cognitive function. In fact, IRH/Us are required by CMS regulations to provide multiple disciplines of care, including physician, nursing, physical therapy, occupational therapy, speech and language therapy, and clinical social work, and to hold weekly interdisciplinary team meetings. The interdisciplinary team meeting allows members of the treatment team, which includes clinical social workers, to coordinate care and communication regarding the patient's plan of care and treatment goals. Interdisciplinary and coordinated care is essential to getting patients back to their homes and work sooner and gives them improved physical, social and emotional functioning and wellbeing.

Rehabilitation hospital care is patient-centric and accountable for each patient's exposure to potential risk factors. Social risk factors are most certainly taken into account on a patient-by-patient basis, especially as part of the discharge planning process. Discharge planning begins at – and ideally before – a patient admission to the IRH/U. The interdisciplinary team collaborates to evaluate the patient's medical, social support, and financial support needs, and develops a discharge plan that addresses those needs accordingly. Specifically, a social work care management team meets with the patient and caregivers to conduct psychosocial and socioeconomic evaluations and to collect information about how social risk factors can influence an anticipated trajectory of care. This information is fed back to the clinical team at the interdisciplinary team conference to help inform the discharge planning process.

A person-centered approach means identifying the type of support and reasonable adjustments that enable each person's needs to be met. The clinical social worker helps plan for long-term management of health care needs, including referrals to resources in the community to promote the highest level of independence. While this data may not be collected based on an industry-standardized platform, IRH/Us gather many data points and pay close attention to each patient's unique situation and respond accordingly.

2. **For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?**

A patient's disability, functional status, or frailty has a profound impact on the service they will need. The more severe a patient's disability or impaired their functional status, the more challenging it can be for providers to ensure that the patient is receiving all the necessary care. Furthermore, the impact of socioeconomic status (SES) factors are oftentimes much more

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[3] *Id.*

pronounced for lower-functioning patients who are likely to require multiple professional services after discharge; however, low SES individuals are less likely to be insured and are more likely to avoid medical care due to cost.[4]

It is undeniably more challenging for certain patients to reenter the community following their IRH/U stay. As an example, some brain injury patients with cognitive impairments demonstrate risk-seeking behavior and might not have the adequate social resources (family or friends) to turn to for support. In instances where patients lack a social support network for a hospital to turn to, the hospital case worker recognizes that lifelong institutionalization may be a likely outcome for this patient. Similarly, with regard to frailty, many older patients do not have living relatives nearby to turn to for caregiver support.

3. Are there especially promising strategies for improving care for patients with social risk?

Early identification of social risk factors enables IRH/Us to better prepare for potential services or supports that patients may additionally need after discharge from the rehabilitation hospital. To do this, the IRH/U team is highly proactive in liaising and dialoguing with the referring hospital, oftentimes as part of the pre-admission assessment, to get key information such as the patient's unique living situation, social support, geography and payer status.

When it comes to successful strategies, however, perhaps the most prominent are those providers use to minimize the negative impact of a patient's lack of coverage when their payer does not cover downstream post-acute services, such as home health or skilled nursing care. To address the needs of these patients, IRH/Us employ proactive and targeted strategies such as:
- Utilizing a paramedicine program to conduct home visits for patients who could not receive home health benefits. This type of program helps ensure that patients are progressing along their care trajectory as expected and can also help mitigate potentially preventable hospital readmissions.
- Providing financial guidance services to help patients understand and navigate their benefits. In some instances, when a primary payer does not cover services such as skilled nursing care, IRH/Us will assist patients and their caregivers in applying for Medicaid to obtain coverage for these services after IRH/U discharge.
- Providing financial assistance programs for underfunded patients.
- Partnering with other providers along the care continuum to help defray the costs of certain services (*e.g.*, sharing the cost of durable medical equipment or medications with the acute care hospital), and facilitating smooth downstream transitions of care (*e.g.,* leveraging relationships with downstream providers to help an unfunded patient gain access to those services after IRH/U discharge).

Post-discharge, some IRH/Us also use "transition clinics" to provide a transitioning physician for patients being discharged who do not have a primary care physician overseeing their routine care.

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[4] Institute of Medicine, America's uninsured crisis: consequences for health and health care. National Academies Press; 2009. p. 214.

4. **How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?**

Successful care management that facilitates a safe patient transition to the next site of care is a fundamental component of rehabilitation hospital care. The primary return on investment for providing case management and other services, such as those discussed above, are better outcomes as a result of helping patients access necessary post-acute services and transitioning them to the next setting in a timely manner. A post-stroke patient who is able to receive continuous rehabilitative services – from intensive therapy at the IRH/U to continuing to work with a therapist in home health – will achieve greater functional gains more quickly, and is less likely to need additional services in the long run. Hence, an investment in PAC in the shorter term will pay tremendous dividends in the long run. Facilitating transitions along the care continuum enhances efficiencies and reduces costs to the healthcare system overall (*e.g.,* reduced lengths of stay). There are also costs to the provider of investing in experienced social work staff resources, as described further below.

5. **What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?**

Health care providers with demonstrated depth in social work resources are successful in connecting patients with local and regional social service organizations. In that regard, the clinical social workers seated within the interdisciplinary team at rehabilitation hospitals support the entire continuum of care by arranging and furnishing these unique services.

A rehabilitation hospital's patients often come from a wide geographic area and beyond the hospital's immediate market. Accordingly, IRH/Us must develop and leverage partnerships with various entities throughout and beyond their market – including upstream referral sources and social service organizations – as those entities are more familiar with the local supports and resources within a patient's community. IRH/Us also proactively reach out to social service organizations to develop relationships with resources in the community.

Indeed, it takes time and experience for a social work team to cultivate these relationships and it is an investment of a hospital's staff resources. Some IRH/Us take a centralized approach by having a dedicated case worker assigned to patients who may be more challenging to discharge safely (and have a greater need for social services). These dedicated social workers have developed relationships with external partners to readily connect patients with community support services.

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

Our members note that the unpredictability of engaging these patients has been an important lesson, as well as a challenge they continue to grapple with and adapt to. Sometimes, despite a

hospital's best efforts to develop a comprehensive patient-centric discharge plan and support the patient's adherence to it, the patient and/or their caregivers do not follow through with the plan for reasons unknown to the hospital. There is also tremendous value in investing in external partnerships and relationships with other entities along the care continuum, and in staff resources within such as experienced social workers and case managers.

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

From our members' perspective, the following factors can be significant barriers to developing services tailored for a patient's unique care needs and situations:

- **Payer source or funding**: As described above, it is much more challenging for rehabilitation hospitals to ensure that un-/underfunded patients will be able to receive necessary post-discharge care. Hospitals undertake a variety of strategies to try to help patients overcome these barriers, such as offering paramedicine home visits or financial support services, as detailed above.

- **Caregiver presence/availability**: The presence and willingness of family or community supports are critical drivers for IRH/Us when deciding upon a patient's appropriate discharge destination. For example, even though a patient has met the goals of a rehabilitation hospital admission (*e.g.*, regained household level ambulatory function and is able to walk on level surfaces at discharge), if he or she lives alone in a third floor walkup without handicap access, a discharge home may not be safe. Although a return to home or the community is the gold standard, it is not always the safest discharge setting. Even when the caregiver's presence is expected at the outset, situations often change and families/caregivers' involvement may shift as they come to appreciate the extent of support needed. To help mitigate this phenomenon, IRH/Us are proactive and engage caregivers throughout the patient stay to educate them on the anticipated post-discharge care needs.

- **Patient activation, engagement, and agency:** An individual's level of activation in managing their own health – patient activation model measure (PAM) – can determine the patient's ability and motivation to "buy into" their care plan. This may vary according to age, education level, health literacy, motivation and illness. Providers aim to communicate health information in ways that are tailored and accessible to patients as one way of overcoming this barrier.

- **Cultural factors:** With regard to language barriers, IRH/Us and health care providers have invested in translation technologies to facilitate their communication with diverse patient populations. In rehabilitation, there is even a greater need for having a live translator due to the highly dynamic nature of clinician-patient interactions in an intensive therapy session. IRH/Us help patients overcome language barriers by providing on-hand translators in therapy.

8. **Which social risk factors are most important to capture?**

To AMRPA members, some of the most important factors to capture are payer status, caregiver availability/presence, and geographic location.

9. **Would standardized data elements for EHRs help you to collect social risk data? What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**

As described above, IRH/Us collect information on social risk factors to inform the development of a patient-centered care plan, and specifically a discharge plan. The data collection process is already well integrated into a hospital's clinical workflow and furthermore is likely to have been adapted to suit the needs of the hospital, community, or region. At this time, it is unclear how standardizing data collection in EHRs, in a global aggregate sense, could help providers improve upon how they collect and use this information for care planning purposes for individual patients.

There is a benefit to adjusting for social risk factors in Medicare payments and quality reporting programs. AMRPA strongly supports a methodologically sound approach to risk-adjustment for social risk factors, which we have recommended in the past. Our members perceive dual-eligible status, low-income subsidy status, and geographic area of residence as important factors that are also more readily accessible in currently available data sources. In evaluating provider performance, CMS should compare quality performance and resource use for providers that have comparable proportions of similar patients, such as low-income beneficiaries. We also strongly encourage CMS to develop a way to account for family/caregiver status and/or community supports. Research shows that beneficiaries who lack the adequate caregiver support have higher rates of readmission and lower rates of discharge to the community following PAC.[5,6] CMS should be cognizant of these factors as it continues to consider options to increase transparency in Medicare's quality programs.

10. **What are barriers to collecting data about social risk?**

One barrier is resources – a hospital must have the adequate financial health to be able to invest in developing the depth of its social services bench. In addition, because IRH/Us oftentimes rely on the upstream referring hospital for this information, another common barrier is limited availability of pertinent information from the acute care hospital.

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AMRPA appreciates the opportunity to provide input to the ASPE for a follow-up report to Congress on how providers serve beneficiaries with social risk factors. AMRPA is a strong supporter of the principles and objectives of the IMPACT Act, and remains committed to

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[5] Everink IH, van Haastregt JC, van Hoof SJ, Schols JM, Kempen GI. Factors influencing home discharge after inpatient rehabilitation of older patients: A systematic review. BMC Geriatrics 2016; 16: 5.

[6] Rodakowski J, Rocco PB, Ortiz M, et al. Caregiver integration during discharge planning for older adults to reduce resource use: a metaanalysis. J Am Geriatr Soc 2017; 65: 1748–1755

working with HHS to achieve the Act's objective to enhance how socioeconomic status and social risk factors are accounted for in Medicare programs. If you have any questions, please contact Mimi Zhang, AMRPA Senior Policy and Research Analyst (mzhang@amrpa.org).

Sincerely,

Richard Kathrins, PhD
Chair, AMRPA Board of Directors
President and CEO, Bacharach Institute for Rehabilitation

Suzanne Kauserud, FACHE, MBA, PT
Chair, AMRPA Quality Committee
Vice President, Continuing Care Division - Inpatient
Carolinas Rehabilitation / Atrium Health

November 14, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
Assistant Secretary for Planning and Evaluation, Room 415F
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically: ASPEImpactStudy@hhs.gov

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

Dear Deputy Assistant Secretary Destro:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments in response to the US Department of Health and Human Services Assistant Secretary for Planning and Evaluation' (ASPE) Request for Information (RFI) on the IMPACT Act Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA strongly believes that the understanding of social risk factors and their impact on the delivery and receipt of health care services will continue to evolve over time. Therefore, we encourage ASPE to be responsive to future developments and strategies that provide solutions for the risk adjustment of social risk factors across post-acute care settings. For example, APTA is encouraged by the National Quality Forum's (NQF) efforts to examine whether measures should be risk adjusted for socioeconomic status and other factors, and we recommend that

ASPE incorporate NQF's findings into the agency's future work. We appreciate the opportunity to provide comments to ASPE. Please find our detailed comments below.

How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?
Providers', payers', and consumers' understanding of the historical, social, and cultural processes that shape individual and collective experiences is narrow. Additionally, there is little guidance for clinicians how to improve the care experience for Medicare beneficiaries with social risk factors. As such, the extent by which providers are working to improve health outcomes for beneficiaries, especially those with social risk factors, is limited. This is likely due to many factors, including incentives for providers and insurers to avoid patients with social risk factors, underpayment to providers who disproportionately serve socially at-risk populations, and underinvestment in quality of care.[1] It is imperative that clinicians better understand the broader networks of people, ideologies, and practices in which patients are enmeshed and the historical, geographical, and cultural spaces in which they operate.

Although guidelines exist for the management of many health conditions and their associated impairments and limitations, many health care providers assume that written guidelines that accompany plan of care education or discharge paperwork is equivalent to providing the information that the patient and their families or caregivers need for successful outcomes. Determining one's communication style or a preferred learning style should occur at the first encounter and then be communicated among the members of the patient's health care team to optimize outcomes. Exploring how a person seeks and uses information may likely lead to the identification of social risk factors that require further investigation and specialized interventions. For example, some providers are working to improve outcomes for beneficiaries by modifying how they provide "education" to address the health literacy and capacity of their patients.

Factors that are important for a provider to capture and incorporate into a care plan include the patient's perceptions and expectations about their health and how their current socioeconomic status affects their ability to understand and implement the recommendations they are given at the time of the transition of care. Further, members of interdisciplinary teams should be reimbursed for the time it takes to determine the optimal transition of care plan for any individual changing care settings or transitioning to home from a care setting. Individual team members also should be reimbursed for the time and resources it takes to ensure that these recommendations are successfully implemented and to problem-solve solutions when the plan was not optimally implemented. Every provider must understand the impact their individual actions have on a patient's health and well-being. Until individuals are reimbursed for the quality of work they perform, the cultural shift needed in the US health care system will be too slow to keep up with the unprecedented growth of the older adult population.

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[1] NCBI Methods to Account for Social Risk Factors in Medicare Value-Based Payment. https://www.ncbi.nlm.nih.gov/books/NBK379198/. Accessed November 6, 2018.

Delivery of Services

Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?
Addressing social risk factors is important for improving health and reducing longstanding disparities in health and health care. Physical therapists use social risk data to:

- Contribute to the overall risk stratification or risk modeling of a patient or patient population
- Determine necessary referrals to address the unique and or comprehensive needs of a patient or patient population
- Determine the most appropriate treatment plan and strategies to address the unique and/or comprehensive needs of an individual patient or patient population
- Iteratively improve the care delivery process and determine appropriate areas for and or critical timing of intervention

Beneficiaries with risk factors are identified through interview, chart review, and gathering of the history. The most important source of information is often the individual, but additional sources may include the medical record, the referring clinician, and communication from or with other health care providers, family members, and caregivers.

Unfortunately, data on social risk factors is not being widely collected, and in the majority of cases, even when it is collected it is not being used by providers to improve outcomes. Providers lack an understanding of how social risk factors affect short- and long-term clinical outcomes, payment, and compliance with the treatment regimen. However, even if providers do recognize the impact of social risk factors on outcomes, the regulatory and administrative burdens being imposed on them significantly influences their ability to properly account for such risk factors. For example, while many clinicians recognize that dual-eligible beneficiaries are at higher risk for poorer outcomes, they are overwhelmed with processing and responding to the ongoing changes in the regulatory and payment environment. As such, actively trying to address social risk factors is of low priority.

Are there especially promising strategies for improving care for patients with social risk?
After a clinician has gathered information about an individual's social risk factors, the clinician should start a dialogue with the patient regarding his or her desires, goals, and needs, and what actions would be most helpful. The clinician should offer advice and not only refer the individual to other services but also facilitate access to those services in a sensitive, culturally acceptable, and caring way.

Further, strategies that are designed to increase health literacy, address activation and engagement, promote coordination of care, and address resource gaps are highly effective. Early identification and intervention is critical. Collaboration and information-sharing with other stakeholders are essential elements to any successful strategy.

How are costs for targeting and providing those services evaluated?
Under the current fee-for-service model, physical therapists are not paid for delivering services that address social risk factors, and so such services generally are not part of the cost assessment of interventions. Physical therapists do, however, in the normal course of practice provide an ongoing evaluation of the patient's status to include guidance and referrals for those at risk.

However, costs for education, training, nutritional support, therapy services to address functional risk factors, and targeted transitional and ongoing care management may be evaluated in the context of a risk-bearing or bundled-payment arrangement, whereby the up-front investment reduces downstream costs for high-risk adverse events including re-hospitalization. Proper management of individuals with social risk factors that are negatively impacting disease state management and/or health status represents a return in investment in the form of avoidance of preventable high-cost adverse events.

What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?
In the shift to value-based models, physical therapists should be recognized as essential components of the care team and integral to recommendations for at-risk individuals. ASPE should help to evolve health policy approaches, looking at the issue of social risk not solely from the perspective of payment and data, but also from how to improve the health of communities.

ASPE, in collaboration with the Centers for Medicare and Medicaid Services (CMS), should use its Medicare and Medicaid dollars more efficiently to transform society, taking a holistic approach to the patient. Further, ASPE should strive to develop partnerships with providers, embedding clinicians in entry points of care and creating care pathways that result in automated referrals and coordination of care based on risk factors.

For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?
There is a correlation between the presence of social risk factors and the degree of patients' frailty, functional limitations, and disability. The risk of frailty is increased based on the number of negative factors impacting health, including access to adequate nutrition, necessary medications to manage chronic disease, and the ability to engage in safe and meaningful physical activity. Additionally, disability is often a factor of the influence of an environment on a patient's ability to adapt to functional impairments. Individuals with social risk factors also are more likely to experience greater environmental challenges. With limited mobility, such individuals may not be interacting with health care providers who could assist with proper resource identification and allocation.

Data

Which social risk factors are most important to capture?
Important social risk factors to capture include inadequate and/or unsafe housing; inadequate nutrition; health literacy; isolation; depression; lack of family or other support; financial insecurity; job insecurity/unemployment; unsafe environment at home (violence or other); unsafe behaviors of individual or close/responsible family member (such as smoking, or drug or alcohol

use); language barriers; cultural preferences; education; socioeconomic status; transportation; and neighborhood.

We understand that ASPE commissioned the National Academies of Sciences, Engineering, and Medicine (NASEM) to investigate social risk factors for the Medicare program, resulting in NASEM's report, "Accounting for Social Risk Factors in Medicare Payment." This report highlighted the social risk factors that may influence health care outcomes of interest to Medicare.[2] APTA supports the findings in this report and encourages ASPE to rely upon it as the agency engages in further efforts to capture data on social risk factors. Additionally, work performed by the NQF should be used to inform the collection and use of social risk factor data.[3]

Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?
While the importance of gathering this information is critical, as it speaks to access, the vast majority of providers, including physical therapists, do not currently collect data on social risk. Not only do providers not understand the need to collect such data, but screening for social needs is different from, and typically not included in, current medical or health screening tools.

However, physical therapists do collect data in accordance with The International Classification of Functioning, Disability and Heath (ICF), which is part of the "family" of international classifications developed by the World Health Organization (WHO). The ICF, with a focus on human functioning, provides a unified, standard language and framework that facilitates the description of the components of functioning that are impacted by a health condition. It is a tool that enables the collection of data as to how people with a health condition function in their daily lives rather than focusing on their diagnosis or the presence or absence of disease. The ICF describes the situation of the individual within health and health-related domains and within the context of environmental and personal factors.

Physical therapists engage in an examination process that includes taking the individual's history, conducting a standardized systems review, and performing selected tests and measures to identify potential and existing movement-related disorders. The data gathered during history taking, including answers to review-of-systems questions, enables the physical therapist to generate diagnostic hypotheses and select specific tests and measures to identify and characterize signs, symptoms, and risk of movement dysfunctions. To establish the individual's specific diagnosis, prognosis, and plan of care through the evaluation process, physical therapists synthesize the collected examination data and determine whether the potential or existing disorders to be managed are within the scope of physical therapist practice.

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[2] NASEM Accounting for Social Risk Factors in Medicare Payment.
http://nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payment-Programs/Medicare-Social-Risk-Factors-Overview. Accessed November 6, 2018.
[3] NQF Social Risk Trial Final Report.
https://www.qualityforum.org/Publications/2017/07/Social_Risk_Trial_Final_Report.aspx. Accessed November 6, 2018.

History taking is a systematic gathering of data related to who the individual is and why he or she is seeking the services of the physical therapist. These data include demographic information, social history, employment and work information, growth and development parameters, living environments, general health status, social and health habits (past and current), family history, medical and surgical history, current conditions or chief complaints, functional status and activity level, medications, and other clinical test findings.

Data gathered from tests and measures yield a range of findings that may indicate that an intervention may be appropriate for a given individual, including:

- Risk factors, such as smoking history, falls risk, and recent trauma

- Health, wellness, and fitness, such as sedentary lifestyle, limited leg strength for squatting, and lack of understanding of plantar foot shear during recreational activities

- Pathology/pathophysiology, such as diabetes, cellulitis, and congestive heart disease

- Signs and symptoms of pathology and health condition, such as joint tenderness, pain, elevated blood pressure at rest or with activity, numbness or tingling, and edema

- Impairments to body functions and structures, such as aerobic capacity, anthropometric characteristics, balance, circulation, cranial and peripheral nerve integrity, gait, integumentary integrity, mental functions, mobility, motor function, muscle performance (including strength, power, endurance, and length), neuromotor development and sensory processing, pain, reflex integrity, skeletal alignment and integrity, sensory integrity, and ventilation and respiration

- Activity limitations and participation restrictions, such as environmental factors in built or natural environments affecting movement-related performance; need for assistive products or technology to enhance performance; and environmental or personal factors impacting an individual's quality of self-care or domestic, education, work, community, social, or civic life

An annual checkup by a physical therapist, per a template developed by APTA,[4] includes collection of a subset of the data listed above that is most relevant to the topic being discussed. Collection of this data assists physical therapists in identifying individuals with social risk factors. It includes questions about ethnicity, race, occupation and employment status, education level (highest grade completed), adequate food, adequate housing, and access to health care.

The greatest burden of any data collection relates to the means by which the data is collected. Providers who do not have access to electronic health records (EHRs) face significant barriers. Moreover, when beneficiaries interact with multiple providers who lack interoperable EHRs, such providers, as well as beneficiaries, are placed at a significant disadvantage. In these instances, the beneficiaries are required to repeat the same or similar information for each

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[4] American Physical Therapy Association. Annual Checkup by a Physical Therapist. http://www.apta.org/AnnualCheckup/. Accessed November 14, 2018.

provider with no standardization and or system interoperability or integration. Additional barriers may include language, literacy, and cultural competence for beneficiaries with social risk factors.

Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?
Standardizing data elements for EHRs would help providers collect social risk data while also helping policymakers better understand the problems facing beneficiaries with social risk factors. APTA recommends that ASPE pursue standardizing the collection of social risk factors on a national basis. This would better allow providers and payers to understand and identify the beneficiaries who are most significantly impacted by these social risks. It also would allow quality measure developers to examine more closely the impact of these variables on patient outcomes in order to adjust risk appropriately. However, to use social risk factors as a risk adjuster for outcomes, there must first be a high degree of compliance with data collection.

Further, standardized data elements for EHRs would allow for more consistency in the comparison of individuals and populations, and would improve providers' ability to standardize care based on common risk factors. These elements could be standardized based on available evidence related to meaningful and predictive social risk factors. Moreover, by standardizing data collection, CMS would be better able to make sound decisions about cost-effective benefit design.

What are barriers to collecting data about social risk? How can these barriers be overcome?
Barriers include a lack of standardization and a lack of system interoperability. Private practices are particularly challenged by the financial outlay and information technology expertise required to adopt an interoperable medical record. Additional barriers include:

- Lack of ongoing shared access or interoperability to meaningful data
- Inflexible care delivery models that fail to support providers and patients in matching resources to identified needs
- Barriers to addressing the comprehensive needs of patients, including nonmedical health needs such as limits in payment
- Barriers to timely access to the most appropriate provider, including but not limited to prior authorization, a need for a referral, and visit limits

The barriers can be overcome by:

- Educating clinicians on the value (cost vs benefit) of and need (avoiding adverse outcomes) to address social risk factors
- Educating patients and caregivers on the availability of services, and the importance of self-advocacy and accessing available resources
- Expanding community resources through local, state, and national efforts

Collecting data about social risk also is difficult given the significant reliance on patients to self-report. Patients may not understand the importance of collecting this information and may believe that disclosing information about themselves will lead to discrimination. For this reason,

patient education is critical. Clinician and policymaker education also is important, as neither group is fully aware of how social risk factors influence patient outcomes. As a result, as previously stated, clinicians may fail to understand the importance of collecting data on social risk factors. While including standardized data elements in EHRs is a step in the right direction, it will not be the sole driver of data collection. It is critical that payers, working alongside clinicians and policymakers, better highlight the need for the collection of this data. Financial and administrative incentives also must be properly aligned for clinicians to collect and use this information in a meaningful way.

There also must be a better understanding of health disparities and bias in health care. Addressing bias must be a conscious decision, but to avoid making assumptions, providers should commit to screening for social determinants of health across their entire patient population.

What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?
APTA supports the National Prevention Strategy, which prioritizes prevention by integrating recommendations and actions across multiple settings to improve health and save lives. The strategy "envisions a prevention-oriented society where all sectors recognize the value of health for individuals, families, and society and work together to achieve better health for Americans."[5] To fully support Americans in leading longer and healthier lives, it is critical that collection of social risk factor data and utilization of such data is increased. To do so, we recommend that ASPE, in conjunction with other federal and state agencies, place a greater emphasis on the need to collect data on social risk factors and how to use the data to tailor practice and improve population health.

For example, to improve data collection and patient outcomes, we recommend that ASPE rely on specialty society registries to test the collection of this data. Additionally, ASPE should engage and work with EHR vendors to standardize how this information is collected. Additionally, ASPE should consider how the development of a standardized tool for data collection would ensure consistency across providers and settings. As the growth of value-based models continues, requiring social-risk data collection and sharing could be a condition of participation.

Within and outside of the health care system are other opportunities to address social risk factors. We are encouraged that as of 2017, 19 states require Medicaid managed care plans to screen for and/or provide referrals for social needs.[6] APTA recommends that ASPE work with CMS, Centers for Disease Control and Prevention, US Department of Housing and Urban Development, state Medicaid agencies and managed care organizations, commercial payers, health professional associations, and patient advocacy groups to build upon existing evidence to shape future strategies to fully address disparities in health.

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[5] Centers for Disease Control and Prevention Surgeon General National Prevention Strategy. https://www.surgeongeneral.gov/priorities/prevention/strategy/index.html. Accessed November 6, 2018.
[6] Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/. Accessed October 29, 2018.

Conclusion

APTA thanks ASPE for the opportunity to respond to the RFI on improving care for Medicare beneficiaries with social risk factors. Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

SLD: krg

Via Electronic Submission to ASPEImpactStudy@hhs.gov

November 16, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
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Washington, DC 20201

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

Dear Deputy Assistant Secretary Destro:

I am pleased to submit these comments on behalf of the American Society of Clinical Oncology (ASCO) in response to the recently proposed request for information (RFI) regarding the IMPACT ACT Research Study.

ASCO is the national organization representing nearly 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. ASCO members are also dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for the prevention, diagnosis, and treatment of cancer are available to all Americans, including Medicare beneficiaries.

In furtherance of ASCO's mission, the Society operates multiple quality assessment improvement initiatives and has taken concerted steps to address the needs of underserved populations. For example:

- ASCO's rapid learning system, CancerLinQ, is a "big data" solution to help practicing physicians distill massive volumes of data into meaningful information that supports the delivery of high-quality, high-value oncology care. This platform provides real-time feedback to oncologists on performance, allows point of care decision support, and provides rapid insight into patient outcomes. Through the Minimum Common Oncology Data Elements (M-CODE) project, ASCO is working to identify the core data elements necessary to populate an oncology EHR.

Making a world of difference in cancer care

- ASCO has invested substantial time and resources over the past 15 years in developing a Qualified Clinical Data Registry (QCDR) called the Quality Oncology Practice Initiative (QOPI). ASCO's QCDR includes 27 cancer-specific measures that have undergone an extremely robust, evidence-based process to ensure their clinical validity and reliability. As part of ASCO's criteria for measure development, the society assesses the degree to which its measures are meaningful and relevant to a wide range of patient populations.

- To ensure oncology practices caring for medically underserved patients can take advantage of, and benefit from, ASCO's growing quality improvement efforts, ASCO offers a grant program to teach practices serving underserved populations to improve their care delivery. A key goal of this program is to utilize QOPI and ASCO's Quality Training Program to coach teams through measurable and sustainable improvements in a clinical setting to improve the capacity and capability of participating practices to provide evidence-based, high-quality care. Another important goal is to understand better the quality improvement needs and challenges that may be unique to and/or exacerbated in low-resource settings, and to devise better strategies to address these needs. Additional information on this program description can be found [here](#).

- ASCO's work has also included evaluation, and analysis of the impact of new payment models, delivery systems and other policies in the Medicare and Medicaid programs and beyond. To that end, we have recommended ways that CMS could consider underserved populations in the Quality Payment Program (QPP). Collection of social risk factors could help in identifying the most appropriate measures to ensure clinical quality improvement through activities that are achievable for underserved populations, including in small practices and rural areas. For example, we recommended:

  o Within the (QPP), CMS create standards that are achievable and do not impose substantial burdens for participants practicing in small practices and rural areas. We also recommended that CMS not establish burdensome requirements for practices that treat underserved and minority populations, so that existing disparities in access and outcomes in oncology care would not be exacerbated. Many of the administrative burdens that are created by new regulatory actions impact the smaller or rural practices most.

  o CMS should seek to compare providers at the subspecialty level in a manner that promotes fairness to ensure that resource use is fairly compared among providers in the QPP. It is imperative that CMS make adjustments that account for the extreme variation that may exist in the cost of treating cancer compared to other diseases, as well as in treating different types and stages of cancer. Risk adjustment is especially crucial in oncology since there is significant variance in resource use among oncologists based on their subspecialties.

  o In addition to assuring appropriate comparisons across subspecialties, CMS should develop a mechanism to adjust for resource-constrained practices or practices that care for historically underserved populations.

In response to specific questions in the RFI regarding the collection and use of data by providers and health plans on Medicare beneficiaries' social risk factors, ASCO offers several points of consideration and input, provided herein.

Which social risk factors are most important to capture?

ASCO believes that race/ethnicity, gender identity, health literacy, family income level, travel distance to cancer centers and social support (marital support or caregiver support) should be captured. Measures of race, ethnicity, sexual orientation and gender identity should be self-reported, not based on observation. In the case of race and ethnicity, questions could address ancestry, and enclave effects. To assess neighborhood and structural effects on health, measures of the built (man-made) environment should be included, or patient address should be collected and geocoded, so that physical and other contextual effects, in addition to individual-level impacts, can be considered. Also, social networks/support, beyond marital/caregiver status including social companions is essential, as well as religious support/communities, psychosocial risk factors, addictive behavior, BMI/Weight/Diet/Physical Activity Food Insecurity are also important.

Do you routinely and systematically collect data about social risk?

Most ASCO members do not routinely and systematically collect data about social risk. Where practices do collect the data, the factors frequently vary and depend on disease-specific/clinical programs or cancer registry requirements. Area-level proxy census data may be good proxies for some social risk measures. However, they are imperfect and may represent a distinct phenomenon from measures collected at the individual level.

Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e., Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

Cancer registries are required to capture race/ethnicity which should be self-reported by patients. Medicare, however, does not collect this information unless it is provided directly by the providers themselves and when Medicare providers have the data it is invalid and incomplete. Providers have much variability in what they collect and what they report. There may also be inconsistencies due to patient fear and resistance to self-reporting. Additionally, many of the factors mentioned above are not collected in a standardized fashion. Some measures could be collected at a single point in time (e.g., educational attainment), but others, like social support and community resources, may change over time.

Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

Unless mandated, social risk data is not typically captured in EHRs. ASCO is concerned that mandated capture could result in additional burden for practices if it were not through standardization of data elements. This would require EHR vendors to standardize the fields captured in a structured field so that they can be abstracted. Currently, many of the fields like race and ethnicity are in unstructured data fields which would need to be manually abstracted. Standardization of data elements and fields would be a positive step toward interoperability. One strategy is identifying key social factors that could be collected once at Medicare enrollment (e.g., educational attainment, nativity), reasonable area-level proxies from

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census data (e.g., median income, urban/rural status), and those that might be most important to collect at multiple times (e.g., social support).
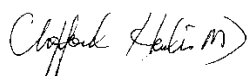
The impact of ASCO's initiatives could be significantly enhanced with the availability of data on social risk factors for the Medicare population. Because many social risk factors affect health care use and adherence to treatment, a related question is: what are the burdens of not having social risk information for plans and providers?

In 2017 ASCO issued a position statement in collaboration with the American Association of Cancer Research (AACR), American Cancer Society (ACS), and the National Cancer Institute (NCI) to foster cooperation across the cancer research community to ensure that all patients — regardless of social demographics, socioeconomic status, or the communities in which they live — benefit from cancer research. The joint statement noted patient data are often incomplete, inaccurate, or overly-simplified and usually do not consider many social and community factors. As a result, cancer disparities research is limited by a lack of comprehensive, consistent data on factors that impact disparities in cancer care and patient outcomes, including a patient's social status and demographics, community and lifestyle factors, and biology and genetics, as well as by widespread variation in data collection methodology.

To address these issues, the 2017 statement called for improved steps to define and improve data measures and tools for cancer disparities research, noting that patient data are often incomplete, inaccurate, or overly-simplified and usually do not consider many social and community factors. In addition to calling for the collection of specific data elements referenced above, the statement recommended providers, patients, and the public should be educated regarding the rationale for and importance of collecting sociodemographic data, some of which may be perceived as potentially sensitive questions (e.g., sexual orientation and gender identity). Standard guidelines to facilitate collection and to mitigate patient or participant concerns should be offered. As well, we recommended that the cancer health disparity community establish reporting standards for measurement variables, similar to CONSORT and PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines, for journal editors and peer reviewers to facilitate and standardize assessment of the quality of the data collection method when evaluating health disparity research findings for publication.

Thank you for the opportunity to provide input on this RFI. We look forward to the opportunity to work with the Agency as you continue to identify ways to deliver high-quality care to high-risk patients and those living in underserved communities. Please contact Sybil Green at Sybil.Green@asco.org or 571-483-1620 with any questions.

Sincerely,

Clifford A. Hudis, MD, FACP, FASCO

ASCO Chief Executive Officer

November 16, 2018

Brenda Destro, PhD
Deputy Assistant Secretary
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 415-F
200 Independence Ave. SW
Washington, DC 20201

Request for Information: IMPACT Act Research Study—provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

Dear Deputy Assistant Secretary Destro:

Thank you for the opportunity to submit comments on the above-captioned request for information. America's Essential Hospitals appreciates the commitment of the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) to continue its work to evaluate the impact of social risk factors on quality measures and measures of resource use under the Medicare program. This important work will help identify the needs of our nation's vulnerable and determine how to best support the efforts of essential hospitals, which care for a disproportionate share of patients with social risk factors.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care to all. While our members represent just 6 percent of hospitals nationally, they provide 20 percent of all charity care nationwide, or about $3.5 billion, and 14.4 percent of all uncompensated care, or about $5.5 billion.[1] The high cost of providing care to low-income and uninsured patients leaves essential hospitals with limited financial resources. Even with their limited means, our more than 320 member hospitals demonstrate an ongoing commitment to serving vulnerable patients. Essential hospitals provide specialized services that their communities otherwise would lack (e.g., trauma centers, emergency psychiatric facilities, burn care); expand access with extensive networks of on-campus and community-based clinics; furnish culturally and linguistically appropriate care; train health care professionals; supplement social support services; and offer public health programs.

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[1] Clark D, Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2016 Annual Member Characteristics Survey. America's Essential Hospitals. June 2018. www.essentialdata.info/. Accessed October 30, 2018.

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Essential hospitals continually are called to meet the complex clinical and social needs of the patients that come through their doors. Our members provide comprehensive ambulatory care through networks of hospital-based clinics that include onsite features—radiology, laboratory, and pharmacy services, for example—not typically offered by freestanding physician offices. Their ambulatory networks also offer behavioral health services, interpreters, and patient advocates who can access support programs for patients with complex needs.

As providers of care to vulnerable populations, essential hospitals are uniquely positioned to tackle complex clinical and social needs. Our members are engrained in their community as a trusted and central resource for care. They work tirelessly to have a profound impact on equitable and efficient care delivery. To support ASPE's efforts to address social risk factors in the Medicare program, we offer the following comments and examples of relevant work at essential hospitals.

Essential Hospitals' Mission to Serve the Vulnerable

As required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, ASPE in December 2016 released the first of two reports that clearly connected social risk factors and health care outcomes.[2] The report provides evidence-based confirmation of what essential hospitals and other providers have long known: patients' sociodemographic and other social risk factors matter greatly when assessing the quality of health care providers. Further, as noted by the National Academies of Sciences, Engineering, and Medicine, in its series of reports on accounting for social risk factors in Medicare programs, "achieving good outcomes (or improving outcomes over time) may be more difficult for providers caring for patients with social risk factors precisely because the influence of some social risk factors on health care outcomes is beyond provider control."[3]

Essential hospitals' commitment to caring for all people, including the vulnerable, has made them providers of choice for patients of virtually every ethnicity and language. Racial and ethnic minorities made up 68 percent of member discharges in 2016.[4] Further, in 2016, three-quarters of essential hospitals' patients were uninsured or covered by Medicaid or Medicare. Our members reach outside their walls and into the community, expanding access to care where otherwise none would exist. However, proposals to reduce Medicaid funding and policy changes in the private insurance market threaten to swell the ranks of the uninsured and erode support for essential

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[2] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Washington, D.C.; December 2016. https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf. Accessed November 2017.
[3] National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment*. Washington, D.C.: The National Academies Press; January 2017. http://nationalacademies.org/hmd/Reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx. Accessed November 14, 2018.
[4] Clark D, Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2016 Annual Member Characteristics Survey. America's Essential Hospitals. June 2018. www.essentialdata.info/. Accessed October 30, 2018.

hospitals, putting this access at risk.

Identifying Patients with Social Risk Factors

Recognizing the effect of upstream factors outside a hospital's control, essential hospitals increasingly work to mitigate social determinants of poor health in various ways. In most cases, the first step is to identify the needs of the patient population. Many essential hospitals screen patients for food insecurity, housing instability, and other social determinants of health and refer these patients to community resources to help meet their social needs.

SOCIAL NEEDS SCREENING

Many essential hospitals screen patients for social needs or are in some stage of working to develop and implement a screening process. Some hospitals focus on a specific social need across the patient population; for example, an essential hospital in Illinois employs a validated two-question screening tool to identify food insecurity during patient intake. When a patient screens positive, the hospital offers them vouchers for fresh produce and referrals to the Supplemental Nutrition Assistance Program; Women, Infants and Children program; and other benefits, as appropriate. Other hospitals screen patients more comprehensively—e.g., several hospitals conduct social needs screening for all patients seen at designated clinic sites. Finally, some essential hospitals focus on screening for social needs within a program that serves a specific subpopulation. For example, several essentials hospitals incorporate a social needs screening component when implementing interventions specific to patients admitted to the hospital after sustaining a violent injury. Given the common co-occurrence of—and strong interrelationship between—social determinants of health, patients who are victims of interpersonal violence often face one or more social needs. Screening for and mitigating those needs helps prevent violent reinjury and generally improve health.

The social needs screening and referral process comprises several core components: the screening tool, an inventory of referral resources, a follow-up mechanism to assess whether a referral was completed, an evaluation of impact, and adequate staffing and processes to complete all the above. Essential hospitals employ a variety of tools and approaches for this resource-intensive endeavor.

Several essential hospitals use existing social needs screening tools to assess patients' needs. For example, several of our members use a sophisticated resource linkage software that enables staff to screen patients for social needs; link patients to appropriate resources and agencies; track follow-up; and measure impact.[5] Other hospitals adapt existing tools or devise their own, new innovations. An essential hospital in New York recently completed a process whereby a work group of various stakeholders developed a social determinants screening tool and accompanying list of referrals to local resources.

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[5] *Essential Communities.* America's Essential Hospitals. https://essentialcommunities.org/. Accessed October 31, 2018.

Some essential hospitals incorporate social needs screening and referral into other patient care interactions, while others employ dedicated staff—or execute agreements with nonprofit partners—to conduct screenings. It is critical that hospitals create and maintain structures and relationships to facilitate referral to the appropriate services that meet the identified needs. In Massachusetts, one essential hospital created a data sharing mechanism whereby the hospital and community organizations alike can update and share information to better track follow-up for patient referrals. **We urge ASPE to examine the use of various screening tools to identify the needs of vulnerable populations.**

LANGUAGE PREFERENCE

Members of America's Essential Hospitals work daily to improve care quality through a broad variety of initiatives, including programs to break down language barriers and engage patients and families to improve the care experience. For example, individuals with limited English proficiency (LEP) require appropriate language assistance or auxiliary aids and services to fully take part in their care plan. People with LEP account for about 8 percent of the U.S. population overall—they represent more than 20 percent of the uninsured population and 12 percent of the Medicaid population.[6] Language barriers jeopardize the health of many LEP individuals by reducing access to care and hindering communication with providers. A patient's ability to read, understand, and ultimately act on discharge instructions has a direct impact on patient safety and the likelihood of readmission.

America's Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. By involving the patient as an active participant in their care, hospitals can better assist patients in identifying care choices, as well as clinical and social needs that might improve health outcomes. America's Essential Hospitals partners with other industry leaders in the National Call to Action to Eliminate Health Care Disparities, which promotes the culturally appropriate collection of patient race, ethnicity, and language (REL) information. **We encourage ASPE to examine the ways in which hospitals collect REL data to identify preferences and needs and to tailor a care plan to specific patient characteristics.**

DISCHARGE PLANNING

Members of America's Essential Hospitals understand the importance of non–health care social services in achieving effective care transitions and improved outcomes, including reduced readmissions. For example, some of our members participate in Project ACHIEVE, which studies care transitions among Medicare beneficiaries and those dually eligible for Medicare and Medicaid. This work is supported by a Patient-Centered Outcomes Research Institute grant to Essential Hospitals Institute, the association's research and quality arm. Through such efforts, members of America's

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[6] Gonzales G. State Estimates of Limited English Proficiency (LEP) by Health Insurance Status. Robert Wood Johnson Foundation State Health Access Data Assistance Center. 2014;40. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414189. Accessed November 14, 2018.

Essential Hospitals promote a patient-centered and whole-person approach to care, despite the significant cost of using integrated care models.

Filling a safety-net role in their communities, essential hospitals use their scarce resources efficiently to provide cutting-edge care to all, regardless of income or insurance status. An essential hospital in Missouri developed a care transitions program that reduced hospital admissions, emergency department (ED) visits, and costs. This hospital identified the need for a multidisciplinary team, bringing together licensed clinical social workers, client-community liaisons, and advanced-practice registered nurses, among other staff, to address both the clinical and social issues affecting their patient population.

The patients treated at essential hospitals often are disadvantaged and require extensive time and resources to ensure that the discharge planning process is tailored to their clinical and social needs. During discharge planning, essential hospitals must consider factors outside the control of the hospital—homelessness, cultural and linguistic barriers, and low literacy, for example. Our members understand the careful attention required to capture and respond to patient care goals and treatment preferences, while considering of the availability of posthospital services. **We encourage ASPE to examine ways to accurately capture the needs of a patient—including the role discharge planning might play in identifying those needs—without adding administrative burden to patients and providers.**

Addressing the Needs of Beneficiaries with Social Risk Factors

Essential hospitals' work to mitigate social risk factors generally falls into two categories: direct responses to the social needs of the individual patients they serve (e.g., referral to needed services); and efforts to ameliorate the social conditions in the community at-large (e.g., improving infrastructure). The latter represents community-integrated health care, where efforts to influence social determinants are made in partnership with other sectors beyond health care. For many hospitals, these activities are complementary, not mutually exclusive, to efforts that address direct patient needs. The following examples are not an exhaustive list; they highlight a subset of the social risk factors addressed by essential hospitals and the approaches taken to mitigate such factors. Our Essential Communities website presents further case studies of essential hospital programs on a wide variety of social determinants of health.[7]

FOOD INSECURITY
Food insecurity is defined as lacking reliable access to a sufficient quantity of affordable, nutritious food. Food insecurity disproportionately affects vulnerable populations and is driven by social, economic, and environmental factors. Neighborhoods with high rates of poverty often are "food deserts"—areas without fresh fruit, vegetables, and other healthful whole foods, generally because there are no grocery stores, farmers' markets,

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[7] *Essential Communities.* America's Essential Hospitals. https://essentialcommunities.org/. Accessed October 31, 2018.

or other such vendors available. Within communities served by essential hospitals, more than 10 million individuals have limited access to healthy food.[8]

Inadequate access to nutritious foods has well-documented connections to both physical and mental health outcomes. Although it often manifests as hunger, food insecurity conversely can result in obesity when individuals who lack access to nutritious food opt instead to consume cheaper, easily accessible, high-caloric foods with low nutritional value. Poor health and food insecurity often exacerbate each other, perpetuating a cycle of chronic illness that contributes to high health care costs and utilization.[9]

Essential hospitals are acutely aware of the effect of food insecurity on the patients and communities they serve and have taken steps to confront this social determinant of health, including healthy food distribution onsite or through mobile units and healthy shopping and cooking demonstrations paired with food assistance. For example, essential hospitals in Massachusetts and Minnesota engage in partnerships with local food banks to offer a food pantry or distribute grocery bags onsite to patients experiencing food insecurity. Other essential hospitals operate community gardens that generate produce in neighborhoods near the hospital designated as food deserts. **We urge ASPE to examine the link between food insecurity and poor health outcomes, as well as the resources needed to provide access to healthy food within a community.**

HOUSING INSTABILITY

Issues associated with housing have profound impact on health. The most dramatic of these is homelessness, but housing instability also includes difficulty paying rent, spending more than 50 percent of household income on housing, frequently moving, living in overcrowded conditions, or staying with friends and relatives.[10] As with food insecurity, housing instability and poor health can create a vicious cycle. Homelessness and unstable housing produce significant stress and make it difficult to adhere to medications, healthy eating, and proper hygiene.

Communities served by essential hospitals include more than 350,000 homeless individuals.[11] These individuals are more likely to use the ED and be admitted to the hospital for conditions that would have been amenable to primary care.[12] Several

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[8] Clark D, Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2016 Annual Member Characteristics Survey. America's Essential Hospitals. June 2018. www.essentialdata.info/. Accessed October 30, 2018.

[9] Susman K. Food Insecurity, Health Equity, and Essential Hospitals. June 2016. https://essentialhospitals.org/wp-content/uploads/2016/06/Food-Insecurity-Health-Equity-Essential-Hospitals.pdf. Accessed October 31, 2018.

[10] *Essential Communities.* America's Essential Hospitals. https://essentialcommunities.org/. Accessed October 31, 2018.

[11] Clark D, Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2016 Annual Member Characteristics Survey. America's Essential Hospitals. June 2018. www.essentialdata.info/. Accessed October 30, 2018.

[12] Schrag J. Health Care for the Homeless: Essential Hospitals and Community Partnerships. June 2015. http://essentialhospitals.org/wp-content/uploads/2015/07/Homelessness-Quality-Brief-June-2015.pdf. Accessed October 31, 2018.

essential hospitals work to overcome this social risk factor by offering temporary housing or long-term rental assistance, developing new affordable housing capacity, and other approaches. For example, an essential hospital in Maryland developed and operates hundreds of affordable housing units in the neighborhood surrounding the hospital, partnering with local organizations to build the housing facilities and coordinate related services for residents. In Illinois and Vermont, essential hospitals provide temporary housing and case management to meet the needs of homeless patients. **We urge ASPE to examine approaches that mitigate the financial and social circumstances that contribute to housing instability, including direct assistance and wraparound support.**

TRANSPORTATION

Lack of access to affordable and reliable transportation affects access to health care and exacerbates other social determinants of health. These transportation barriers are financial and logistical: not having a car or the financial means to take a cab or rideshare, and/or living in an area without accessible, reliable, or efficient public transportation. These barriers prevent people from accessing the health care they need and result in high rates of missed appointments that strain health care operations. Transportation issues also are implicated in other social needs; for example, lack of transportation can trap low-income individuals within the food deserts where they live, perpetuating food insecurity.

As with other social determinants of health, improving access to transportation can improve health outcomes, both related to and independent of health care itself. A few essential hospitals, including one in Illinois, have partnerships with a rideshare company to help patients without access to affordable transportation get to their medical appointments. Further, in Ohio, an essential hospital invested in the municipal transportation system to help add a bus line that services the hospital's main campus, improving access to the hospital and the surrounding neighborhood. In these examples, the underlying goal is to support patients' needs—whether directly or indirectly. **We urge ASPE to examine the impact of transportation on access to care and other critical services, as well as health outcomes.**

TELEHEALTH

Essential hospitals are transforming health care delivery through telehealth. Our members are dedicated to caring for the vulnerable, and telehealth allows them to more broadly meet this commitment for people who otherwise would lack access to high-quality health care. Telehealth allows many essential hospitals, particularly academic medical centers, to reach populations across an entire state or region.

Further, cutting-edge connected care services, such as remote patient monitoring or mobile health applications, have been used to respond to a variety of health challenges, including diabetes management and opioid dependency. Using telehealth, patients can take preventive steps and avoid hospital stays, reducing costs and improving outcomes. For example, an essential hospital in Mississippi partnered with a mobile broadband provider to remotely monitor diabetes patients in rural Mississippi via tablet computers.

Results of this pilot program included a marked decrease in blood glucose levels, early recognition of diabetes-related eye disease, and no diabetes-related hospitalizations or emergency room visits among the patients in the pilot.[13] In terms of cost savings, the pilot program resulted in nearly $700,000 in annual savings due to reductions in hospital readmissions alone. The potential of telehealth to improve access and lower costs of care is significant. **We urge ASPE to examine the role of telehealth to address social risk factors and assist in disease management among vulnerable populations, and existing barriers to its use.**

BEHAVIORAL HEALTH

America's Essential Hospitals recognizes the complexity and importance of addressing behavioral health issues, particularly as they relate to improving care for our nation's vulnerable patients. Patients suffering from behavioral health issues often seek treatment and episodic care from local EDs, contributing to rising health care costs, higher readmission rates, and fragmented care. Vulnerable patients and underserved populations often are most affected by this sporadic treatment model, as they have limited access to continuous behavioral health services for long-term management of their condition. Essential hospitals work to meet the behavioral and mental health needs of their patients by expanding behavioral health services within community health centers, as well as offering "curbside consultations" through which primary care providers can obtain an informal consultation from a psychiatrist. The goal is to train primary care providers to provide moderate psychiatric interventions themselves.

Additionally, as key stakeholders in combating the opioid crisis, essential hospitals stand ready to implement practices proved effective in reducing opioid dependence and to adopt new care models to respond to this public health emergency. For instance, an essential hospital in Oregon worked with several partners—including community organizations and a Medicaid accountable care organization—to conduct a needs assessment and subsequent response to substance use disorder in its area. The hospital and its partners then created a care model for medically complex patients experiencing substance use disorder; the model employs a consultation service, direct access to post-hospital treatment, and a medically supported residential care program.[14] **We urge ASPE to examine the behavioral health needs of patients and the influence access to care can have for at-risk individuals.**

MEDICAL-LEGAL PARTNERSHIPS

Many patients cannot meet key social needs because of issues within the legal sphere, including housing discrimination, accessing insurance and other public benefits to which they are eligible, and obtaining income via channels such as child support. Many essential hospitals have implemented Medical-Legal Partnerships—a collaborative

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[13] Promoting Telehealth for Low-Income Consumers—Notice of Inquiry. Federal Communications Commission. August 3, 2018. https://docs.fcc.gov/public/attachments/FCC-18-112A1.pdf. Accessed October 31, 2018.
[14] Susman K. The Opioid Crisis: Hospital Prevention and Response. America's Essential Hospitals. June 2017. https://essentialhospitals.org/wp-content/uploads/2017/06/Opioid-Brief-1.pdf. Accessed October 31, 2018.

arrangement that embeds legal professionals in the health care environment to screen for and consult on legal matters that could mitigate social needs for some patients.

For example, an essential hospital in New York has a working partnership with LegalHealth, a division of the New York Legal Assistance Group, to staff attorneys in designated clinics across multiple hospital sites. The attorneys work closely with the care team, especially social workers, and are available for consultation or warm hand-offs when legal needs arise. **We urge ASPE to examine the potential of medical-legal partnership to reduce the burden on physicians to address patients' complex, nonmedical needs, while increasing internal capacity to form vital connections to legal and other social service resources.**

Capturing Social Risk Factors

Data is a key driver in health care delivery, as it informs providers of patient needs while engaging patients in their own care. Social needs data must be captured appropriately, with standards for adding in and extracting from electronic health records (EHRs). The collection and reporting of social risk factor data requires accuracy and validity to ensure appropriate use in Medicare programs. To mitigate social risk factors, data is needed on patients' sociodemographic characteristics, including socioeconomic status; self-reported race, ethnicity, and preferred language; and housing and social support structures. All health care professionals and others working in the delivery system must be trained on collecting accurate socioeconomic and sociodemographic data, and on how to educate patients about data collection. **We urge ASPE to fully examine the resources required to collect and report on data about social risk and associated burden to hospitals.**

To the extent that providers collect such data, it is important to establish validation standards for collection methods and the data itself. For example, in the context of quality measurement, policymakers often seek guidance from organizations with measurement expertise, such as the National Quality Forum (NQF) and its Measures Application Partnership (MAP)—a partnership of various stakeholders that guides HHS' selection of performance measures for federal health programs. NQF endorsement and MAP approval are imperative to ensure measure validity and reliability. Through these processes, HHS, the public, and other stakeholders can fully vet and approve measures through a consensus-building approach. **We urge ASPE to consult consensus-building entities for their expertise when determining which social factors are most important to capture and how to do so in a standardized way.**

Providers have not yet fully realized the potential of EHRs. While there are multiple private- and public-sector initiatives to improve the interoperability landscape, there is much work to be done to allow providers to easily exchange information. Further, providers serving vulnerable populations face tangible barriers in EHR adoption and use due to financial constraints, infrastructure challenges, or reasons outside their control (e.g., vendor issues or unique patient populations). **We ask APSE to consider the barriers that exist in EHR adoption and use, as well as how these barriers might affect providers' ability to capture social risk data.**

Certification criteria are tailored to enable new capabilities in EHR products, such as the use of application programming interfaces and the electronic exchange of information. However, the health care field overall has not reached a point in which CMS can reasonably expect providers to seamlessly share information, particularly between hospitals and community providers. As previously noted, approaches to meet the social needs of a patient population often rely not only on the hospital, but also its community partners. **We urge ASPE to examine the challenges that exist in linking data from medical and nonmedical sources**, as well as how to capture such data in a way that is actionable and informative to a broad group of stakeholders.

The Government Accountability Office has highlighted the many remaining challenges to attaining a truly interoperable nationwide health information technology infrastructure.[15] Further, the Office of the National Coordinator for Health Information Technology (ONC) has conducted important work to promote new technology for providers and encourage increased interoperability. As directed in the 21st Century Cures Act, ONC in January 2018 released the Trusted Exchange Framework and Common Agreement, which outlines a set of principles for trusted information exchange to enable interoperability.[16] Improved interoperability is critical in enabling providers to use certified EHR technology to seamlessly exchange health information with patients and other providers.

Challenges and Barriers
The populations receiving care at essential hospitals require resource intensive, evidence-based quality improvement strategies that extend beyond the hospital walls and into communities. The challenge for our members is compounded by the need to determine whether a patient or caregiver can access or provide necessary, post-discharge care and to identify the availability of nonhealth, community-based services, such as meal services, housing for homeless patients, transportation, and language assistance. Providers need resources to address social determinants of health within the context of evolving payment and delivery models and continuous reimbursement cuts. We urge ASPE to examine the barriers that impede essential hospitals—the very institutions whose mission is to reduce disparities and provide quality care for all—from meeting the needs of their complex patient population.

RESOURCES
Essential hospitals strive for quality and performance improvement each day, in innovative ways and with limited means. Essential hospitals are innovative, partnering with community organizations to leverage existing resources, such as food banks, to better meet social needs. However, resources are scarce—particularly for more costly needs, such as housing—and the services patients need most are not reimbursable. For example, an essential hospital in Texas partnered with a Medicaid plan, the local

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[15] U.S. Government Accountability Office. Nonfederal Efforts to Help Achieve Health Information Interoperability. GAO-15-817. September 2015. http://www.gao.gov/assets/680/672585.pdf. Accessed October 31, 2018.
[16] Office of the National Coordinator for Health Information Technology. Draft Trusted Exchange Framework. January 2018. https://www.healthit.gov/sites/default/files/draft-trusted-exchange-framework.pdf. Accessed September 20, 2018.

homeless services coalition, and the Salvation Army to provide 50 permanent housing units, along with supportive case management, for homeless patients in the community. Like other such initiatives that alleviate pressing social needs, this program reduced avoidable health care utilization—health care costs fell by $1 million over 18 months. While the case management component of the program is eligible for Medicaid reimbursement, the rental assistance relies on other funding. It is critical that value-based financing provides the flexibility to meet social needs and reduce avoidable health care utilization without limiting the capacity of essential hospitals to serve patients in need.

Resources are required to both screen for and address social needs. Hospital staff must undergo training and dedicate time to performing the screenings, IT systems might require updates to incorporate new screening tools and referral systems, and hospitals must build and maintain referral relationships with an array of local organizations. Infrastructure, staff time, and community engagement require resources that are especially scarce for essential hospitals that serve the vulnerable populations most in need of this assistance. Incentives across the health care delivery and payment system need to be aligned to promote equity of care and eliminate disparities. **We urge ASPE to examine the upfront costs of developing infrastructure to address social determinants of health, as well as the existing resource challenges of essential hospitals, which operate with margins less than half that of other hospitals.**

RISK ADJUSTMENT IN MEDICARE PAYMENT PROGRAMS

We are pleased that CMS finalized the provisions of the 21st Century Cures Act related to risk adjustment in the Hospital Readmission Reduction Program (HRRP) rulemaking process.[17] Specifically, section 15002 directs the HHS secretary to "assign hospitals to groups ... and apply the applicable provisions of this subsection using a methodology that allows for separate comparison of hospitals within each such group" for the HRRP.[18] The legislation further specifies that groups are "based on their overall proportion, of the inpatients who are entitled to, or enrolled for, benefits under Part A, and who are full-benefit dual eligibles." But this is only the first step toward true risk adjustment for hospitals treating patients with social and economic challenges. The agency must go a step further and adjust measures so that quality comparisons are accurate and fair.

Outcomes measures, especially those focused on readmissions, do not accurately reflect quality of care if they do not account for social risk factors that can complicate outcomes. A large and growing body of evidence shows that sociodemographic factors—age, race, ethnicity, and language, for example—and socioeconomic status, including income and education, can influence health outcomes.[19] These factors can skew results on certain quality measures, such as those for readmissions. For example, it is well known that patients who lack reliable support systems after discharge are more likely to

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[17] 21st Century Cures Act, P.L. 114-255 (H.R. 34, section 15002), 114th Cong. (2016).
[18] Ibid.
[19] America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. April 18, 2016. http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/. Accessed October 30, 2018.

be readmitted to a hospital or other institutional setting. These readmissions result from factors beyond the control of providers and health systems and do not reflect the quality of care.[20]

Identifying which social risk factors might drive outcomes and how best to measure and incorporate those factors into payment systems is a complex task, but doing so is necessary to ensure better outcomes, healthier populations, lower costs, and transparency. Quality measurement must account for the socioeconomic and sociodemographic complexities of vulnerable populations to ensure hospitals are assessed on their work, rather than on the patients they serve. Ignoring these factors will skew quality scores against hospitals that provide essential care to the most complex patients, including those with sociodemographic challenges and the uninsured. Risk adjusting measures for these factors also will ensure that patients receive accurate information about a hospital's performance.

We urge ASPE to keep in mind that the use of quality measures in Medicare programs without appropriate risk adjustment creates an uneven playing field. The failure to risk adjust could cause hospitals treating a large proportion of complex patients to face penalties at an increased rate, further diminishing resources at hospitals that often operate at a loss.[21] **America's Essential Hospitals strongly supports the inclusion of factors related to a patient's background—including sociodemographic status, language, and postdischarge support structure—in measure development and risk-adjustment methodology.**

ALTERNATIVE PAYMENT MODELS

Under value-based payment models, hospitals no longer are expected simply to treat a diagnosis and episode, but to take responsibility for the overall health and outcomes of their patients. As a result, essential hospitals seek to support patients' broader health and social needs to improve outcomes and efficiency. Our members have developed innovative care delivery models and participate in a variety of initiatives at the federal, state, and local levels. They are well-situated to do so because of the comprehensive, integrated nature of their delivery systems, their strong primary care base, their staffing models, and their historic need to provide high-quality care on a shoestring budget.

Essential hospitals often serve as anchors within their communities, with deep ties to the residents; this leads to a clear understanding of the nonclinical influences on patients and population health. However, significant challenges exist in developing partnerships, building needed infrastructure, engaging patients, measuring progress, and creating sustainable funding models. Additionally, quality metrics, used in Medicare payment models to evaluate performance and determine shared savings or incentive payments, do not yet incorporate social risk factors. In designing new

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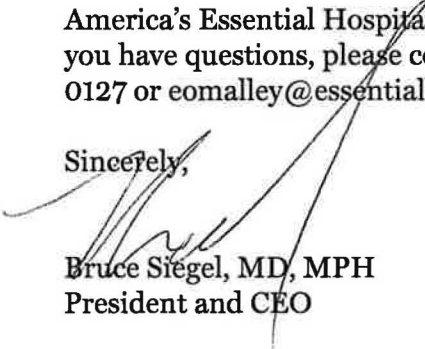
[20] See, e.g., National Quality Forum Technical Report. Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. August 2014. http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx. Accessed October 30, 2018.

[21] Reiter KL, Jiang HJ, Wang J. Facing the Recession: How Did Safety-Net Hospitals Fare Financially Compared with Their Peers? *Health Services Research.* 2014;49(6):1747–1766.

payment systems, policymakers should give special recognition and financial support to providers who disproportionately deliver care to disadvantaged populations with health and health care disparities. **We urge ASPE to examine the barriers for essential hospitals to participate fully in alternative payment models and the influence of social risk factors in participant performance in these models.**

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

AHIP

November 16, 2018

Nancy DeLew
Associate Deputy Assistant Secretary
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Submitted via email to ASPEImpactStudy@hhs.gov

**RE: ASPE Request for Information (RFI) -- IMPACT ACT Research Study: Provider and
health plan approaches to improve care for Medicare beneficiaries with social risk factors**

Dear Ms. DeLew:

America's Health Insurance Plans (AHIP) appreciates the opportunity to submit comments to the
Assistant Secretary for Planning and Evaluation (ASPE) in response to its RFI on provider and
health plan approaches to improve care for Medicare beneficiaries with social risk factors.

AHIP is the national association whose members provide coverage for health care and related
services. Our members offer coverage across the entire spectrum of private-sector and public
programs. We are committed to market-based solutions and believe that every American
deserves affordable coverage that provides them with access to high quality care.

We commend ASPE for seeking public input to inform the study required by the Improving
Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) on issues related to
socioeconomic status (SES) in Medicare's value-based payment programs. AHIP also greatly
appreciates ASPE's recent release of several research reports on the types of services that
Medicare Advantage (MA) plans implement to meet the needs of dually enrolled and other high-
cost, high-need beneficiaries, as well as the types of resources needed to implement these
services.[1]

These research reports demonstrate the commitment of MA plans to help meet the needs of these
enrollees, many of whom have social risk factors. Based on interviews with member plans and
an environmental scan of existing literature, the reports highlight plan activities that include
using data analytics to better target programs toward patients at high risk for hospitalization,

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[1] "Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans:
Findings from Interviews and Case Studies," "Types and Costs of Services for Dual Beneficiaries by Medicare
Advantage Health Plans: An Environmental Scan"

readmission, and nursing home admission; addressing clinical needs through care management and coordination; referring members to programs that address housing, food security, and transportation needs or providing these services directly; and undertaking administrative actions to better integrate Medicare and Medicaid.[2]

AHIP has also authored several issue briefs about the activities and strategies employed by commercial plans (including MA plans) to address social needs. For example, a September 2018 issue brief on housing[3] highlights AHIP member plan activities that include investing in non-profit homelessness organizations, providing short-term housing to certain groups of members, and working with community groups to create and connect members to long-term housing. A July 2018 issue brief[4] describes AHIP member plans' innovative solutions to food insecurity, such as food delivery or transportation to the grocery store for members, and partnering with local food banks. The issue brief also describes how plans are helping beneficiaries who cannot access care by investing in telehealth and using ridesharing services.[5]

Addressing social determinants of health requires multifaceted interventions that target multiple mechanisms simultaneously. Doing so requires a detailed understanding of the unique needs of the populations in a given community, as well as its available resources, to ensure that the right programs are targeted to the right people in the right way. Those designing and implementing programs to improve community health and economic prosperity cannot do it alone; they require resources and community buy-in to achieve the best results. Language barriers, educational gaps, health literacy, mistrust of the health care system, and potential misunderstanding of cultural practices may undermine the success of already difficult initiatives. Designing a program to work on multiple levels with multiple populations concurrently, using evidence-based practices from a comparable sample, can be very challenging.

We expect AHIP member plans will respond to the RFI with further information about challenges as well as opportunities including the array of services they are providing. Further, health insurance providers will continue to develop and test innovative ideas in the future. In this regard, we note that recent regulatory and legislative changes will allow MA plans more flexibility to offer items and services that may help address certain social risk factors for enrollees.

Yet despite these MA plan efforts, as noted in ASPE's Study A[6], achieving high Star Ratings is still very challenging for plans with large dually-eligible populations. The failure of the Star Ratings System to adequately account for social risk factors can jeopardize access to critical services, such as enhanced care coordination, disease management programs, and supplemental benefits (including social services).

We continue to support the use of the Categorical Adjustment Index (CAI) in the Star Ratings System as an interim step while CMS develops a more impactful long-term solution. ASPE's

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[2] "Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies"
[3] https://www.ahip.org/safe-affordable-housing-social-determinants-of-health/
[4] https://www.ahip.org/healthy-food-transportation-to-the-doctor-are-new-frontiers-for-health-insurance-providers/
[5] https://www.ahip.org/healthy-food-transportation-to-the-doctor-are-new-frontiers-for-health-insurance-providers/
[6] https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf

research and findings will be critical in developing a permanent approach that addresses these challenges while continuing to reward organizations currently performing well on the Star Ratings System. Further, as ASPE notes in its research study, "Incorporating Social Determinants of Health in Electronic Health Records: A Qualitative Study of Perspectives on Current Practices among Top Vendors,"[7] data standardization and interoperability are also needed to facilitate the collection and use of social determinants of health data to aid health plans and providers to pursue a more targeted approach to address health care and related needs of beneficiaries. We also urge CMS to continue its policy of not terminating contracts based on Star Ratings performance. Such policy should remain in place until ASPE's analyses are completed and appropriate improvements are made to the Star Ratings methodology. Beneficiaries should not lose access to plans that are serving them well but whose performance may not accurately be reflected in the Star Ratings System.

We appreciate the opportunity to comment. Please contact me if additional information would be helpful or if you have questions about the issues raised in this letter. I can be reached at (202) 778-3256 or mhamelburg@ahip.org.

Sincerely,

Mark Hamelburg,
Senior Vice President, Federal Programs

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[7] https://aspe.hhs.gov/pdf-report/incorporating-social-determinants-health-electronic-health-records-qualitative-study-perspectives-current-practices-among-top-vendors

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Submitted via email to ASPEImpactStudy@hhs.gov

November 16, 2018

Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Office of the Assistant Secretary for Planning and Evaluation:

Anthem, Inc. (Anthem) appreciates the opportunity to respond to the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) Request for Information (RFI) on the "IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors."

Anthem is working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. With over 74 million people served by its affiliated companies, including nearly 40 million within its family of health plans, and 1.7 million Medicare consumers, Anthem is one of the nation's leading health benefits companies. For more information about Anthem's family of companies, please visit www.antheminc.com/companies.

Executive Summary and Overarching Comments

Anthem shares ASPE's commitment to identifying and implementing effective approaches to care for Medicare beneficiaries with social risk factors. As a committed participant in the Medicare Advantage (MA), Part D, and Medicaid programs, Anthem is working every day to improve health outcomes for beneficiaries by addressing Social Determinants of Health (SDoH). It is increasingly important that today's health programs are able to effectively account for social risk in order to not only close persistent gaps in health outcomes, but ensure accurate and meaningful quality measurement. As ASPE continues its work to assess the effect of Socioeconomic Status (SES) on quality measures and measures of resource use in Medicare, Anthem urges ASPE and the Centers for Medicare & Medicaid Services (CMS) to:

- *Develop and Implement a Long-Term Solution for the Impact of Socioeconomic Status (SES) on the MA and Part D Star Ratings Program*

  Beneficiary-level characteristics, specifically dual status and socio-economic factors, have a meaningful impact on Star Ratings and it is critical to enable plans that care for these beneficiaries to compete on a level playing field. The Categorical Adjustment Index (CAI) is insufficient to compensate plans caring for the most high-cost, high-need beneficiaries. CMS has acknowledged that the CAI has a very small impact on plan ratings. ASPE and CMS should continue working with plans to identify and evaluate a long-term, meaningful solution to address the impact of dual status and SES on Star Ratings since the CAI is only a temporary solution.

- *Increase Supplemental Benefit Flexibility and Empower Beneficiaries to Select the Plan that Best Meets their Needs*

  It is imperative that beneficiaries have the information they need to identify the plan that will provide the highest-quality care and most tailored benefits based on their unique needs. Additional support services and supplemental benefits can be particularly important for beneficiaries with social risk factors. However, the tools currently available to beneficiaries such as the Medicare Plan Finder (MPF) do not allow them to fully evaluate the value of different plan benefit options. To empower beneficiaries to take advantage of the new benefits that plans are able to provide, CMS must improve the resources available for beneficiaries to more accurately compare plans.

  Additional flexibility for plans to better address social risk factors like homelessness and food insecurity is a critical tool for plans to attend to beneficiaries' social risk factors. It is critical that health plan benefits can address issues beyond a specific medical condition such as social supports. ASPE should recommend that CMS provide health plans with more flexibility in offering allowable supplemental benefits to expand supplemental benefit offerings to address to social risk factors.

- *Help Facilitate Data Sharing and Collection*

  In our experience, gathering complete and accurate data is an important first step to enhance care coordination and improve outcomes. CMS can play a crucial role in incentivizing and facilitating data collection and allowing for data-sharing between Medicaid programs and Medicare plans to ensure higher-quality care. Having more information about patients likely to need additional supports and services, such as the chronically ill and the dual-eligible populations, will help plans identify the most appropriate and effective steps to address SDoH.

Detailed Comments

Develop and Implement a Long-Term Solution for the Impact of SES on the MA and Part D Star Ratings

Beneficiary-level characteristics have a meaningful impact on Star Ratings and CMS plays a critical role in enabling plans that care for the program's most vulnerable beneficiaries to compete on a level playing field. However, in our experience, the CAI is insufficient to compensate plans caring for the most high-cost, high-need beneficiaries. Moreover, CMS has acknowledged that the CAI is a temporary solution that has a very small impact on plan ratings.

Thus, Anthem urges ASPE and CMS to continue working with plans to identify a long-term solution to the impact of dual status and SES on Star Ratings. Anthem appreciates the ongoing attention to and focus on the impact of beneficiary-level characteristics – specifically, dual status and socio-economic factors – on plan performance. We understand that the CAI is a temporary solution, and we support ASPE's work to fully evaluate proposals to develop a longer-term, meaningful fix. It is also critical to accurately account for social risk factors in MA through more meaningful data, quality performance measures, risk adjustment and value-based payment. A long-term solution that truly reflects the impact of dual status and SES on payment will recognize the unique challenges and outsized investment undertaken by plans who are committed to holistically serving dual eligibles and members with social risk factors.

Increase Supplemental Benefit Flexibility to Address Beneficiaries' SDoH

We appreciate the Administration's efforts to expand allowable health-related supplemental benefits. Anthem and its affiliated health plans are committed to offering plans that provide high-quality medical care and other social supports. For 2019, Anthem developed additional supplemental benefit options by asking beneficiaries' about their needs. At the request of beneficiaries, Anthem is offering the following supplemental benefits:

- Assistive Devices: Provides $500 towards assistive devices such as shower stools, reaching devices, temporary wheelchair ramps, and more.

- Personal Home Helper: Provides an in-home health aide for caregiver respite, home-based chores, and activities of daily living (ADL) due to health issues not otherwise covered under any other Medicare benefit. Assistance can be provided for up to 124 hours of care in a calendar year (up to four hours per day for 31 days in a calendar year).

- Healthy Food Deliveries: Provides up to 16 meals per qualifying event, and allows up to four events each calendar year for 64 meals in total. A qualifying event may include post discharge from a hospital or other need if the beneficiary has a Body Mass Index (BMI) more than 25 and/or an A1C level more than 9.0.

- Pain Management: Provides up to a combined total of 24 medically necessary acupuncture and/or therapeutic massage visits each calendar year. Acupuncture and therapeutic massage participating providers must be licensed or certified, as applicable, by the state.

- Day Center Visits: Provides up to one visit per week for adult day center services. The center must be licensed by the state to provide adult day center services. To qualify beneficiaries must need help with two activities of daily living, and transportation to and from the center is covered.

- Transportation: Covers up to 60 one-way trips each calendar year to and from locations within the local service area when obtaining plan-covered services. Trips may be covered for getting to and from medical visits, SilverSneakers locations and visits to a pharmacy after a covered medical service.

Anthem recommends the Administration provide additional flexibility to plans to better address social risk factors. Currently, supplemental benefits cannot target health care services based on social determinants, like homelessness or food insecurity. However, in 2020 it may be possible for certain offerings to address issues beyond a specific medical condition, such as social supports. ASPE should recommend that CMS provide health plans to have more flexibility in allowable supplemental benefits, and expand supplemental benefit offerings to cover additional services, such as pest control and over the counter items, that will address social risk factors, help beneficiaries manage medical conditions and improve their overall health status.

Empower Beneficiaries to Select the Plan that Best Meets their Needs

Anthem shares CMS' commitment to continuously identifying and implementing innovative approaches for empowering beneficiaries to make the best health care decisions for their unique needs. The MPF is an important tool that seeks to enable beneficiaries to identify, compare, and enroll in the Medicare plan that best meets their needs. By enhancing this tool, CMS would help provide beneficiaries with the information needed to facilitate enrollment in high-value health coverage.

However, aspects of the MPF fails to provide beneficiaries with a tool to holistically and accurately compare annual health care costs.[1] A recent qualitative study of the MPF reported beneficiaries found it difficult to assess the value of health plans and raised concerns about the predictive modeling of current beneficiary cost calculations. This issue is particularly problematic given that most beneficiaries report out-of-pocket costs are the most important consideration when choosing a plan, but do not understand the cost information on MPF.[2]

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[1] Medicare.gov. Out-of-Pocket Costs (OOPC) Data Calculations. Available at: https://www.medicare.gov/find-a-plan/staticpages/oopc-calculations.aspx

[2] NCOA. Modernizing Medicare Plan Finder. Available at: https://www.ncoa.org/wp-content/uploads/CC-2018-MedicarePF-Report-Final-0418.pdf

Today, Medicare plans are sorted by lowest estimated annual health and drug costs based on Out-of-Pocket Costs (OOPC) data calculations that fail to educate beneficiaries on newly allowable supplemental benefits. The actuarial impact of the OOPC data calculations are inadequate because the model fails to account for the full richness of benefit designs and puts high-value health plans with robust supplemental benefit offerings at a placement disadvantage. A lower placement on the MPF makes it more difficult for beneficiaries to choose a health plan that offers affordable benefits that improve their health outcomes and lower their out-of-pocket costs.

CMS granted health plans additional flexibility to offer supplemental benefits that can enhance quality of life and improve health outcomes. By redefining health-related supplemental benefits, CMS has allowed plans to more holistically address the health care needs of Medicare consumers, which can lead to improved outcomes, reduced out-of-pocket costs, and decreased system-wide costs. Anthem implemented supplemental benefit flexibilities to better meet beneficiaries' health care needs. However, the MPF currently fails to value these benefits appropriately or list the available supplemental benefits.

As Anthem has expanded supplemental benefit offerings, the lowest estimated annual health and drug cost ranking based on the OOPC calculations has forced these health plans lower in the MPF options, making it less likely beneficiaries will obtain flexible, high-value supplemental benefit offerings that address social risk factors. Weighting comprehensive dental supplemental benefits, while failing to capture the benefits Anthem has added such as transportation to incentivize preventive care, assistive devices such as grab bars to prevent falls, and in-home health to help avoid hospital readmissions is a methodological limitation of the OOPC estimates that should be rectified.

ASPE should encourage CMS to improve beneficiary cost calculations and redesign MPF comparison and decision support tools to ensure beneficiaries can consider the full spectrum of health plan offerings. At a minimum, CMS should accurately display newly allowable supplemental benefits. The unintended operational consequences of expanding allowable supplemental benefits should be addressed, particularly as additional guidance that could improve social barriers to care is released re-defining supplemental benefits in 2020 and beyond.

Sharing Data would Benefit the Coordination of Services for Dual-Eligibles, Including Those with Social Risk Factors

As ASPE recognizes in its RFI, comprehensive data collection is an essential tool in ensuring that the needs of beneficiaries, including their social needs, are holistically addressed. This is particularly important for dual-eligible beneficiaries, since their data are captured by providers and health plans who participate in both the Medicare and Medicaid programs. Therefore, coordination between data systems is key to improved health outcomes of these high-cost, high-need beneficiaries.

In our experience, the dual-eligible population faces a number of challenges, including social risk factors that can make it difficult for providers and plans to provide proactive care. For example, dual-eligible beneficiaries may frequently change addresses or phone numbers, which means that providers and plans may have out-of-date contact information for these patients and cannot reliably reach them to remind them to attend appointments. More integrated data systems and coordination between Medicaid and Medicare plans can help minimize the chances that member information is out of date. As ASPE and CMS consider ways to improve data sharing between the Medicare and Medicaid programs for this highly complex population, avoiding undue SNP program administrative requirement burden is essential, so that resources are not diverted away from necessary services and care coordination.

Anthem's experience with Medicare-Medicaid Plans (MMP) has illustrated the important relationship between SDoH and behavioral health. Beneficiaries with serious mental illness have a higher rate of comorbidities, and higher health care costs.[3] [4] CMS data shows forty-one percent of dually eligible beneficiaries have at least one mental health diagnosis, while 68 percent have three or more chronic conditions.[5] Data is critical for the early identification of behavioral health challenges to deliver mental health treatment and improve outcomes for dual eligible beneficiaries.

Anthem recommends that MMPs and Dual Eligible Special Needs Plans (D-SNPs) routinely receive updates on Medicaid coverage by carrier from state agencies. Further, Anthem suggests that states develop data collecting mechanisms and disseminate this information to the relevant health plans in a consistent manner, leveraging existing reporting and data sharing platforms.

In addition, it would be helpful to D-SNPs to have historic Medicaid claims data from other carriers in order to provide a more complete picture to the case management team and assist with improved coordination of care for dual eligibles with complex health care needs and social risk factors. Ideally, this type of data would be sent to plans at consistent intervals. This would provide a more complete picture of historical social risk factors and assist health plans in better serving dual-eligible beneficiaries and coordinate services and supports. With a clear and complete view of the data, plan sponsors can serve as the best advocate for the member by coordinating care and social supports.

Increase Support for Effective Approaches to Link Unmet Social Needs and Care Management

In its RFI, ASPE identifies four key strategies and interventions for MA plans addressing social needs, including needs identification and targeting; care management and coordination; directly addressing

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[3] M. De Hert, C.U. Correll, J. Bobes, M. Cetkovich-Bakmas, D. Cohen, I. Asai, et al. "Physical illness in patients with severe mental disorders: Prevalence, impact, of medications and disparities in health care." *World Psychiatry*, 10 (2011): 52-77.
[4] C. Boyd, B. Leff, C. Weiss, J. Wolff, A. Hamblin and L. Martin. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*. Center for Health Care Strategies. December 2010. Available at www.chcs.org.
[5] Medicare-Medicaid Coordination Office, National Profile 2012. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-CoordinationOffice/Downloads/NationalProfile_2012.pdf

social needs; and integration of Medicare and Medicaid. We are already implementing several of these strategies as outlined in examples below and urge ASPE to leverage Anthem's experience as a leader in effective care management for beneficiaries' with social risk factors.

<u>America's 1st Choice</u>

America's 1st Choice is an Anthem affiliated Medicare Advantage organization that offers HMO products, including Chronic Special Needs Plans (C-SNPs) and D-SNPs, under its Freedom Health and Optimum brands in Florida. The plan also operates America's 1st Choice of South Carolina, and currently serves approximately 135,000 Medicare consumers in 25 counties in Florida and three counties in South Carolina.

America's 1st Choice serves dually eligible beneficiaries through a D-SNP with zero-dollar co-pays for primary, specialist, and mental health services. The D-SNP plans offer rich transportation benefits to facilitate access to care. D-SNP beneficiaries' can also receive monthly over-the counter allowances from $20 to $50 each month. Additional benefits like transportation, meals post-hospitalization, and over-the-counter supplies help America's 1st Choice stay in touch with beneficiaries' and deliver care that can help manage chronic conditions and prevent emergency room visits.

One strategy to achieve cost savings and improvements in quality care for vulnerable beneficiaries is care management. The health plan utilizes social workers to better attend to the needs of beneficiaries' with social risk factors. Questions have been added to the America's 1st Choice Medicare Health Assessment Tool and Disease Management Screening Tool to help identify members who feel unsafe, require assistance with activities of daily living and face financial challenges. The social workers identify the highest need beneficiaries and coordinate necessary care, review plan benefits, encourage member engagement with their primary care provider, and inform members of community resources. Social workers also help members apply for financial assistance, and engage with designated care givers to help beneficiaries navigate the health care system and improve health outcomes.

<u>HealthSun</u>

HealthSun is an Anthem affiliated integrated Medicare Advantage health plan and health care delivery network in Florida. HealthSun serves more than 40,000 MA consumers in Miami-Dade and Broward counties through its network of 19 wholly-owned primary care and specialty centers. The health plan population is approximately 83-84 percent dual eligible and/or low-income subsidy.

Providing non-emergency transportation for low-income populations is a cost-effective way to improve life expectancy and quality of life.[6] HealthSun understands that transportation benefits enable dually

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[6] P. Hughes-Cromwick and R. Wallace, et al. Cost Benefit Analysis of Providing Non-Emergency Medical Transportation (2005). Available at: https://altarum.org/sites/default/files/uploaded-publication-files/05_project_report_hsd_cost_benefit_analysis.pdf

eligible beneficiaries to obtain necessary primary, specialist, dental, and vision care. Through an extensive network, the plan is able to provide transportation benefits to enable members to access care at wholly-owned clinics and a broad segment of provider network clinics.

Physical activity is key element of health and wellness. Every 11 seconds, an older adult is treated in an emergency department for a fall-related injury and a growing population of older adults are vulnerable to social isolation.[7] Primary and specialty care visits incorporate time at wellness centers in the HealthSun network. These centers can provide classes from SilverSneakers, social activities like bingo, classes on chronic diseases such as diabetes and even healthy meals. The wellness centers reduce social isolation and hunger, while increasing beneficiaries' physical activity.

In 2019, HealthSun is adding a personal home care benefit for eligible members who have been hospitalized and discharged from an acute or non-acute setting to their home. The benefit will provide up to 16 hours of home care aid twice annually to assist beneficiaries with general activities of daily living to prevent readmissions. Members recently discharged from the hospital may also qualify for a meal service from the Independent Living System, which provides a limited number of days' supply of prepared food delivered to the home.

Social risk factors such as homelessness, income insecurity, and hunger are consistent issues that the health plan is able to better address through benefit flexibility. Dually eligible HealthSun members benefit from over-the-counter benefits for pharmacy related items that may include tooth brushes, tooth paste, and non-prescription medications through additional assistance in Miami-Dade and Broward Counties. Telehealth has also been utilized as a behavioral health benefit for members with social risk factors. However, limited access to technology often prevents vulnerable populations from accessing educational resources which is why it's critical that health plans can leverage additional resources to address beneficiaries' social barriers to care.

CareMore

Individuals enrolled in certain Anthem MA plans receive their health care through CareMore, an integrated care delivery system for Medicare and Medicaid patients. Founded in 1993, CareMore serves 100,000 Medicare and Medicaid beneficiaries across eight states. The three pillars of the CareMore Health model for innovative health care delivery focus on care management:

- Chronic care management: Employing "extensivists," who are highly-trained doctors who understand all aspects of medical care and coordinate care across multiple doctors, specialists, and treatments for patients with chronic conditions and other complex health needs;

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[7] National Council on Aging (2018) Falls Prevention Facts. https://www.ncoa.org/news/resources-for-reporters/get-the-facts/falls-prevention-facts/

- <u>Acute care management</u>: Acting quickly and effectively when a patient needs care and ensuring proper follow-up protocols are adhered to by patients and doctors; and,

- <u>Predictive modeling and early intervention</u>: Identifying where risk lies for patients and patient groups and creating innovative ways to mitigate that risk.

CareMore beneficiaries face a number of risk factors that pose barriers to care. For example, many beneficiaries may experience housing instability and/or transience; lack of mental health related services and supports; limited English proficiency; low income/poverty status; and low health literacy or education level, among other risk factors. However, the CareMore model is specifically designed to target high-risk, chronically ill patients through focused care coordination, patient education, and proactive disease management. Through these efforts, CareMore has achieved costs 18 percent below industry average,[8] while maintaining or improving quality of care.[9]

CareMore beneficiaries regularly meet with social workers who conduct needs assessments and connect them with health-related benefits and Community-Based Organizations (CBOs) to address their needs. For example, lack of transportation is a major barrier to accessing care. Every year, 3.6 million Americans miss or delay medical care due to their inability to access transportation services.[10] Research shows that lack of transportation can reduce use of preventive and primary care[11] while encouraging use of the emergency department.[12] Recognizing this barrier, CareMore has partnered with Lyft to ensure that patients do not miss important medical appointments because they do not have reliable transportation. Through its partnership with Lyft, CareMore has delivered more than 300,000 trips per year across a population of about 85,000 Medicare members.

CareMore also recognizes the importance of wellness. Accordingly, dieticians have long been part of the care team. Additionally, there are Nifty after Fifty gyms located adjacent to CareMore facilities, providing patients easy access to fitness and movement. CareMore partners with gyms through the Prescribed Fitness program in which providers "prescribe" exercise to patients with chronic diseases such as diabetes. In this program, a member with diabetes could be written a "prescription" for exercise by their doctor during an appointment. After doctors' appointment, the member will meet with a case manager, who will "fill" the member's prescription for exercise by working one-on-one with her to create an exercise plan.

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[8] Main, T and Slywotzy, A (2011) The Quite Health-Care Revolution. The Atlantic.
https://www.theatlantic.com/magazine/archive/2011/11/the-quiet-health-care-revolution/308667/
[9] Clear Choices Campaign and National Council on Aging (2018). Modernizing Medicare Plan Finder: Evaluating and Improving Medicare's Online Comparison Shopping Experience. https://www.ajmc.com/journals/ajac/2015/2015-vol3-n2/lessons-from-caremore-a-stepping-stone-to-stronger-primary-care-of-frail-elderly-patients?p=2
[10] http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf
[11] Adolescents who use the emergency department as their usual source of care. Wilson KM, Klein JD. Arch Pediatr Adolesc Med. 2000 Apr; 154(4):361-5.
[12] The effects of access to pediatric care and insurance coverage on emergency department utilization. Johnson WG, Rimsza ME Pediatrics. 2004 Mar; 113(3 Pt 1):483-7.

CareMore is also a leader on addressing the senior loneliness epidemic in the United States. Studies show that loneliness can potentially increase a person's risk of mortality by 45 percent – more than air pollution, obesity, or excessive alcohol use.[13,14] Eighteen months ago, CareMore introduced the Togetherness Program, a comprehensive initiative aimed at identifying and addressing in the loneliness among its senior patients through weekly phone calls, home visits, and encouragement and connection to community-based programs. The Togetherness Program is a first-in-industry clinical approach to address senior loneliness as a treatable condition by focusing on patients' psychological, social and physical health. Participants in the Togetherness program increased engagement with Nifty after Fifty gyms by 53 percent. Additionally, despite a higher disease burden among program participants, emergency department use has declined by 5 percent among program participants, and acute admissions are 11 percent lower per thousand as compared to non-participants.

CareMore also partners with CBOs in their local markets to provide patient linkages to social supports in the community setting. In each CareMore market, the social work team maintains a list of local organizations that can provide important social services. The teams make sure the list is up-to-date and that patients have access to services. For example, during patient assessments, social workers may identify a patient need, such as housing insecurity, and refer the patient to a local housing organization on their list of CBOs for assistance.

CareMore is constantly striving to improve its ability to quickly and efficiently connect its members with the services they need, and its data-driven approach for identifying patients with social risk factors helps CareMore continue to reach out to members as proactively as possible. CareMore is in the process of rolling out a customized, member-specific screening tool that will get to the core of how CareMore practices medicine. The tool maps to the eight domains of SDoH that will be a resource to providers as they work directly with patients to identify potential risks and barrier to care. For example, a provider will routinely ask a member if he is experiencing food insecurity. If the member says yes, the tool will provide a framework of follow-up questions to help the provider understand the nature and causes of the challenges the member is experiencing. This tool will be loaded into providers' Electronic Health Records (EHRs) to allow for uniform implementation and utilization across CareMore facilities.

Collection of complete and accurate data, like the provision of comprehensive care, requires that providers are able to spend enough time with each patient. The primary barrier to collecting data about social risk factors is provider time. For example, CareMore providers would like to spend at least 45 minutes with each patient to gain a full understanding of their needs and to build trust with the patient. However, under the current system, providers struggle to spend enough time with each individual patient to identify unmet social needs.

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[13] Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. PLoS Med 7(7): e1000316.
[14] Perissinotto C, Cenzer I, Covinsky K. Loneliness in Older Persons A Predictor of Functional Decline and Death. Arch Intern Med. 2012; 172 (14): 1078-1084

Increase Electronic Health Record Interoperability

EHR interoperability is a cornerstone of delivering state of the art medical care, providing opportunities to enhance patient satisfaction and enable data sharing. Despite recognition of the importance of interoperability, it has been widely documented that that EHR systems are fractured and siloed, and that more work is needed to effectively exchange of health information. Additionally, many key stakeholders are unwilling to share data with perceived competitors and engage in "data blocking," making it difficult for payers, health care providers, and even patients to access patient data.

Anthem is seeking ways to build trust between payers and providers and promote EHR interoperability. For example, in 2014, Anthem partnered with seven competing health systems in California to create the integrated Anthem Blue Cross Vivity. As part of this initiative, clinical EHR data is shared between health systems, creating a patient-centered approach that closes care gaps and promotes health outcomes.

Recent efforts, like the administration's MyHealthEData and the overhaul of the Quality Payment Program to focus on "Promoting Interoperability", may remove barriers to data sharing, and we appreciate the administration's focus on this important issue. However, we urge ASPE and CMS to continue to promote collaboration among payers and appropriate information sharing – missing and lagged data prevents providers from developing a truly patient-centered approach to managing care and addressing social risk factors.

Advance Telehealth and Telemedicine

Anthem supports the use of telehealth and telemedicine to identify and address social risk factors. We believe that meeting the patient where they are will help ensure robust access to care, improve efficiencies, expand disease management programs, assist in transitional care activities/coordination of care amongst the Medicare population, and drive improvements in patient experience. Moreover, telehealth has the ability to empower patients and caregivers, while improving the lives of beneficiaries. Telehealth can bridge geographic, time, and mobility gaps between patients and their health care providers.

For patients with social risk factors, particularly those with limited ability to ambulate, telehealth is a best practice. Through telehealth, Anthem is meeting patients where they are. Anthem recognizes that CMS is considering how best to incorporate telehealth into benefit packages and how to incentivize the provision of telehealth. However, we believe that more steps need to be taken to ensure that beneficiaries can access cutting edge technologies to improve health outcomes.

ASPE should encourage CMS to improve network adequacy review processes and increase flexibility for time-and-distance standards to facilitate greater use of telehealth services among Medicare beneficiaries. Anthem recommends CMS streamline and improve the network adequacy review process,

including allowing plans to use telehealth to meet adequacy requirements in certain situations to better address health care needs and social risk factors. In CY 2018, CMS began allowing organizations to request an exception if they are using a telehealth or a mobile provider to meet network adequacy requirements. CMS will consider this type of rationale on an Exception Request only for Counties with Extreme Access Considerations (CEAC), Rural, or Micro county types. However, additional guidance and flexibility in the Exception Request process is needed.

CMS' current emphasis on time-and-distance standards can often be overly prescriptive and ultimately limit sponsors' ability to serve certain geographic areas and harder-to-reach members. Flexibility related to the types of providers who satisfy time-and-distance requirements would be helpful. For example, many primary care providers can support certain behavioral health needs, in addition to general medicine, but they have more distinct time-and-distance requirements they must meet than behavioral health providers.

<div align="center">***</div>

Anthem is committed to ensuring that Medicare beneficiaries have access to quality health care, as evidenced by our long-standing relationship with the National Council on Aging (NCOA), with whom we are partnering through NCOA's Benefits Checkup and Aging Mastery Programs. Most recently, with support from the Anthem Foundation, Anthem awarded a grant to NCOA to meaningfully expand their Aging Mastery Program to thousands of older adults across five of the states where Anthem operates. The program addresses social determinants of health and removes barriers for Medicare beneficiaries that stand in the way of accessing quality health care and living more healthy and active lives.

Anthem appreciates this opportunity to provide input on this RFI and welcomes the opportunity to discuss our work and recommendations. Should you have any questions or wish to discuss our comments further, please contact Danielle Horne at 818.298.7830 or Danielle.Horne@Anthem.com.

Sincerely,

Anthony Mader
Vice President, Public Policy

November 16, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation (ASPE)
Department of Health and Human Services
Room 415F
200 Independence Ave SW
Washington, DC 20201

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

Dear Deputy Asst. Secretary Destro:

Doctors Hospital at Renaissance (DHR Health) thanks you for the opportunity to comment on the IMPACT ACT research study RFI: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. **As the largest physician-owned health system in the country, and the only locally-owned and operated health system remaining standing in our county, DHR Health has a unique perspective on care delivery for beneficiaries with social risk factors.**

About DHR Health

DHR Health is a homegrown, grassroots physician-owned community health system developed by local physicians with the goal of addressing all of the health care needs of our community, while eliminating the need for our local residents to seek medical services outside the region. Located in the Rio Grande Valley[1] of Deep South Texas, we serve an area of over 1.5 million people, and provide access to the highest-of-quality and award-winning health care in one of the poorest regions of the country.

We are a world-class full-service health system with 500+ beds, offering the most comprehensive and best medical care in the Rio Grande Valley with over 70 specialties and sub-specialties, 700 physicians, 1,400+ nurses, a rehabilitation hospital, behavioral hospital, the only dedicated women's hospital south of San Antonio, a level III neo-natal intensive care unit that ranks among the top 5% in the world in terms of outcomes, a 24/7 level III trauma center, a robust clinical research division, and the flagship teaching hospital for the University of Texas Rio Grande Valley School of Medicine.

Despite the Rio Grande Valley having the highest adult uninsured rate in the region (36 percent), and over 25 percent of area residents being eligible for Medicaid (which is more than double the state average of 12.5 percent), the four-county area is served by only one basic-service general acute 50-bed public hospital. DHR proudly serves as an area safety-net hospital with 44 percent of our overall patient population being covered by Medicaid and 25 percent by Medicare (by discharge). In fact, of the over 89,000 babies delivered at DHR (approximately 600-800 per month), 85 percent are covered by Medicaid and we have incurred over $1 billion in uncompensated and charitable care since opening our doors. Despite these challenges, DHR continues to increase access to care and meet the health care needs of our community.

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[1] The Rio Grande Valley is made up of the four Southern-most counties in Texas: Starr, Hidalgo, Cameron, and Willacy Counties.

RECOMMENDATIONS:

DHR believes there are ways that the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) can improve evaluation of the effectiveness of existing interventions on beneficiaries' health outcomes and healthcare costs.

Identify Beneficiaries with Social Risk Factors

In order to improve care for Medicare beneficiaries with social risk factors, health systems and providers must be able to identify beneficiaries with social needs and develop care strategies tailored to their community. There are different ways to identify social needs, one of which includes examination of population trends conducted by third-party organizations. As stated in this RFI, data and measurement and comprehensive needs assessments help providers understand their population's health, risk factors and patterns of care. They help systems identify, anticipate and respond to clinical and social needs.

As part of the Texas 1115 Medicaid Transformation Waiver, the state created regional health partnerships (RHPs), responsible for conducting community needs assessments (CNAs), and administering Delivery System Reform Incentive Payments (DSRIP) programs. The CNA's produced by each RHP provide an vital assessment tool for health care providers, community leaders, state and local agencies, universities, and other stakeholders to better understand local population risk factors, health care needs, and gaps. **DHR recommends that HHS and ASPE promote provide funding to incentivize the formation of regional health partnerships and the development of CNA's on a periodic basis.** The information that could be gained and compiled if every region of the country had the resources to conduct localized and tailored health care and population based CNA's would be invaluable to local, state, and national policy makers.[2]

For example, in February 2018, the University Of Texas School Of Public Health Brownsville released the most recent CNA for RHP 5, where DHR is situated. A CNA is produced every The analysis used data from hospitals in the region and state and national sources to evaluate the health status and unique needs of the population in the Rio Grande Valley (RGV). Additionally, the Texas Health Institute recently conducted a report on the population characteristics in the RGV. These assessments illustrate some of the most common socio-economic and demographic factors that influence our patients' social determinants of health.

Their research found that nearly 60% of the residents in our region are classified as low-income, with the median family income ranging from $27,000 to $34,500. An estimated 20% experience food insecurity. Approximately 15% express excessive drinking behavior and 12% smoke. Unemployment currently ranges from 12% to 17%, and the percent of the population without a high school education ranges from 25% to 37%. Additionally, within a randomly selected study of over 4,500 adults in the RGV, 27.6% of adults had

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[2] The ACA does require non-profit hospitals to produce a CNA every three years that demonstrates the community benefit provided by the non-profit hospital. However, a more regionalized approach that does not focus on a single entity will provide a more holistic view of a particular areas' needs.

diabetes, 32% had pre-diabetes, 51% were obese, 27.8% had depression, and 30% had measurable levels of anxiety. Notably, there are at least 10 times as many fast food restaurants as grocery stores in our region. Finally, each county in the region contains neighborhoods known as 'colonias,' or unincorporated rural communities that lack basic infrastructure. Families in these communities are usually poor and living in substandard housing, with little or no access to electricity, indoor plumbing and paved roads, making public transportation and access for emergency vehicles very difficult.

Promote the Adoption of Strategies to Address Social Risk Factors through a Comprehensive Care Approach

DHR Health has transformed the health care landscape and raised the standard of care across the Rio Grande Valley. Through our commitment to quality and to the people of the Rio Grande Valley, DHR continually seeks ways to provide a comprehensive care approach through care coordination, education, counseling and support services across the entirety of our health system and specialty services. We want to ensure that all of our patients' needs are addressed, whether those needs are medical or otherwise.

DHR works tirelessly to provide our clinicians with all the available information and tools necessary to treat patients and coordinate care with all providers, and to provide our patients with all the resources they need to better manage and take control of their own health. Patients present with many social risk factors that make medical treatment and diseases management much more difficult - such as poverty, lower education levels, environmental exposures, and minimal or lower health, nutrition, and medical literacy. Some examples of the many ways DHR is working to address all of our patients' needs are:

- *Care Link Clinic* - Our Care Link Clinic provides education and comprehensive transitional care for patients at high-risk of hospitalization in order to help them manage their disease and stay out of the hospital. The Care Link Clinic tailors services to high-risk patients such as those suffering from diabetes, COPD, acute myocardial infarction, congestive heart failure, renal disease and pneumonia. Patients in the Care Link clinic are provided with the tools to monitor and address their health and diseases with education, one-on-one visits with nurses and pharmacists, nutrition classes, therapy management, home visits, counseling services, and transitional care.
- *Transportation Services* - Our organization evaluates needs of specific populations and provides transportation to assure compliance with appointments.
- *Integration of Mental Health into Clinics and Acute Care Settings* – One of the most important things DHR is doing across our system is integrating mental health professionals in our clinics and acute care settings to help patients cope with their disease and to address chronic issues like poor compliance with medication or other protocols. We have found that one of the most important social determinant of health is mental health. One of the top reasons we see re-hospitalizations or complications is due to mental health issues of the patient and their ancillary effects, such as failing to make medication at the prescribed times or doses.
  - *School Based Mental Health* - In addition, our system provides mental health services to three main school systems providing mental health services to school children to avoid missing school.

- o *Support Groups* - Our system provides support groups to many groups to include: cancer survivors, grief counseling, amputees, stroke, Parkinson's, Empowerment groups to name a few.
- *Social Services and Community Assistance* - Our Social Services team help patients who lack access to many resources by assisting patients find those resources in the community through partnerships and programs with DHR Health.
- *Care Navigation Services*- DHR provides care navigation programs across the health system to assist patients and families navigate the health system to assure continuity of care and transitions of care.
- *Maternal and Fetal Health* – DHR has begun the first maternal fetal medicine program in our area and we participates in pilot program with the State of Texas aimed at helping at-risk mothers to improve pregnancy outcomes. Our MFM program is making tremendous strides in improving outcomes in our region for both mother and child.

These are just a few of the examples of how DHR is working to create a streamlined and comprehensive system of care to holistically address our patients' needs. **We urge HHS and ASPE to implement programs and develop incentives to increase access to comprehensive care that includes care coordination, education, counseling and support services that will help patients overcome social risk factors so that they may have the tools to better manage their health.**

Adjust Quality Performance Categories for Social Risk Factors

One simple strategy to improve the evaluation and effectiveness of existing interventions is to adjust all measures included in the Quality Performance Category of the Merit-based Incentive Payment System (MIPS) for socioeconomic factors. Adjusting these measures for social determinants of health will incentive health systems and providers to put more focus on addressing underlying issues of disease and will foster innovation in the delivery of care that goes beyond medicine and traditional health care.

Patient outcomes are influenced by factors other than the quality of the care provided. Socio-demographic factors beyond the control of a provider- such as the availability of primary care, physical therapy, ease of access to medications and appropriate food, and options for post-discharge care and services – influence performance on outcome measures. When comparing the quality of care provided by a variety of entities, risk adjustment helps account for these aforementioned factors. Hospitals with a large number of low-income patients, such as DHR, are more likely to be penalized often as a result of elements outside of the hospital's control.

What CMS is currently missing are the various other elements in the healthcare environment which have an undeniable effect on quality measurement, including:

- *Socio-demographic factors* such as poverty, lack of access to healthcare, lack of transportation, lack of access to healthy food, and lack of resources in their areas
- *Readmission risks* which includes patients with 6 or more chronic conditions who statistically have a higher change of readmission versus a patient with one or two chronic conditions
- *Mental health factors* which include readmissions with the secondary diagnosis or psychiatric disorders. We experience, first hand, that nearly half of our readmissions have a secondary diagnosis of psychiatric disorders where their mental state interferes with their compliance of

self-care (such as medication regimens, discharge instructions, physical activity, and/or medical visit follow-ups).

These factors can be integrated into current quality measurement without collecting additional data. It merely requires mining the currently collected data in the acute and ambulatory settings.

Allowing for adjustment in all measures included in the quality category would align CMS policy with Congressional intent and action with respect the 21st Century Cures Act. Specifically, because CMS program data showed that hospital readmission rates and penalties under the Hospital Readmissions Reduction Program (HRRP) were positively correlated with the hospital's share of low-income patients, Congress amended the HRRP in order to address shortcoming of the program and to ensure inclusion of socio-economic data into the calculation and to not unduly penalize hospitals due to the socio-demographic characteristics of their patient population. **DHR urges the robust use of risk adjustment – including socioeconomic adjustment, where appropriate – to ensure caring for more complex patients does not cause providers to appear to perform poorly on measures.**

We appreciate the opportunity to provide these comments and we look forward to working with HHS and ASPE to improve health outcomes for beneficiaries. If you have any additional questions, please do not hesitate to contact our Counsel for Government Affairs and Policy, Mr. Roberto Haddad, by phone at (956) 362-7138 or by email at r.haddad@dhr-rgv.com.

Sincerely,

Dr. Carlos J Cardenas
Chief Administrative Officer
Chairman of the Board
Doctors Hospital at Renaissance

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
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200 Independence Avenue, SW
Washington, D.C. 20201

November 16, 2018

Submitted via email: ASPEImpactStudy@hhs.gov

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

Dear Ms. Destro:

On behalf of Ascension, I appreciate the opportunity to submit comments on the Request for Information (RFI) entitled *IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.[1]*

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. As the largest non-profit health system in the U.S. and the world's largest Catholic health system, Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. In FY2018, Ascension provided nearly $2 billion in care of persons living in poverty and other community benefit programs. Ascension includes approximately 156,000 associates and 34,000 aligned providers. Ascension's Healthcare Division operates more than 2,600 sites of care – including 151 hospitals and more than 50 senior living facilities – in 21 states and the District of Columbia, while its Solutions Division provides a variety of services and solutions including physician practice management, venture capital investing, investment management, biomedical engineering, facilities management, clinical care management, information services, risk management, and contracting through Ascension's own group purchasing organization.

We applaud the Assistant Secretary for Planning and Evaluation (ASPE) for engaging the plan and provider communities to gather input on the questions set forth in the RFI and we offer the following input for your consideration. Given the geographic variation of our Ministries, diversity of our patient populations, and breadth of services offered, Ascension represents a microcosm of the U.S. healthcare landscape writ large, able to offer insights into how promising programs can best be identified, scaled, and replicated across the country. To that end, we offer some observations and learnings from our own efforts to identify and address social risk factors among our patients and within our communities. We very much welcome the opportunity to continue engaging with ASPE on this important issue going forward.

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[1] https://aspe.hhs.gov/system/files/pdf/259906/ImprovingCareMedicareBeneficiariesSocialRiskFactorsRFI.pdf

How Providers Identify Medicare Beneficiaries with Social Risk Factors

In recent years, Ascension has undertaken a systemwide effort to make healthcare more equitable. Ascension's leadership has called on all our sites of care to establish national goals around healthcare equity and to reduce disparities by Fiscal Year 2022. We believe that improving health equity involves addressing the societal risk factors that have an impact on vulnerable populations' health. To achieve these goals, Ascension convened health equity forums in 2015 and 2017 attended by hundreds of our system and facility leaders. The conclaves were used to further understanding of variables driving health inequity and to develop strategies. Out of our work, a five-pronged strategy was developed that includes:

- Establishing health equity as a strategic priority for all of Ascension's care sites, including hospitals, long-term care facilities, and outpatient locations;
- Putting in place structures and processes to ensure that Ascension facilities can collect and use patient demographic and socioeconomic data **in a standardized way**—including the collection of patient race, ethnicity, and language data systemwide;
- Deploying specific strategies including clinical improvement initiatives that address social risk factors related to health;
- Decreasing the implicit bias that staff may have when delivering care, such as misunderstandings that may arise when patient and caregiver do not speak the same language, or have different ethnicities or belief systems; and
- Partnering with community organizations to improve health and health equity.

Furthermore, we have committed our organization to an Advanced Strategic Direction for 2025 that will guide our actions and decision-making in the coming years. The Strategic Direction is rooted in our commitment to provide Healthcare That Works, Healthcare That Is Safe, and Healthcare That Leaves No One Behind, for Life. To achieve the goals comprising the Advanced Strategic Direction, Ascension has committed to coordinating the development and implementation of Holistic Health Models – models that improve the health of individuals and communities throughout their lifetime by leveraging nonclinical care models to impact the social influencers of health (*e.g.*, level of patient activation and engagement, behavioral health/psychological factors, functional status, residential and community context, spiritual needs).

Given these commitments, it is critical for Ascension that our providers are able to assess and identify potential social risk factors among all patients – including Medicare beneficiaries. We have also found that it is vital to our success that our system move toward a standardized approach, which will foster the development and sharing of best practices. To accomplish this, however, we must navigate and achieve alignment across differing assessment standards that have been implemented across the myriad programs that exist today. These include the Promoting Interoperability Program, state Medicaid programs, the Accountable Health Communities Model, Comprehensive Primary Care (CPC)+, and Medical Home Models, among others.

While some helpful tools have emerged in recent years, our practitioners found themselves hindered by a relative lack of a widely available best practice screening tools. To best meet the needs of our patients and providers, Ascension independently developed a comprehensive and scalable screening tool by leveraging and building on existing options and screening questions that have been made available but have proven fragmented or otherwise limited. While existing tools, like the *Accountable Health Communities Health-Related Social Needs Screening Tool*[2] developed by the Centers for Medicare &

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[2] Available at: https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

Medicaid Services (CMS), may prove helpful for certain practices or in certain care delivery models, our organization has set out to create a single tool that can be scaled across multiple practices, states, and models. Our long-term goal is to develop one screening tool that can be used across the enterprise, which will allow us to better identify patient needs as they arise, identify and predict trends across the country, and strategically utilize resources at a national level or through community partners with whom we can engage to best address our patients' needs. As we move in this direction, we also encourage ASPE to work with the Department and CMS on ways to better align the various programs' screening and assessment requirements to create greater consistency.

In its current state, our screening tool allows providers to identify issues where additional information or investigation may be warranted to fully understand and address an unmet need or risk factor that may impact a patient's health status. We continue to refine and enhance this tool as we roll it out across multiple markets and care settings.

Approaches Used to Address the Needs of Medicare Beneficiaries with Social Risk Factors

To help providers address the needs of Medicare beneficiaries and other patients who are identified as facing one or more social risk factors that may impact their health status, Ascension has developed and is finalizing for dissemination a Community Inventory Tool and a Community Resource Template. When finalized, the Community Inventory Tool will offer a variety of approaches to providers for connecting patients with community resources. It supports practices in evaluating gaps in community partnerships and prioritizing specific linkages their patient population may need. It also includes office-based strategies that support the use of the Community Resource Template.

The Community Resource Template assists providers with populating a resource guide to quickly and efficiently connect patients to social services they need. It prompts practice staff to identify community agencies that offer services across a range of domains (e.g., financial assistance, food insecurity, and housing assistance), as well as specific contacts at community agencies to facilitate effective referrals from the practice to a single point of contact. The purpose is to stimulate the development of an extended set of contacts at community agencies that can meet patients' social service needs as identified by the Determinants of Health Assessment. The Template also includes a one-page domain-specific "Quick Reference", which is designed to share with patients an identified resource need in a specific area. It can be printed to provide patients with a list of resources once a need has been identified.

These tools have been designed in a manner that allows practices to leverage them in a way that makes the most sense for each practice. For example, practices that have an embedded social worker may have different needs and opportunities as compared to practices that only have the ability to provide patients with a handout containing information about community resources.

One of the publicly available resources that our providers have also found useful is Aunt Bertha[3]. Aunt Bertha is the largest closed loop referral network in the United States. The service allows consumers, patients, and providers to search for free and reduced cost social services based on zip code. Individuals seeking information and referrals can search the Aunt Bertha data base of verified programs at no cost and from a variety of platforms.

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[3] https://www.auntbertha.com/

Evidence Regarding the Impact of Approaches on Quality Outcomes and Total Cost of Care

Ascension uses an "integrated scorecard" systemwide to incent improvements and gauge how well we are addressing disparities in health outcomes for certain prevalent conditions. Our success is based in part on how well we are able to manage social risk factors. For example, Ascension sites have been working to improve the health outcomes of vulnerable low-income heart failure patients. This involves individualized follow-up with these patients after hospital discharge to connect them with resources that address socioeconomic barriers that may make it harder to comply with doctors' instructions and manage chronic heart disease. Care navigators help coordinate the patients' post-acute care across multiple specialties and providers. We have also set a goal of achieving a reduction in all-cause, unplanned heart failure **admissions and readmissions** for all person served by an Ascension Medical Group (AMG) primary care provider, which similarly relies on assessing and addressing social risk factors. To date, we have achieved a reduction of 17% of avoidable admissions and improved access to care for persons with heart failure.

Ascension facilities have also increased colorectal cancer screening rates for low-income patients by partnering with churches and other community organizations to meet patients where they live, worship, and socialize in order to build awareness of the value of the screenings. To date, we have significantly improved screening rates across the system, screening roughly 100,000 additional persons.

Additionally, this past year we launched diabetes prevention programs across the entire system as part of our integrated scorecard goals in community health. We have been strengthening existing programs or starting new programs to reach more at-risk persons in their communities, encourage healthy living, generate greater diabetes awareness, and incent weight loss where applicable.

We disentangle and separately address social and medical risks using a standalone set of questions focused on specific social risk factors and then connect individuals with our community partners who can assist with the matters that have been identified.

Conclusion

Ascension appreciates the opportunity to provide this information and looks forward to working with ASPE on these important issues going forward. We would be very pleased to connect directly with ASPE and share the tools discussed above, including our standardized screening and assessment tool, the Community Inventory Tool, and the Community Resource Template, if any of these would be helpful to the Assistant Secretary. If you have any questions, or if there is any additional information we can provide, please contact Mark Hayes, Senior Vice President for Federal Policy and Advocacy at 202-898-4683 or mark.hayes@ascension.org.

Sincerely,

Reverend Dennis H. Holtschneider, C.M.
Executive Vice President and Chief Operations Officer
Ascension

November 16, 2018

Assistant Secretary for Planning and Evaluation
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted via electronic submission system to ASPEImpactStudy@hhs.gov

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

The Association for Community Affiliated Plans (ACAP) greatly appreciates the opportunity to provide comments to Assistant Secretary for Planning and Evaluation (ASPE) on the IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. ACAP is an association of 63 not-for-profit, community-based Safety Net Health Plans located in 29 states. Our member plans provide coverage to over twenty-one million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Advantage Dual-Eligible SNPs. Twenty-three of our member plans are D-SNPs, twenty-three operate Managed Long-Term Care Supports and Services (MLTSS) plans, 13 of our member plans participate in the Financial Alignment Demonstration, and our plans make up thirty-three percent of all Medicare-Medicaid plans' enrollment.

ACAP plans have developed several initiatives to address social risk factors prevalent in their communities by working with states and community-based organizations. These initiatives have improved beneficiaries' health outcomes and demonstrated long-term cost savings. The dual-eligible beneficiaries our plans serve are most at risk due to their socioeconomic status. Below includes details of our plans initiatives and our comments in response the questions posed in the RFI.

Identifying Medicare beneficiaries with social risk factors

ACAP-member D-SNPs and MMPs leverage multiple data sources to compile information on their Medicare members' social risk factors. Plans glean information on members' social risk factors through the annual member assessments and during the assessments that occur during care transitions or at the member's request. They also gather information on social risk factors from member touch points that occur through care management activities. Community-based partners are another data source for social risk factors. For example, UPMC works with their community partners to obtain information on housing instability for their Cultivating Health for Success program (more information on that program is available below).

However, plans do experience challenges with collecting information on social risk factors and integrating that information into their care management data systems. One challenge is educating providers on the need to assess beneficiaries for social risk factors and how they can document that information. For example, one ACAP-member works with their network providers to educate them that the providers can document homelessness using the ICD-10 Z59 code.[1] It can also be a challenge for plans to identify how best to synthesize social risk factor information from multiple sources, such as providers, community-based organizations, and care manager notes, and merge that information into plans' care management systems.

We are hopeful that through this study, ASPE is able to identify best practices for identifying and tracking social risk factors, and can share that information with plans and providers.

Addressing the needs of beneficiaries with social risk factors

ACAP-member D-SNPs and MMPs employ multiple strategies to address beneficiaries' social risk factors, including developing pilot programs and forming partnerships with community-based organizations. Some of the social risk factors that ACAP plans report to have the most affect on beneficiaries' health are lack of adequate and stable housing and inadequate nutrition. Below are details on how some ACAP-member plans address these social risk factors.

Commonwealth Care Alliance's Medically Tailored Meals Program

Commonwealth Care Alliance (CCA) provides home-delivered medically tailored meals to their dual-eligible Medicaid and Medicare beneficiaries through Community Servings, a Boston-based not-for-profit food and nutrition program. CCA's medically tailored meal program is designed for younger individuals with higher rates of disability that were at nutritional risk. These meals are approved by a registered dietitian and determined to be an appropriate medical diet per evidence-based practice guidelines for addressing nutrition-related health outcomes.[2] The program includes meals that vary across 15 medical diet tracks and can include up to three different dietary combinations.

Community Health Group's Homeless Program

Community Health Group of San Diego contracts with Project 25, a program that seeks to improve health outcomes and to reduce costs of care for homeless individuals. Project 25 helps to identify housing opportunities for a small, high-need subset of the plan's members, including dually eligible beneficiaries, and links them to preventive medical care, intensive care management, and round-the-clock case workers. Project 25, which began as a three-year pilot, has saved San Diego taxpayers more than $2 million per year. The Medi-Cal managed care plans

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[1] National Health Care for Homeless Council. "Ask & Code: Documenting Homelessness Throughout The Health Care System." October 2016. https://www.nhchc.org/wp-content/uploads/2017/06/ask-code-documenting-homelessness-throughout-the-healthcare-system.pdf.
[2] Community Servings. "The Impact of Medically Tailored Meals." 2018. https://www.servings.org/wp-content/uploads/2018/06/MTM_Community-Servings-Final_Web-Friendly.pdf

in San Diego cover up to 40 percent of service costs for Project 25 clients, and the program receives additional funding from the Substance Abuse and Mental Health Services Administration.[3]

Health Plan of San Mateo's Housing Program

The Health Plan of San Mateo developed the Community Care Settings Program to help members transition out of institutions to the community and avoid unnecessary institutionalizations. Members receive intense case management, housing assistance services, and medical care. The plan partnered with a care management agency and a housing agency to create the program, which also leverages the plan's relationships with other organizations in San Mateo County, including: affordable supportive housing providers; county agencies; hospital and nursing facility discharge planners and social workers; and a network of community Residential Care Facilities for the Elderly. Health Plan of San Mateo uses various funding sources to operate the program, including a Money Follows the Person grant, state waiver programs, and the health plan's own reserves.[4]

CalOptima and Inland Empire Health Plan Programs on Housing Instability

CalOptima and Inland Empire Health Plan recognized the need to develop a discharge plan that addresses housing instability and ongoing medical oversight for their high-need members. Both of these ACAP MMPs partnered with the Illumination Foundation, an organization that provides recuperative care (i.e., a combination of interim housing, integrated medical oversight, interdisciplinary case management, and targeted support to identify housing options) for homeless individuals in southern California. The Illumination Foundation found that providing recuperative care and connecting beneficiaries to housing has reduced hospital readmissions by 50 percent and lowered the daily cost of care by 90 percent for homeless members participating in the program.[5]

L.A Care's Intensive Case Management Services for Homeless Members

In a new pilot program, L.A. Care Health Plan awarded a grant to the Corporation for Supportive Housing to provide intensive case management services to its highest-need, highest-cost homeless members and link them to a large network of housing and social service resources to reduce readmission rates. This program meets a significant need: in Los Angeles County, the top

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[3] Center for Health Care Strategies, Inc. "ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons." June 2016. http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Medicare-Medicaid%20Plans%20and%20the%20Financial%20Alignment%20Demonstrations.pdf
[4] Center for Health Care Strategies, Inc. "ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons." June 2016. http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Medicare-Medicaid%20Plans%20and%20the%20Financial%20Alignment%20Demonstrations.pdf
[5] Center for Health Care Strategies, Inc. "ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons." June 2016. http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Medicare-Medicaid%20Plans%20and%20the%20Financial%20Alignment%20Demonstrations.pdf

10 percent of highest-need homeless individuals account for 72 percent of homeless health care spending. L.A. Care hopes that the two-year pilot program can be replicated to target its approximately 20,000 homeless Medi-Cal members. [6]

UPMC's Housing Initiative

Since 2010, UPMC *for You*, located in Pennsylvania, has partnered with Community Human Services, a local contractor with the U.S. Department of Housing and Urban Development (HUD), to create the Cultivating Health for Success (CHFS) program. This program provides permanent housing, a patient-centered medical home, and case management and care coordination to their homeless beneficiaries, which are estimated to be approximately 40 to 50 of their Medicaid and Special Needs Plan members. Coordination of care was problematic prior to this program due to lengthy housing waiting list and access to quality resources. To qualify for the program, beneficiaries must be defined as homeless by HUD, have a medical disability, enrolled in the plan's Medicaid or SNP program, and have at least one year of health care expenditures. Beneficiaries of the program receive a secure living environment with social supports, coordinated medical care, in-home assistance with daily living activities, medical monitoring, and basic life skills training.

Evidence on quality outcomes and the total cost of care

ACAP-member plans have found that services for social risk factors improve quality and reduce the cost of care. As stated above, CCA developed a program on medically tailored meals. CCA was also able to conduct an evaluation of the program. In collaboration with Massachusetts General Hospital, CCA evaluated the impact of the medically tailored meals on emergency department visits and hospital admissions. The analysis showed that beneficiaries receiving the medically tailored meals had approximately 1.5 fewer emergency department visits, 0.3 fewer inpatient admissions, and 1.14 fewer uses of emergency transportation.[7]

UPMC has also found positive outcomes from their housing initiative (described above). The program reduced cost and resolved several housing issues for their beneficiaries. Within the first five years of establishment, 51 to 60 members were securely housed, and the stable housing and coordinate case management saved $6,384 for each housed member. CHFS had fewer unplanned claims compared to members within the U.S. Department of Housing and Urban Development (HUD).[8] Savings also increased for members after being stably housed for ten months. Visits to primary care providers and specialists also increased and results suggest that medication adherence improved. Due to the success of the program, UPMC is planning to expand their program in order to provide these services to housing insecure beneficiaries that

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[6] Center for Health Care Strategies, Inc. "ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons." June 2016. http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Medicare-Medicaid%20Plans%20and%20the%20Financial%20Alignment%20Demonstrations.pdf

[7] American Journal of Managed Care. "Home-Delivered Meals Keep Medicare, Medicaid Population Out of ED, Lower Costs." April 2018. www.ajmc.com/newsroom/homedelivered-meals-keep-medicare-medicaid-population-out-of-ed-lower-costs.

[8] UPMC Health Plan. Department of Health Economics HUD Initiative Analysis. May 2017.

do not meet HUD's definition of homeless (i.e., beneficiaries living on friend's couch). Although different funding would be required, the infrastructure of the program would remain the same.

<u>Disentangling beneficiaries' social and medical risks and address each</u>

ACAP-member plans have found that, for the dual-eligible population, the social and medical risks can be inseparable. Plans assess for both social and medical needs during assessments and when care managers are working with beneficiaries on their plan of care. In some instances, beneficiaries prioritize their social needs over their medical needs and want to work with care managers on their social needs first.

Social risks – such as inadequate housing, food insecurity, and social isolation – often have a direct impact on beneficiaries' medical risks. When necessary, plans address beneficiaries' social needs first and then work with beneficiaries on their medical risks after their social risks are addressed. Sometimes, addressing a social risk has a direct, positive impact on a beneficiary's medical risk. For example, diabetes can be better controlled when a beneficiary has access to adequate and stable housing, healthy food, a refrigerator, and electricity. Working with beneficiaries on their social needs first also helps to establish trust between the beneficiary and the health plan. Plans have found that establishing trust and a relationship with beneficiaries is particularly important for the dual-eligible population that tends to have experienced poor and fragmented care prior to joining the health plan.

Conclusion

ACAP is prepared to assist with additional information, if needed. If you have any questions, please do not hesitate to contact Christine Aguiar Lynch at (202) 204-7519 or clynch@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer

November 16, 2018

Brenda Destro, MSW, Ph.D
Deputy Assistant Secretary for Planning and Evaluation
Office of Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
ASPEImpactStudy@hhs.gov

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

Dear Dr. Destro:

The Association of American Medical Colleges (AAMC or Association) welcomes this
opportunity to comment on the Office of the Assistant Secretary for Planning and Evaluation
(ASPE) Request for Information on provider and health plan approaches to improve care for
Medicare beneficiaries with social risk factors (SRF).

The AAMC is a not-for-profit association dedicated to transforming health care through
innovative medical education, cutting-edge patient care, and groundbreaking medical research.
Its members are all 152 accredited U.S. and 17 accredited Canadian medical schools; nearly 400
major teaching hospitals and health systems, including 51 Department of Veterans Affairs
medical centers; and more than 80 academic societies. Through these institutions and
organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals
and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000
resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the
biomedical sciences.

The AAMC appreciates ASPE's work on identifying SRFs that play a major role in health. We
commend ASPE for its use of the definition of SRF provided by the National Academy of
Science, Engineering, and Medicine (NASEM), which includes: 1) socioeconomic position; 2)
race, ethnicity, and community context; 3) gender (gender identity and sexual orientation); 4)
social relationships (marital/partnership status, social support); and 5) residential and community
context (housing, social environment). We applaud ASPE for recognizing that the term gender
captures social dimensions of gender and encompasses both cis- and transgender identities.

The Association supports efforts to reduce inequities in care and to improve quality, care
coordination, and access to services for vulnerable populations. Accounting for risk factors in

ways that isolate inequitable differences in measured quality can raise awareness and lead to the development of interventions that reduce disparities and improve quality and efficiency. It can also improve accuracy in reporting and compensating providers fairly. Academic medical centers (AMCs) provide a disproportionate share of care to vulnerable patients. AAMC teaching hospital members represent only 5% of all hospitals yet provide 31% of all hospital charity care and treat 25% of all Medicaid hospitalizations, as well as a disproportionate share of community services, often at a financial loss. AMCs also provide highly specialized services for entire regions of the country and receive transfers from other hospitals that cannot care for patients with complex clinical and social needs.

Many of our members have been collecting data on social risk factors for the patients and communities they serve and have been leaders in developing innovative programs to improve care for patients and promote community health and health equity. These comments are informed by the experiences of our members.

DATA: CAPTURING MEDICARE BENEFICIARIES' SOCIAL RISK

ASPE requests information on how providers currently capture beneficiaries' risk. Specific feedback is also solicited on which SRFs are most important to capture, who collects the data, and whether standardized data elements for electronic health records (EHRs) might help to collect SRF data.

It is important to capture social risk factors at both the individual patient-level and the community-level as both sets (and their interactions) have independent effects on health and health care outcomes. The County Health Rankings model, which was developed collaboratively by the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, helps to explain the many factors that influence health and its use should be considered in an approach to improving health in the community.[1]

Individual-level factors include characteristics such as education, race, income, gender, disability status, level of social support, etc. Complementary community-level factors that impact health outcomes include aspects of both the physical environment (e.g., housing, walkability, transportation options, air quality, and proximity to services) as well as the social environment (e.g., safety and violence, social disorder, and presence of social organizations). A community's compositional characteristics may also include dimensions of income, poverty, educational attainment, and employment and the proportion of racial/ethnic minority residents, single parent households, or English language proficient residents.

The health/healthcare outcome must be considered in order to determine which individual- and community-level SRFs should be collected to inform local interventions, as well as national quality measurement and risk adjustment schemes. For example, an environmental factor like

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[1] 2018 County Health Rankings Key Findings Report, Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute (March 2018) (http://www.countyhealthrankings.org/explore-health-rankings/reports)

poor air quality might significantly impact the risk of pneumonia readmissions but have minimal influence on hip replacement readmissions.

Thus, while the national standardization of a select number of "the most relevant" SRFs is an important measurement and policy goal, we do not yet know which patient- and community-level factors "explain" the most variance for the most health/healthcare outcomes. **We urge ASPE to support research that will identify which SRFs, and interactions between them, explain the most variance for the most healthcare outcomes.**

We similarly urge ASPE <u>not to rely</u> solely on the data elements that are currently feasible and available. This will likely limit options to two: Medicare and Medicaid dual eligibility status (DE) and Black race as stand-ins for all SRFs, patient- and community-level alike. Given that race and DE are both correlated with SRFs that directly impact health and healthcare outcomes, their use as proxies neither helps us isolate true inequities in quality nor identifies intervention points to address such quality gaps.

<u>Who/How/When to Collect Data</u>

ASPE solicits feedback on who should collect SRF data and the best approach to collecting this information. The most appropriate data collection methodology will vary by the group being assessed. Primary care physicians (PCPs), registered nurses (RNs), or community health workers (CHWs) could be responsible for collecting the data, depending on the patient. In other instances, data collection could occur using a patient portal, either at home or in a waiting room. **We recommend that further research be conducted to determine which data collection modality (e.g. PCP, RN, CHW, portal, other) provides the most accurate social risk data for specific population groups.**

Community members, patients and families, and health system staff are the main stakeholders likely involved in SRF data collection and should be part of the research dialogue. Active engagement from each of these stakeholder groups is essential to learn how to collect SRF data in the most valid way and how best to use SRF data once available.

To identify community health priorities and salient SRFs, we suggest ASPE turn to the methodologies developed and deployed in service of non-profit hospitals' and public health departments' formal community health needs assessments (CHNAs). These publicly available documents will not only provide ASPE with a variety of approaches used by hospitals to define "community", they also present an array of qualitative and quantitative SRF data collection methodologies. Further, a national review of CHNAs can focus ASPE on the handful of health conditions and social determinants deemed most important by the American people as ASPE works to identify the "most important" SRFs to collect and potentially standardize.

When engaging patients in developing patient-centered SRF data collection methods, the following questions might be considered: 1) how patients will feel about the specific questions being asked; 2) what is the best process for getting valid data from patients; 3) how would patients prefer to be asked questions and by whom; and 4) and how can the patient's data be shared between institutions who may use different EHR vendors.

For health system stakeholders, it is important to address: 1) who is going to ask the questions; 2) what training is needed; and 3) how the collection processes can be standardized across systems or will different processes work best in different systems.

In addition to research aimed at developing data collection methods, **we urge ASPE to support research on how health systems and communities can translate SRF data collection into action**. Potential research questions include: 1) how is SRF-related information reported back to patients and families?; 2) how is the information used to improve care for patients?: 3) how can patient-specific SRF data be used in conjunction with population/community level data to identify the best treatments and local resources; and 4) how can the information be used to expand care beyond clinical care.[2] These issues are discussed more fully in the following section.

DELIVERY OF SERVICES AND IDENTIFICATION OF BENEFICIARIES WITH SOCIAL RISK FACTORS

ASPE is interested in understanding how beneficiaries with social risk factors are identified and services targeted to Medicare beneficiaries with social risk factors.

Hospitals and health systems are deeply investing in identifying **both patients with social risk and communities of social risk.**

Physician and health care professionals' notes contain valuable information on social risk factors. Hospitals are using automated methods for analyzing these notes within EHRs along with billing codes and other data contained in the EHR to identify patients with social risk factors. Increasingly, hospitals are also using tools to screen patients for a range of health-related social needs (e.g. housing, food insecurity, safety, transportation discounts). Hospitals use this information to form a "social needs" snapshot of patients and their community.

Since 2010, nonprofit hospitals and health systems, including teaching hospitals, have been required to conduct a triennial community health needs assessment (CHNA) that identifies and prioritizes local health needs. Each hospital must make the CHNA widely available to the public and develop an implementation strategy (IS) that describes how the hospital will address selected health needs.

The results of a recent qualitative review of nearly 100 CHNA/IS pairs from academic medical centers nationwide showed that (1) considered together, the social determinants of health (SDOH) were the 5th most prioritized community health need, and (2) food access, social support, and poverty were the top three social factors teaching hospitals targeted. [3]

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[2] RoCCHe: Moving EHRs Upstream Meeting. AAMC Health Equity Research and Policy. June 18, 2015 Available at https://www.aamc.org/download/437592/data/rocchemeetingreport.pdf
[3] Teaching Hospitals' Commitment to Addressing Social Determinants of Health, AAMC, https://www.aamc.org/download/480618/data/aamc-teaching-hospitals-addressing-sdoh.pdf

Below are select examples of how teaching hospitals are addressing social determinants of health.[4]

Food Access:
- Hospitals are using hospital food "prescription programs" to connect patients to healthier food options.
- Hospitals are creating "Veggies in the Backpack" programs for school-aged children to bring home fresh vegetables.

Poverty:
- Hospitals are launching job creation programs for the underserved and patients with mental illness.
- Hospitals are increasing efforts to hire individuals from surrounding low-income areas.

Transportation:

- Hospitals are creating partnerships with taxi services to provide medical transport services at no cost for patients.
- Hospitals are providing vans to transport chronically ill and elderly patients to and from medical appointments.

Social Support:
- Hospitals are using SDOH screening tools to identify and address unmet social needs in a clinical setting, including social isolation.

Education:
- Hospitals are creating programs for kindergarten and college readiness.
- Hospitals are using telemedicine to reduce school absences by connecting schools and pediatricians.

Housing:
- Hospitals are creating medical respite programs to provide recuperative care for homeless men and women who are too sick to return to a shelter or the streets.
- Hospitals are employing housing retention specialists to work with patients and assess potential barriers to maintaining stable housing.

As discussed previously, caring for people with complex medical and social needs requires an approach that recognizes non-medical factors such as housing, transportation, food insecurity, and social supports. **To help address these underlying needs, many hospitals have broadened their health care teams to include community health workers (CHW) and, through Medical-Legal Partnerships (MLP), lawyers.**

Community health workers link health/social services and the community to facilitate access to services and improve the quality of service delivery. By serving as a liaison between communities and health care agencies, CHWs can help avoid unnecessary hospitalizations; enhance residents' ability to effectively communicate with health care providers; provide health and nutrition education; coordinate follow-up services; and proactively identify and enroll

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[4] Teaching Hospitals' Commitment to Addressing Social Determinants of Health, AAMC, https://www.aamc.org/download/480618/data/aamc-teaching-hospitals-addressing-sdoh.pdf

eligible individuals in federal, state and local private or nonprofit health and human services program.[5, 6]

Many complex health-related social problems such as poor housing conditions and unlawful denial of health/social-related benefits are beyond the scope of a health care provider and require legal expertise to address. Attorneys can be embedded as specialists in a health care setting to resolve specific problems for patients while also helping clinical and non-clinical staff navigate system and policy barriers. Early results of a forthcoming, CDC-funded evaluation (analyses available upon request) of the MLP model has demonstrated not only significant "cost avoidance" post-MLP intervention, but also marked improvement in screening and referral behaviors by trainees exposed to MLP, and improved self-efficacy and empowerment of families post MLP intervention.[7]

As ASPE examines solutions to disparities, we recommend a review of the work of *Finding Answers: Solving Disparities Through Payment and Delivery System Reform (Finding Answers)*, a national program of the Robert Wood Johnson Foundation that has been a leader in implementing solutions to disparities.[8] From 2005-2013 the program team produced 12 systematic reviews of the literature and awarded 33 grants to health care organizations with innovative interventions to identify best practices for reducing racial and ethnic disparities in care and outcomes. Based on the findings, they created the Roadmap to Disparities (Roadmap)[9] that includes best practices and guidelines for health care organizations and policymakers to address disparities through quality improvement efforts.

In addition, we recommend ASPE examine the activities of organizations participating in the Accountable Health Communities Model funded by the Centers for Medicare and Medicaid Innovation Center. This model, which began in 2017, is testing whether systematically identifying and addressing beneficiaries' social needs impacts total health care costs and reduces inpatient and outpatient utilization. Organizations in the model identify and partner with clinical delivery sites (e.g. physicians, hospitals) to conduct screenings of beneficiaries and make referrals to community services to address health related needs, and coordinate and connect high-risk community-dwelling beneficiaries to community services providers.

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[5] CDC. Integrating Community Health Workers on Clinical Care Teams and in the Community. Centers for Disease Control and Prevention (2018).

[6] Scott K, Beckham S, Gross M, et al. What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Human resources for health.* (2018).

[7] www.aamc.org/AHEAD

[8] Robert Wood Johnson Foundation. Finding Answers: Solving Disparities Through Payment and Delivery System Reform Available at
www.solvingdisparities.org/sites/default/files/Lessons%20Learned%20Web%20PDF%2009_25_2018b.pdf.

[9] Robert Wood Johnson Foundation. Roadmap to Reduce Disparities, Available at
http://solvingdisparities.bytrilogy.com/tools/roadmap

BARRIERS AND OPPORTUNITIES

ASPE requests feedback on the barriers that exist to collecting data about social risk and improving care for Medicare beneficiaries with social risk factors, and how these barriers can be overcome.

One key barrier is the lack of trust between patients/communities and the health care system. To collect data on social risk, to develop interventions, to implement changes, and to evaluate the impact of these changes requires patient- and community-engagement. Without authentic, bidirectional trust, this meaningful engagement cannot occur, imperiling the validity of data collected and undermining the effectiveness of interventions.

Another barrier is the lack of infrastructure and resources needed to promote health equity. Most health systems do not have the infrastructure, staffing, evaluation expertise, or financial incentive to develop comprehensive screening and referral protocols, community health coordination functions, data stratification and analyses, or robust, multi-sector relationships needed to address their patients' health-related social needs. Community based organizations often bring even fewer resources to the table.

To address this barrier, payment models could be designed that promote quality and financially support the development of equity-promoting structures. CMS' recent distribution of "healthcare disparities reports" that stratify pneumonia readmission rates by dual eligibility (DE) status is an important first step in terms of raising awareness, but the reports' reliance on DE status as an SRF proxy undermines both the isolation of true quality inequities and fails to suggest intervention points.

Instead, value-based payment models could encourage health care providers to prioritize disparities reduction if they (1) reward the minimizing or eradication of hospital-specific inequities over time and (2) reward hospitals for developing the data and human capacity to better identify, understand, and intervene on local healthcare disparities. Providing accurate feedback on provider performance related to disparities is also important to motivate change.

Support to promote best practices for achieving equity could be provided through several additional approaches. For example, payers could make capitated payments to institutions to promote services for at risk populations. Goals that focus on equity, such as increasing screenings in under-screened populations, in field treatment of at-risk patients, coordinating patient care, and follow-up patient care in certain counties could be established and providers could be rewarded with incentive payments for achieving these goals. Payers could provide reimbursement to providers for stratifying EMR data by social at-risk status. Patient navigators, CHWs and MLP lawyers (especially those who enhance the health system's language congruency) can also have a significant impact if their positions are adequately funded.
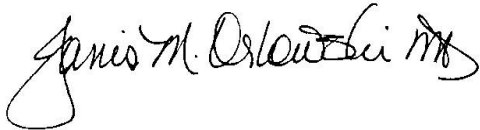
CONCLUSION

Thank you for the opportunity to provide comments on provider approaches to improve care for Medicare beneficiaries with social risk factors. We are committed to reducing disparities and

improving quality of care for patients. If you have additional questions, please contact Philip M. Alberti, Ph.D, Senior Director, Health Equity Research and Policy at palberti@aamc.org or Gayle Lee, Director Physician Payment Policy and Quality at galee@aamc.org.

Sincerely,

Janis M. Orlowski, MD, MACP
Chief Health Care Officer

cc: Philip Alberti
cc: Gayle Lee
cc: Ivy Baer

To whom it may concern,

Attached, please find Benefits Data Trust's response to the Office of the Assistant Secretary for Planning and Evaluation's Request for Information on social risk factors and Medicare's value-based purchasing programs.

In the memo, we provide examples of successful ways plans, providers and partners can identify and address the needs of beneficiaries with social risk factors. The two research studies referenced in our memo are also attached to this e-mail and provide strong evidence regarding the positive impact interventions have had on quality outcomes and care costs among dual eligibles.

Thank you for the opportunity to provide input on this important topic. We welcome any questions you may have about our work or the research that it supports it.

Regards,

Jessica Maneely
Policy Coordinator
Centre Square West
1500 Market Street, Suite 2800
Philadelphia, PA 19102
215.207.9156
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November 16, 2018

Office of the Assistant Secretary for Planning and Evaluation
Room 415F
US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Better Medicare Alliance Response to Request for Information on IMPACT Act Research Study: Provider and Health Plan Approaches to Improving Care for Medicare Beneficiaries with Social Risk Factors

Submitted Electronically to ASPEImpactStudy@hhs.gov

Good afternoon.

Better Medicare Alliance (BMA) is pleased to submit this response to the request for information (RFI) on ASPE's research on approaches to improving care for Medicare beneficiaries with social risk factors. We applaud the Administration ongoing efforts to explore efforts to address social risk factors and improve the health of Medicare beneficiaries. BMA believes that the experience of Medicare Advantage health plans and providers will help to inform ASPE's forthcoming report and continuing work in this area.

Medicare Advantage health plans have led the health care system in the shift to value-based payment and care delivery and away from a fragmented fee-for-service (FFS) system. In the most recent report published by the Health Care Payment Learning and Action Network (the "LAN"), half off all Medicare Advantage payments to providers are in some type of shared risk or capitated model. By comparison, 38 percent of FFS Medicare and 28 percent of commercial payments are value-based.[1] Moreover, Medicare Advantage health plans have flexibility not available in FFS Medicare to tailor benefit packages and target items and services to those with the greatest needs, often those with multiple social risk factors. In the attached White Paper, we outline several examples of Medicare Advantage health plans partnering with providers and community-based organizations to target specific social determinants of health, such as nutritional security, social isolation, and transportation.
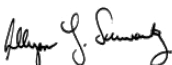
BMA believes that policymakers can take additional steps to expand upon the success of Medicare Advantage and ensure that progress is not slowed or stifled. In the attached White Paper, we outline five policy recommendations that would allow continued innovation in Medicare Advantage:

1. Expand the definition of allowable supplemental benefits to directly address social determinants of health.
2. Expand the new uniformity rule flexibility to Part D for integrated Medicare Advantage-Part D (MA-PD) plans.
3. Ensure the Medicare Advantage Star Rating System incorporates social determinants of health into the measurement of quality.
4. Account for social determinants of health in risk adjustment.
5. Provide flexibility in Medicare Advantage payment and coverage.

In addition, we have been engaged most recently in conversations about the importance of identifying and addressing functional impairments, as a particular aspect of social risk factors that have a significant and direct impact on health outcomes. We hope to pursue this area in the months ahead and would welcome the opportunity to talk further with you on this issue.

Thank you for the opportunity to provide feedback to this RFI. Should you wish to discuss issues raised in this letter and the attached White Paper, or other relevant issues , please contact James Michel at jmichel@bettermedicarealliance.org or (202)853-3900.

Sincerely,

Allyson Y. Schwartz
President & CEO
Better Medicare Alliance

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[1] Health Care Payment Learning & Action Network. Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Medicare Fee-for-Service Programs. October 22, 2018.

BETTER MEDICARE ALLIANCE

Addressing Social Determinants of Health for Beneficiaries in Medicare Advantage

WHITE PAPER NOVEMBER 2018

TABLE OF CONTENTS:

I. Overview

Social determinants of health are the conditions in which people live, work, and age that impact their health.[1] They include factors such as socioeconomic status, access to health services, and the social and physical environment.[2] Increasingly, health care payers, such as Medicare and Medicaid, are interested in more holistic care for beneficiaries by directly addressing their social determinants of health with the goal of improving health outcomes while reducing unnecessary health care utilization. This White Paper explores social determinants of health, discusses the challenges of addressing social determinants in Medicare, and provides examples of how Medicare Advantage health plans are working to directly address social determinants of health. This White Paper also recommends actions policymakers can take to improve the ability of Medicare Advantage health plans to more directly address social determinants of health to improve patients' health outcomes.

POLICY RECOMMENDATIONS:

1. Expand the definition of allowable supplemental benefits to directly address social determinants of health.

2. Expand Medicare Advantage Value-Based Insurance Design (V-BID) to Part D for integrated Medicare Advantage-Part D (MA-PD Health Plans).

3. Ensure the Star Rating System incorporates social determinants of health.

4. Include social determinants of health in risk adjustment.

5. Provide flexibility in Medicare Advantage payment and coverage.

II. Background

Social Determinants of Health

Although U.S. health care spending is the highest in the world, life expectancy is shorter than any other industrialized nation.[3] Improving health care outcomes and lowering costs requires the coordination of resources to attend to social determinants of health. These social, economic and environmental factors impact the availability of resources to meet people's non-medical and medical needs.[4]

The move to value in health care, which includes risk-assumption for the provision and cost of care for individuals over a period of time, is placing greater attention on health status beyond the outcome of specific episodes of care. Responsibility and accountability for the cost and health status of individuals or populations is incentivizing stakeholders to address barriers to care in order to improve health status and health outcomes. Increasingly health plans and providers are partnering with community-based organizations and private companies to address social and economic barriers to health that can include unsafe housing, food insecurity, and a lack of access to social services and supports that are known to contribute to the health status of individuals and communities. Key social determinants of health are outlined in Figure 1.

FIGURE 1

Key Social Determinants of Health					
Safety in the Home	**Food Insecurity**	**Lack of Access to Transportation**	**Utility Needs**	**Lack of Family and Social Support**	**Lack of Income**
Having difficulty paying rent or affording a place of one's own, living in unsafe conditions	No reliable access to enough affordable, nutritious food	No affordable and reliable ways to get to medical appointments or purchase healthy food	Not able to regularly pay utility bills	No relationships that provide interaction and nurturing	Lack of ability to get needed income to cover expenses

Source: Deloitte Center for Health Solutions, https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/addressing-social-determinants-of-health-hospitals-survey.html

Social determinants of health can be divided into social and physical environmental factors. The social environment is comprised of the institutions, norms, patterns, and processes that influence individual's health such as poverty, social isolation and health behaviors. The physical environment is comprised of the air, water and soil in the natural environment, and the human-made living and working built environments that impact an individual's health.[5] The social and physical environment reinforce each other over time and factors such as low income, unsafe communities, and inaccessible public transit impact the health of individuals and communities down to the zip code.[6]

As Figure 2 illustrates, clinical care is estimated to account for approximately 20 percent of the health outcomes of a population, and the other 80 percent of health contributors are social determinants of health, including health behaviors, social and economic factors and physical environment. Social determinants contribute to individuals length and quality of life.[7] Despite the fact that the largest drivers of health care costs fall outside of the clinical setting, the U.S. spends more on health care than social services.[8] Illustrating the imbalance between investments in clinical care and social determinants of health, approximately 95 percent of the trillions spent on health care in the U.S. go directly to medical services.[9] In spite of these investments in clinical care, an estimated 40 percent of deaths are caused by behavioral patterns.[10]

FIGURE 2

Source: County Health Rankings & Roadmaps, County Health Rankings & Roadmaps, http://www.countyhealthrankings.org/our-approach.
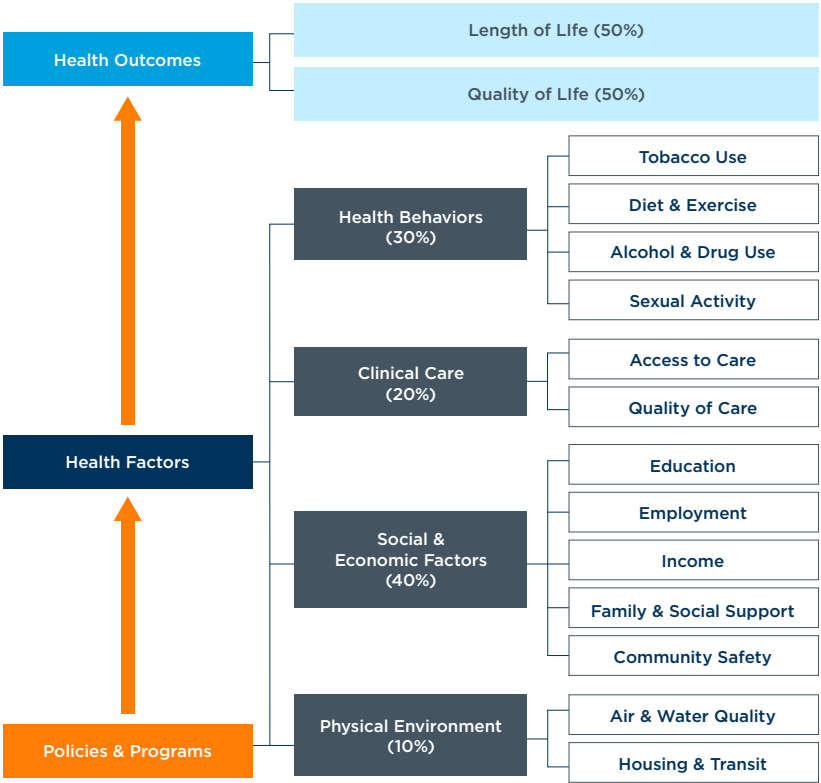
As the CEO and chairman of Aetna said, "Your ZIP code has more to do with your health status than your genetic code."

Social Determinants of Health and Medicare Advantage

Medicare is the largest health care payer in the U.S., with costs projected to be approximately 5% of the total economy by 2048.[11,12] If policymakers hope to bend this cost curve and extend the life of the Medicare program, it will be critical to directly address social determinants of health, particularly for beneficiaries with multiple chronic conditions.[13] Studies have shown the neighborhood a Medicare beneficiary lives in is a significant predictor of functional limitations associated with multiple chronic conditions that lead to worse health outcomes.[14]

Medicare traditionally has not paid for supports and services that directly address social risk factors. Medicaid, on the other hand, provides some home- and community-based services, though services and coverage policies vary widely by state for Medicaid-eligible Medicare beneficiaries. In addition, those who are eligible for Medicare due to disability may have access to additional support services. However, for most seniors on Medicare, the historic disconnect between clinical care for medical needs and the services that address factors impacting health outcomes has led to inadequate investments in efforts to attend to social determinants of health, leaving risk factors unaddressed, even when they are recognized.

Conversely, Medicare Advantage, the integrated care option in Medicare whereby Medicare benefits are administered by private health plans, is increasingly delivering value-based care that includes efforts to meet patients' social and clinical needs. Medicare Advantage and plans are structured in a way that ties quality and cost to performance, establishing a rationale for increased attention to identification and intervention in order to address social risk factors that impact health. Value-based payment arrangements in Medicare Advantage facilitate effective partnerships between health plans, medical providers, and social services to integrate clinical care into a broader care model that improves population health outcomes.

Unlike Traditional Fee-For-Service (FFS) Medicare, Medicare Advantage provides an integrated care system through networks of providers, offers chronic disease management programs not available in FFS Medicare, and has strong incentives to focus on primary care and care management. Providers are increasingly held accountable for the health outcomes of patients. As a result primary care teams are at the center of care, incentivized to attend to gaps in care important to improving health status. Medicare Advantage health plans are transforming Medicare by facilitating coordination between providers and multi-sector partners to develop and implement new ways to address social determinants of health.

While Medicare Advantage health plans have more flexibility to address social determinants than FFS Medicare, comprehensive change requires fundamental cultural shifts throughout the health system, including in the way health care is paid for and how it is organized. Progress towards greater coverage of services needed to meet social determinants is being made due to recent regulatory and legislative changes to allowable Medicare Advantage supplemental benefits. These changes are expected to result in the expansion of programs to address social determinants in 2019 and 2020.

Social Determinants of Health and FFS Medicare

The fragmented nature of care in FFS Medicare leads to challenges in effectively addressing the complex social risk factors that influence a person's health and well-being. Recent policy changes, such as the addition of chronic care management payments, have illuminated the challenges of operationalizing more coordinated care in FFS Medicare. When the payments were first introduced in 2015, the Centers for Medicare & Medicaid Services (CMS) estimated 35 million Medicare beneficiaries were eligible, but nearly one year into the program, CMS had received only about 100,000 requests due to implementation challenges.[15]

Recognizing the challenge of addressing social determinants of health in FFS Medicare, CMS, through the Center for Medicare & Medicaid Innovation (CMMI), developed the Accountable Health Communities Model to provide funding for health care providers and community-based organizations to address gaps between clinical care and community services for Medicare and Medicaid beneficiaries through screening, referral and community navigation services. Over 30 organizations, ranging from county governments, to hospitals and universities are participating in the model. The demonstration began in May 2017 and will continue for five years. Therefore, results are not yet available for these clinical-community collaborations.[16]

Work is also being done to study ways to better account for social risk factors in Medicare payment. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 required the Secretary of Health and Human Services (HHS), through the Assistant Secretary for Planning and Evaluation (ASPE), to examine the effect of individual's socioeconomic status on Medicare. The studies examine the impact of social risk factors such as race, health literacy, and limited English proficiency on quality measures and payment.[17] To analyze social risk factors in Medicare, ASPE convened an expert panel through the National Academies of Sciences, Engineering, and Medicine. The first report was released in 2016, five reports have been released thus far, and a final report is due to Congress in October 2019.[18] Four goals of ASPE reports

1. Reducing disparities in access, quality, and outcomes;
2. Improving quality and efficient care delivery for all patients;
3. Fair and accurate reporting; and
4. Compensating health plans and providers fairly.[19]

The ASPE reports concluded that it is critical to account for social risk factors in Medicare payment to achieve health care equity. However, the reports acknowledged that accounting for social risk factors that influence performance in value-based payment models is complex. The ASPE reports identified four key categories to account for social risk factors in Medicare outlined in Figure 3. The reports further encourage the use of value-based payment models where providers are incentivized to take on risk to achieve better population health management and greater attention to quality and cost. The assumption is that when the provider or health plan is at financial risk, investments will be made to address social risk factors to improve patient outcomes. This has proven to be accurate as evidenced in Medicare Advantage.

FIGURE 3

Four Categories of Ways to Account for Social Risk Factors in Medicare from ASPE Reports:

1) Public data reporting

2) Adjustment of quality performance measure scores

3) Direct adjustment of payments

4) Restructuring payment incentive design

III. Medicare Advantage is Addressing Key Social Determinants of Health

Evidence shows that it is difficult to improve Medicare beneficiaries' health if social determinants such as housing instability, food insecurity and access to transportation are not addressed. Medicare spending is approximately $700 billion per year, and over half of that spending is driven by 15 percent of the sickest and highest-need beneficiaries.[20][21] Attending to social determinants of health is a high-value way to address the challenge of caring for the influx of baby boomers in Medicare with multiple chronic conditions and social risk factors.

Social determinants of health are often interconnected, as illustrated by the story below. Approximately 40 percent of high-need isolated adults have incomes below $15,000 per year, and 80 percent of those report worrying about having enough money to pay bills or afford healthy foods.[22] Studies outlined below show that addressing social determinants like nutritional needs, social isolation, home accessibility, and poor access to transportation improves beneficiaries' outcomes and lowers health care costs.

Medicare Beneficiary Story

Elizabeth is 94 and she lives in the same rural farmhouse in Maine she grew up in, where she raised her four children and cared for her own mother as she aged. Congestive heart failure, a stroke, and other health complications have left her homebound and largely confined to a recliner. Her family is spread out across the U.S., deceased, or estranged. With only a TV and phone to pass the time, Elizabeth is challenged by social risk factors such as a limited income, food insecurity and social isolation. Across the country Medicare beneficiaries like Elizabeth are struggling to have their health basic needs met as they age in place.

Nutritional Needs

Adequate nutrition plays a critical role in the health of Medicare beneficiaries. Older adults are at risk of malnutrition and can become more nutritionally vulnerable when recovering from a hospitalization. It is estimated that 50 percent of the seniors who enter the hospital are already malnourished when they arrive.[23] Seniors experiencing hunger are three times more likely to suffer from depression, 50 percent more likely to have diabetes, and 60 percent more likely to have congestive heart failure or a heart attack compared to their peers who do not experience hunger.[24]

Home-delivered meal programs have been found to improve diet quality and increase nutrient intake, while keeping older adults out of more expensive sites of care like the hospital and nursing homes.[25][26][27] In addition to fewer inpatient admissions, beneficiaries of food delivery programs reported fewer falls, and lower medical spending, illustrating the positive impact of nutritious food on health outcomes for vulnerable patients.[28]

Medicare Advantage is Addressing Nutritional Needs

Currently Medicare Advantage beneficiaries may receive nutritious meals post-surgery or hospitalization. Greg from Kentucky said his Medicare Advantage health plan provided him with food and follow-up contact after surgery and rehabilitation. Nutrition programs that would serve patients in other circumstances are also being developed through Medicare Advantage.

The Commonwealth Care Alliance (CCA), a not-for-profit, community-based healthcare organization based in Massachusetts recently participated in a study to expand access to nutritious meals. Dedicated to improving care for dually eligible beneficiaries in both Medicare and Medicaid, CCA has a Medicare Advantage Special Needs Plan called the Senior Care Options program. In a recent pilot, CCA provided beneficiaries with at least six months of continuous enrollment access to meal delivery programs. Each week beneficiaries received five days of nutritious lunches, dinners and snacks. The study found that emergency department visits significantly decreased among CCA beneficiaries who participated.

Social Isolation

A growing population of older adults is living alone, vulnerable to the negative health impacts of social isolation. Studies have shown socially isolated seniors incur higher Medicare spending and have increased risk of chronic disease and death.[29] Loneliness has health impacts similar to smoking, shortening a person's lifespan by an average of eight years.[30] The lack of social contact among older adults is associated with an estimated $6.7 billion in additional federal spending annually.[31] Risk factors that predict social isolation in Medicare beneficiaries include a lack of access to family support, a caregiver or a care coordinator. [32]

Medicare Advantage is Addressing Social Isolation

CareMore Health, an integrated care delivery system with over 150,000 Medicare, Medicaid and dual-eligible patients in 10 states, identifies high-need seniors who lack social support. CareMore works to diagnose and treat loneliness by making sure patients have access to free medical transportation and programs like exercise classes. The CareMore "Togetherness Program" assigns patients a togetherness pal for weekly phone calls to encourage preventive care to reduce patients need for health care services. As Thanksgiving approaches, CareMore staff even call seniors to see if they have a place to go and connect them with a community organization providing Thanksgiving dinner.

Home Accessibility

Every 11 seconds, an older adult is treated in an emergency department for a fall-related injury. Every 29 minutes, an older adult dies from a fall, leading to 27,000 deaths among older adults each year.[33] Treating fall-related injuries places a significant burden on the health care system, given that such injuries are among the most expensive medical conditions to treat. The average hospital cost for a fall injury is over $30,000, and the costs of treating fall injuries increases as seniors age. Currently, $31 billion of Medicare annual costs are related to falls each year, and this number is expected to rise to $67.7 billion by 2020.[34]

Evidence-based falls prevention programs like "A Matter of Balance" developed by the Centers for Disease Control and Prevention (CDC), as well as home accessibility modifications have been shown to reduce the risk of falls in older adults. Most falls prevention programs incorporate physical activity and fitness to improve balance, flexibility, coordination, muscle strength, and endurance. In addition to falls intervention programs, approximately 44 percent of households have some need for home accessibility features due to disability or difficulty navigating areas of the home.[35][36] Falls prevention programs and home modifications also help older adults remain in their homes safely for as long as possible.

Medicare Advantage is Improving Home Accessibility

Medicare Advantage health plans contract with community-based organizations and companies to provide falls prevention services. Research has shown Medicare Advantage beneficiaries with access to programs such as SilverSneakers report better emotional and physical health, with fewer limitations in activities of daily living to help keep people safe at home.

Greg, a Medicare Advantage beneficiary from Kentucky said he is an active user of SilverSneakers. He said the program has been particularly helpful with his hip issues following rehab. He said, "My plan has been quite useful!" In addition, Bonita, a Medicare Advantage beneficiary from Texas said SilverSneakers allows her to attend water aerobics and tai chi three to four times a week.

Access to Transportation

Providing non-emergency transportation for low-income populations has been shown to be a cost-effective way to improve life expectancy and quality of life.[37] Lack of accessible transportation inhibits beneficiaries' access to needed health care services. One study found 3.6 million Americans miss or delay non-emergency medical care due to a lack of transportation.[38] If just one percent of medical trips result in an avoided emergency department visit, the return on investment for a state would be $11.08 for each dollar invested in medical transportation.[39] The increased utilization of ride-sharing companies using private companies has shown promising results, with one study concluding that the market entry of Uber reduced the per capita ambulance volume by at least 7 percent.[40]

Medicare Advantage is Improving Access to Transportation

ChenMed has physician-led, integrated care medical centers that deliver high-quality health care for seniors who are Medicare Advantage beneficiaries. The ChenMed model provides patient-centered care by elevating primary care to increase access to services, enhance care coordination, and address social determinants of health. ChenMed makes preventive care as easy as possible to access by encouraging office visits and providing patients with transportation to and from ChenMed facilities. Door-to-doctor transportation ensures these physician practices can focus on high-touch care to address patients' needs.

IV. How Medicare Advantage is Able to Address Social Determinants of Health

Medicare Advantage is paid through a capitated system which puts health plans at-risk for the care and cost of each beneficiary enrolled in their plan. In addition, without additional payment, Medicare Advantage health plans are allowed to provide extra benefits not offered under FFS Medicare, such as hearing, dental and vision care, known as supplemental benefits. This integrated system of payment and flexibility enables and incentivizes Medicare Advantage health plans and providers to focus on primary care and early interventions, risk identification, and care management.
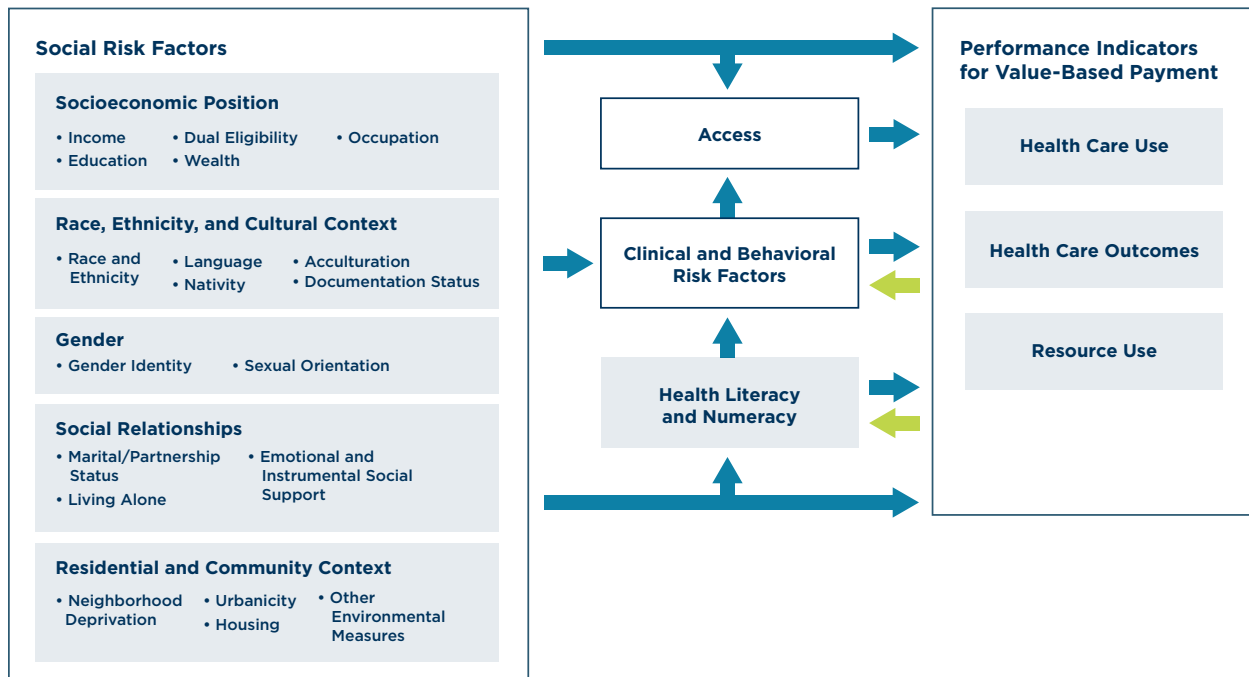
Medicare Advantage has been shown to encourage more use of preventive care, reduce hospitalizations and lengths of facility stays, and improve outcomes.[41] Moreover, Medicare Advantage has maximum out-of-pocket limits for beneficiaries, which are not available in FFS Medicare. By focusing on value-based payment arrangements, tailored benefit design and care coordination, Medicare Advantage is able to deliver a higher value at an affordable cost for beneficiaries. These key elements of Medicare Advantage provide a critical opportunity to address beneficiaries' social determinants of health.

Value-Based Payment Arrangements

Medicare Advantage, health plans offer innovative, value-based care delivery models to improve outcomes for beneficiaries. Medicare Advantage leads the transition to value-based care in Medicare, with more than 1 in 5 dollars paid through alternative payment models in 2016.[42] In fact, research has shown that Medicare Advantage achieves better health outcomes at comparable or lower costs compared to FFS Medicare for high-need Medicare beneficiaries and those with chronic conditions.[43] Medicare Advantage health plans play a critical role in facilitating value-based, risk assumption payment arrangements with providers through data analytics and risk stratification expertise, as well as access to community-based programs that can enhance health outcomes for beneficiaries.

Medicare Advantage is a capitated system in which health plans accept full financial risk for the provision of all Medicare benefits to enrollees. Research shows that Medicare Advantage is playing a crucial role as an incubator for innovative value-based care that improves quality and access, while reducing costs. Despite lower costs for chronically ill beneficiaries, Medicare Advantage substantially outperforms FFS Medicare on quality and outcomes measures.[44][45] Studies of provider and payer collaborations across the country have concluded that Medicare Advantage value-based contracting arrangements improve clinical outcomes and survival rates, while generating costs savings.[46][47] Value-based contracts inherently incentivize payers and providers to identify and address social determinants to improve beneficiaries' health. The interaction between social risk factors and Medicare value-based payment are illustrated in Figure 4. The figure shows value-based payment arrangements are impacted by beneficiaries' access, clinical and behavioral risk factors and health literacy.

FIGURE 4

Social Risk Factors

Socioeconomic Position
- Income
- Education
- Dual Eligibility
- Wealth
- Occupation

Race, Ethnicity, and Cultural Context
- Race and Ethnicity
- Language
- Nativity
- Acculturation
- Documentation Status

Gender
- Gender Identity
- Sexual Orientation

Social Relationships
- Marital/Partnership Status
- Living Alone
- Emotional and Instrumental Social Support

Residential and Community Context
- Neighborhood Deprivation
- Urbanicity
- Housing
- Other Environmental Measures

Access

Clinical and Behavioral Risk Factors

Health Literacy and Numeracy

Performance Indicators for Value-Based Payment

Health Care Use

Health Care Outcomes

Resource Use

The National Academies of Sciences, Engineering, Medicine, January 2017

The Star Rating System

Quality care in Medicare Advantage is measured and reported through a Star Rating System. The system plays a critical role in promoting quality, ensuring public accountability, and giving beneficiaries the tools to choose high-quality plans. The Star Rating System evaluates Medicare Advantage health plans on a 1-5 scale, with a 5-star rating indicating the highest quality. Performance is based on health plan and prescription drug specific measures.

Medicare Advantage health plans' star ratings are displayed on the Medicare Plan Finder, the government's online tool that allows consumers to search for high-quality health plans and compare cost and coverage information. Medicare Advantage health plans with at least 4 Stars receive quality bonus payments on the rebates. Rebates, along with quality bonuses, must be used to directly benefit beneficiaries. These payments are used to invest in supplemental benefits including home-based care, risk stratification to identify high-need patients, care management, wellness programs, and telemedicine as well as reduced cost sharing, dental, vision and hearing services for beneficiaries, all of which enhance the availability of services and play a role in identifying and addressing the social determinants of health.

The measure development process in the Star Rating System includes identifying measures, testing measures in a clinical setting, and ensuring the data collected is accurate and meaningful. CMS measures often undergo a stringent endorsement process spearheaded by the National Quality Forum (NQF) prior to program inclusion. NQF has endorsed 17

measures to account for social risk factors which include measuring family experience with care coordination and respondent education, discharge to community and marital status, 30-day unplanned readmissions for cancer patients and dual eligible status.[48] NQF has also recommended a three-year initiative to further examine socioeconomic status and other demographic factors. Established quality entities such as the National Committee for Quality Assurance and the Pharmacy Quality Alliance are examining ways to adjust measures to take social risk factors into account.

In recent years, stakeholders have expressed concerns that the Star Rating System does not accurately reflect the quality of care delivered by health plans serving a high proportion of dual-eligible beneficiaries and/or low-income enrollees. Several studies have found socio-demographically disadvantaged patients have worse outcomes on some quality measures that inform Star Ratings.[49][50] Additionally, ASPE reported that dual-eligible status was found to be one of the greatest predictors of poor health outcomes, leading to high health care needs and cost indicated by disability status, low income, and a lack of social supports.

To address this issue, CMS implemented an interim adjustment in the 2017 Star Ratings for dual-eligible, low-income, and disabled beneficiaries for certain Star Rating measures called the Categorical Adjustment Index (CAI). CMS will continue to apply the CAI in 2018 while it works with various federal agencies and stakeholders to develop a longer-term solution and collect better data on social risk factors. The CAI has resulted in small movements of Star Ratings. While CMS left the CAI adjustment unchanged in 2019, it's expected that the agency will revisit the adjustment in years to come.[51]

Risk Adjustment

The Federal government, through CMS, pays Medicare Advantage health plans a capitated monthly amount per enrolled beneficiary to provide all Medicare inpatient and outpatient benefits. To ensure these capitated payments accurately reflect the expected cost of providing health care to each beneficiary, CMS uses a process called "risk adjustment" to adjust payments based on the health status of each enrollee. Risk adjustment aims to accurately predict expected health care costs, encouraging plans to compete for beneficiaries based on price and quality, not health status. An accurate risk adjustment model ensures payments to Medicare Advantage plans adequately compensate for the costs of treating and managing both high- and low-cost individuals.

In 2017, CMS modified the current risk model to account for concerns that it underpredicted costs for lower-income beneficiaries. In response to these concerns, CMS evaluated how accurately the current community risk model predicted costs for full benefit, partial-benefit, and non-dually eligible beneficiaries. CMS determined that the 2014 community model under-predicted costs for full-benefit dual-eligible beneficiaries by 9 percent, while over-predicting costs for partial-benefit dual-eligible beneficiaries by 9 percent and non-dually eligible beneficiaries by 1.5 percent. The 2017 model changes satisfy the 21st Century Cures Act requirement for CMS to provide separate adjustments for dual-eligible beneficiaries. As a result of the model change, payments for full-benefit dual-eligible beneficiaries have increased.[52]

The 21st Century Cures Act also required CMS to evaluate the impact of certain diagnoses and the number of conditions to the risk adjustment model. For 2019, CMS will include additional adjustments for mental health, substance abuse, and chronic kidney disease diagnosis. In 2020, CMS will begin implementing the proposed "Payment Condition Count" model, which will account for the number of conditions a beneficiary has among those included in the payment model.

In the Announcement of Calendar Year 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, CMS stated the agency will continue to evaluate whether additional conditions or social determinants of health meet the requirements to be included in the risk adjustment model for future payment years.[53] As Medicare Advantage grows it will prove critical to gain a better understanding of how social determinants of health affect costs, and adjust payments accordingly.

Care Management

Care management is a team-based, patient-centered approach designed to assist patients in managing medical conditions more effectively. The financial framework of risk-based, capitated payments under Medicare Advantage offers the opportunity to improve care delivery through the provision of care management to better meet patient needs and improve outcomes. Successful Medicare Advantage-driven care management programs depend on access to real-time, robust data resources to identify high-need patients from integrated electronic health records and payer data.

Strong physician leadership and use of primary care teams of health professionals who work together to address the clinical and social needs of high-risk patients is key to successful risk intervention strategies. The literature on care management cites the importance of patient-centered rather than service-driven care. Other studies describe trust and continuity as foundational to effective care management. Finally, evaluations of successful care management programs emphasize the injustice of stakeholders' ability to effectively stratify patients' risk, using real-time data paired with flexibility in matching patient needs with appropriate interventions.[54]

According to CMS, Medicare Advantage health plans are in a unique position to see the individua's total care. Care management that coordinates both health care and social services can effectively address beneficiaries' social determinants of health. One study showed Medicare Advantage results in more appropriate use of ambulatory services and lower rates of avoidable hospitalizations and ER visits when compared to FFS Medicare. This difference is potentially a result of a focus on preventive services and care management.[55] Another study showed connecting Medicare Advantage beneficiaries with social services decreased medical costs by 10 percent.[56] Figure 5 provides a blueprint for effective care management that includes elements to address social determinants, such as identifying patients' needs and removing barriers to care.

FIGURE 5

VALUE BASED PAYMENT SYSTEM

Aligned incentives

Flexibility

Innovation

CULTURE OF CARE MANAGEMENT

Organization wide buy-in

Investments in infrastructure and personnel

Education and training

EFFECTIVE TEAMS

Communication

Transitions of Care

Clear roles and responsibilities

Continuity

Co-location of team members

Community presence and engagement

CUSTOMIZED CARE

Identify patient needs

Individual care plans

Removal of barriers

Risk Stratification

TRUST

Relationships

Top down and bottom up

Patient buy-in

Bright Spots in Care Management in Medicare Advantage, June 2017

Flexible Benefit Design & Expansion of Supplemental Benefits

Recent changes in Medicare Advantage policy offer additional opportunities for health plans to address social determinants, primarily through new flexibilities in benefit design. Building on the framework of the Medicare Advantage V-BID demonstration, CMS has reinterpreted what is known as the uniformity rule. The uniformity rule requires that Medicare Advantage health plans offer uniform benefits and cost-sharing to all enrollees in a given plan. However, beginning in 2019, health plans may target certain benefits to specific subsets of enrollees in the health plan, as long as the group of enrollees meet objective, measurable medical criteria. For example, a health plan may provide patients with diabetes access to low- or no-cost transportation and/or reduced or eliminated copays for visits to the endocrinologist. To comply with the uniformity rule, these targeted benefits must be offered to every enrollee with a similar diabetes diagnosis. These types of additional flexibilities are designed to enable Medicare Advantage health plans to implement innovative ways to eliminate barriers that prevent beneficiaries with chronic conditions from utilizing necessary, high-value care essential to treating their conditions and improving their health.

In addition to adding more flexibility in benefit design, CMS also expanded its definition of supplemental benefits starting in 2019. Medicare Advantage health plans currently may offer additional supplemental benefits beyond those covered under FFS Medicare. Common supplemental benefits offered by Medicare Advantage health plans include vision, dental, and hearing services, which are not covered by FFS Medicare. Almost all health plans offer one or more of these supplemental benefits, and over half offer all three

benefits.[57]   Recently, the definition of allowable Medicare Advantage supplemental benefits has been expanded to include services to address physical impairments, health conditions, and avoidable health care utilization. Allowable supplemental benefits may now include adult day care services, in-home support services, non-opioid pain management, home safety modifications, and transportation. However, supplemental benefits most be targeted to certain populations and still cannot target health care services based primarily on social determinants, like homelessness or food insecurity.[58 59 60]

These new benefits may include ride-hailing services, home visits, home renovations like grab bars and other accommodations to prevent falls, and home health aides.[61] Studies have shown potential savings of over $2,000 per beneficiary when social needs are met.[62] Areas where Medicare Advantage health plans are most likely to add supplemental benefits include housing modifications, transportation and in-home support of activities of daily living as a result of this new flexibility.

Additionally, the recent passage of provisions of the CHRONIC Care Act in the Bipartisan Budget Act of 2018 (BBA) provides CMS with additional authority to re-define supplemental benefits starting in 2020. Specifically, the BBA explicitly states that effective in 2020, supplemental benefits need not be "primarily health-related," potentially opening the door for health plans to offer additional benefits that directly address social determinants, possibly to include meal-delivery and services to address food insecurity or social isolation.

V. Recommendations for Action

1.   Expand the Definition of Allowable Supplemental Benefits to Directly Address Social Determinants of Health

Congress should encourage CMS to use the new authority provided by the BBA to allow supplemental benefits, starting in 2020, to directly address social determinants of health like food insecurity and social isolation.[63 64] Beginning in 2019, CMS is expanding the definition of "primarily health-related" to consider an item or service as primarily health related if it is used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and health care utilization. While this guidance is a step forward in enabling Medicare Advantage to provide services such as expanded care in the home, transportation, and health-related items and medications available without a prescription, CMS stated that supplemental benefits cannot target health care services based on social determinants. In 2020, CMS has the opportunity to enable health plans to better serve beneficiaries by attending to their social determinants of health.

2.   Expand V-BID to Part D for Integrated MA-PD Health Plans

CMS recognized the potential of V-BID strategies in Part C by recently reinterpreting the benefit uniformity requirements beginning in plan year 2019 but stopped short of enabling Medicare Advantage health plans to utilize the same V-BID flexibilities in Part D. Congress

should instruct CMS to leverage the success of V-BID strategies in Part D, particularly for integrated MA-PD health plans. V-BID has the potential to realize billions in cost savings, while improving treatment and outcomes, particularly for beneficiaries with multiple chronic conditions. Expanding V-BID to Part D for MA-PD health plans has the potential to realize cost savings for consumers, while improving quality across the health care system.

3.   Ensure Star Rating System Incorporates Social Determinants

Congress should ensure CMS continues to evaluate whether adjustments to the Star Rating System for social risk factors are appropriate and effective. Research has suggested that the Star Rating System does not accurately reflect the quality of care delivered by health plans serving a high proportion of dual-eligible beneficiaries and/or low-income enrollees.[65] To begin addressing this issue, in 2017 CMS implemented the CAI, an interim adjustment to overall and summary scores for dual-eligible, low-income, and disabled beneficiaries for certain Star Rating measures. CMS should continue to monitor and adjust the CAI to ensure the Star Rating System accurately incorporates needs based on social determinants of health.

4.   Evaluate Social Determinants in Risk Adjustment

Congress should ensure CMS continues to evaluate whether additional conditions or social determinants of health meet the requirements to be included in the risk adjustment model for future payment years. There are six main beneficiary subgroups in the community risk model, including individuals eligible for both Medicare and Medicaid, called dual-eligible beneficiaries. The community risk model adjusts health plan payment for dual-eligible beneficiaries. In recent years, CMS has found that the current risk model underpays Medicare Advantage health plans for dual-eligible beneficiaries. It's critical that the risk adjustment model is accurate and ensures that payments to Medicare Advantage health plans adequately anticipate the costs of treating and managing both high- and low-cost individuals.

5.   Provide Flexibility in Medicare Advantage Payment and Coverage

Medicare Advantage's capitated payments enable flexibility, culture of collaboration, and continuous learning to achieve evidence-based, enhanced protocols for chronic disease management. It also promotes the development of multidisciplinary teams, data-driven, and regular communication that is essential for care management. Providing flexibility in Medicare Advantage payment and coverage enables providers to treat patients at the most appropriate site of care. Increased flexibility would also allow health plans to offer additional benefits to ensure access to needed services, particularly for those with chronic conditions, and care management teams to offer additional options to address social determinants of health and improve health outcomes for at-risk populations.

Conclusion

Medicare Advantage is leading the way in addressing social determinants of health. Health plans are focusing on effective care management and innovative ways to meet patients' clinical and social needs, to improve health outcomes at lower costs, resulting in improved overall quality of life for beneficiaries. CMS is eliminating barriers to flexible benefit design and transforming supplemental benefits to include additional social supports and services, ultimately bridging broader health needs with clinical care to create the opportunity for a more holistic approach to health care for Medicare Advantage beneficiaries. CMS is also working to account for social determinants of health in the calculation of risk scores and Star Ratings, a major step towards a more holistic health care system.

As a result, this is a critical moment for Medicare Advantage, as health plans develop new innovations to attend to the social risk factors in the population of seniors and people with disabilities they care for. As Medicare Advantage continues to grow, it will be crucial that value-based payment arrangements, the Star Rating System, risk adjustment, care management, and flexible benefit design are optimized to address beneficiaries' social risk factors. It is essential that payments to health plans are both adequate and accurate by accounting for clinical and social determinants of health to ensure high quality, effective care for high-need enrollees. This will ensure resources are available to address social risk factors and will yield high-quality outcomes at a lower cost, particularly for chronically ill beneficiaries.

Health care alone cannot address all the social determinants of health that impact patient's outcomes. Yet, health care is a significant part of the solution. As evidence above shows, Medicare Advantage health plans, providers and community partners are working effectively to build healthier lives for Medicare beneficiaries. Greater attention to social determinants of health in Medicare Advantage can save money and improve health status and serve as an example for the entire U.S. health care system.

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November 16, 2018

U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

To Whom it May Concern,

BJC HealthCare ("BJC") represents fifteen acute care hospitals across the St. Louis metropolitan region, as well as part of mid and southeastern Missouri and southwest Illinois. Those hospitals range from large, urban teaching hospitals serving a disproportionate share of economically disadvantaged patients, to suburban community hospitals, to Critical Access Hospitals in rural areas. BJC's Center for Clinical Excellence is responsible for improving clinical quality and facilitating change throughout the organization. As such, BJC's Center for Clinical Excellence holds a broad view of the potential impacts of changes to the national health care landscape, and sincerely appreciates the opportunity to comment for the IMPACT Act Research Study.

BJC strongly supports the Department of Health and Human Services' ("HHS") interest in social determinants of health ("SDOH") and is encouraged by the thoughtful, deliberate approach to this complex area. We know that social determinants play an outsized role in our community's health and well-being and appreciate HHS's desire to spur change across the country. Having been actively engaged in addressing social determinants of health in our community for a number of years, we appreciate the opportunity to share our experience and provide commentary on a number of key points as HHS continues to evaluate its next steps.

Our comment is divided into the following sections:

1) Our experience in collecting and using data on social determinants of health
2) Capturing data on social determinants of health
3) Using data to impact social determinants of health and improve the health of our community

Experience with Social Determinants of Health

Social risk factors and their effect on health care, have been a substantial focus for BJC over the last few years. BJC is actively working to integrate social determinant of health data to support providers and communities in disparities elimination in a number of ways:

1) Targeting community health interventions: BJC personnel collaborated with the Missouri Hospital Association to develop the Missouri ZIP Health Rankings tool available via the Explore MO Health public online data platform that combines hospital and census-type data to map SDOH and outcomes at the ZIP code level

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for use by hospitals, foundations, public health organizations, and community organizations to identify high priority areas for interventions. These data as well as similar analyses conducted internally are being used in selected BJC markets to target interventions.

2) Standardized collection: BJC is in the process of standardizing SDOH collection across its hospitals and is involved in a regional collaborative of community health centers, hospital systems, public health, and social service agencies working to standardize SDOH collection regionally.

3) Quality reporting: BJC has introduced an equity domain into its enterprise-wide quality reporting scorecard and is beginning an internal peer learning network to support use of social risk factors data in projects using an equity lens.

Capturing SDOH

Throughout our experience in working with SDOH, the collection of actionable data has been a challenge. We have the following recommendations and key considerations for ASPE, which we will explain in more detail below:

1) Standardize fields for SDOH data: HHS should follow CMS' Accountable Health Communities ("AHC") model when considering which fields should be captured and used to better understand SDOH. We would recommend the establishment of a "minimum" data set using the AHC model as a framework.

2) Provide incentives for standardization: HHS should provide incentives for providers (through the Promoting EHR Interoperability Program) to implement standardized collection of SDOH data.

3) Capture SDOH data across the social safety net: HHS should explore opportunities to align SDOH data collection among health care providers, other community service providers (e.g. food banks), and other governmental agencies (e.g. U.S. Department of Agriculture). This would require incentives to support a robust data infrastructure for community-based organizations/non-profits and mechanisms to enforce standardization of data collection.

Standardize fields for SDOH data

BJC along with our partners in the St. Louis metropolitan region are strong supporters of the Accountable Health Communities demonstration program. Although our region is not participating in the CMS-sponsored initiative, we are continuing work to implement its components, specifically in capturing standardized fields.

The Accountable Health Communities model focuses on collecting data in the following subject areas:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs
- Interpersonal safety

We think capturing data in these areas is a great place to start. In addition to being comprehensive, many regions across the country are already working on standardized data collection for these fields. Leveraging existing work and research could significantly cut down on the implementation time for this effort.

We also would advocate that HHS examine coding practices and guidelines to ensure that SDOH data can be adequately captured by hospital and outpatient providers. Specifically, we would ask HHS to support guidance to ensure that ICD-10 coding can be consistently applied to capture patient responses to AHC or other SDOH screening tools.   We also would urge continued support for allowing coders to use data from non-physicians (e.g. care coordinators), including across all care settings and with new healthcare roles such as community health workers.

Provide incentives for standardization

In addition to identifying the appropriate fields for collection, it is important that healthcare (and other) providers are capturing the same information and in a similar manner. We think HHS can accomplish this goal by creating an incentive for capturing specific SDOH fields through the Promoting EHR Interoperability Program (formerly Meaningful Use).

Should SDOH data be used to compare hospital performance to one another, it is vital that data collection be standardized across the country. CMS is already using the Promoting Interoperability Program to standardize best practices for addressing the national opioid epidemic. We think a logical next step would be to use the program to help advance the important SDOH work.

We strongly support standardized data collection and using existing CMS payment programs to incentivize this work across the country.

Capture SDOH data across the social safety net

An important component of capturing relevant SDOH data is acknowledging the role of non-healthcare providers in the process. The data collection burden cannot be on hospitals alone. We know that patients with SDOH challenges encounter the social safety net at multiple points. It is important to gather information on patients' health and other risk factors throughout their interactions in order to paint a robust picture of their SDOH challenges. Having more comprehensive information would allow for better targeting of support services and interventions to improve health.

Much of this data could be collected via existing government programs and agencies (e.g. the U.S. Department of Agriculture's food assistance programs). However, many community-based social service providers are not currently equipped to collect and share this data. Therefore, we would ask that HHS should engage its interdepartmental stakeholders and other community-based providers in a process to standardize this information beyond the healthcare sector. We also would ask HHS to consider making funding available to social services organizations to develop the technology systems needed to collect SDOH data, and to support ongoing licensing fees.

Using Data to Impact Social Determinants of Health

It's one thing to collect robust data on social determinants of health. But using that data to impact change in our communities is a challenge. To achieve success, there needs to be a robust support infrastructure between healthcare organizations and other community services providers. Our recommendations and key considerations to help build such an infrastructure are:

1) Support for Behavioral Health: In our community, many patients with SDOH challenges and high healthcare utilization also have behavioral health comorbidities. Therefore, it is important to identify pathways for behavioral health screening, referral, and navigation in addition to the work to identify and impact SDOH.
2) Increase social service provider capacity: SDOH screening, referral and navigation by clinical providers has limited utility when there is a lack of downstream social service providers in a given sector or geographic area. We think it is vital for HHS to provide support to service organizations in areas with diminished capacity via reimbursement to social service agencies.
3) Develop and support alternative care models: HHS should sponsor models, like the Accountable Health Communities and Community Health Workers initiatives, to support addressing SDOH challenges and to foster partnerships between healthcare providers and their communities.

To conclude, we sincerely appreciate the opportunity to provide comment on this important topic. We encourage the government's involvement in helping to find solutions to these challenges and look forward to an active partnership.

Sincerely,

Wm. Claiborne Dunagan, MD, MS
Senior Vice President and Chief Clinical Officer, BJC HealthCare
Director, Center for Clinical Excellence

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November 16, 2018

Ms. Nancy Delew
Associate Deputy Assistant Secretary
Office of the Assistant for Planning and Evaluation
Department of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

Submitted to the Assistant Secretary for Planning and Evaluation (ASPE) at: ASPEImpactStudy@hhs.gov

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

Dear Associate Deputy Assistant Secretary Delew:

The Blue Cross Blue Shield Association (BCBSA) is pleased to have the opportunity to respond to the "Request for Information: IMPACT ACT Research Study: Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors" recently issued by your office.

BCBSA – a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide healthcare coverage for one in three Americans – currently enrolls millions of Medicare beneficiaries in our Medicare Advantage (MA), Part D and Medigap products as well as our employer retiree options.

We share the agency's interest and concern with the social risk factors that are present in the Medicare community. Environmental factors, such as access to safe housing and healthy foods, are core to the well-being of individuals and can greatly impact an individual's overall health.

We appreciate the steps the federal government, particularly the Centers for Medicare & Medicaid Services (CMS), has taken to address these needs. We offer the following next steps to improve the health and well-being of Medicare beneficiaries:

- **First,** we commend CMS for expanding guidance on supplemental benefits (i.e., additional services offered by MA plans that are not covered under Medicare Part A, Part B, or Part D, including transportation to physician visits, coverage of over-the-counter drugs, adult day care services, and other supplemental services that promote beneficiary health and wellness). CMS' new guidance allows plans to cover a broader array of items and services as supplemental benefits so long as they are used to diagnose, prevent or improve the effects of injuries or health conditions, or reduce avoidable emergency department visits. However, in practice this new flexibility has been somewhat narrowly interpreted with CMS denying approval for plans to provide meaningful benefits to address food shortage and safe housing needs. While many MA plans will be offering new types of supplemental benefits in 2019, a number of MA plans have been restricted from offering additional benefits designed to improve patients' day-to-day lives. We believe additional flexibility is still needed to more fully address underlying social risk factors.

- **Second,** we urge CMS to continue working with plans to identify a long-term solution to the impact of dual status and socioeconomic status on Star Ratings. Plans appreciate CMS' ongoing attention to the impact of beneficiary-level characteristics on plan performance and understand that the current Categorical Adjustment Index is a temporary solution. However, we urge CMS to work quickly to develop a longer-term, meaningful fix so social risk factors are properly accounted for in measurement. As part of the fix, we recommend CMS base plan performance in the Star Rating program on absolute rather than relative outcomes, weight measures based on outcomes data rather than those from subjective sources, and reflect plan performance in such a way that is consistent with the experience of a beneficiary in the local area.

- **Third,** the healthcare system as a whole could benefit from the federal government developing and disseminating guidelines, best practices, measurement standards and training on collecting, using and sharing social determinants of health (SDoH) data. Improving existing measurement and data infrastructure, such as standardized electronic health record (EHR) data elements or improving access to EHRs, could help plans connect the dots and create a picture of a member's whole environment, risks and challenges. Furthermore, CMS can play a crucial role in incentivizing and facilitating data collection and allowing for data-sharing between Medicaid programs and Medicare plans to ensure higher quality care.

- **Fourth**, we recommend ASPE encourage CMS to improve the network adequacy review processes and increase flexibility for time-and-distance standards for telehealth services. For patients with social risk factors, particularly those with limited ability to ambulate, telehealth is a best practice. CMS' current emphasis on time-and-distance standards can often be overly prescriptive, and ultimately, limit sponsors' ability to serve certain geographic areas and harder-to-reach members. In CY 2018, CMS began allowing organizations to request an exception if they are using a telehealth or a mobile provider to meet network adequacy requirements. CMS will consider this type of rationale on an Exception Request only for Counties with Extreme Access Considerations (CEAC), Rural, or Micro county types. We recommend that CMS improve the guidance for, and increase the flexibility in, the Exception Request process to allow plans to use telehealth to meet adequacy requirements to better address healthcare needs and social risk factors.

- **Fifth,** as CMS updates its demonstrations or launches new ones, we encourage CMS to include quality measures focused on social determinants of health. Demonstrations provide valuable opportunities to examine how these measures can be used and improved to help drive better outcomes for MA beneficiaries.

To address ASPE's research question more specifically, Plans are taking a number of actions to identify needs and improve health outcomes for all members with social risk factors, including Medicare beneficiaries.

Identifying beneficiaries with social risk factors

BCBSA engages in a number of efforts to help Plans identify members with resource needs beyond medical care, leveraging existing data as a key component of the solutions:

- **Blue Cross Blue Shield Institute[SM] (BCBS Institute).** To address the social and environmental factors that influence health and health outcomes, BCBSA created the BCBS Institute, a new subsidiary of BCBSA. A first-of-its-kind organization in scope and scale, the BCBS Institute combines a social mission with business innovation and insight to target barriers to healthcare that can be solved with technology and strategic alliances. The BCBS Institute analyzes geographic population patterns via ZIP code data to inform BCBS providers and payers about the

most problematic gaps in community access to resources. Through these efforts, the BCBS Institute goes beyond the walls of the traditional provider setting to reach into the daily realities of communities across the country.

The BCBS Institute leverages powerful data by ZIP code about social determinants of health and brings together the partners best positioned to tailor solutions to meet community needs. In collaboration over the last year with Lyft®, the BCBS Institute has made it possible to dispatch rides for patients via Lyft's network of drivers. The BCBS Institute additionally plans to address fitness and nutrition-based disparities as well as pharmacy access for BCBS members through strategic partnerships with CVS Health and Walgreens.

- **BCBS Health Index**. BCBSA also produces the BCBS Health Index, which uses de-identified data from more than 41 million BCBS members to identify the top 200 health conditions with the greatest impact on commercially insured Americans by ZIP code. This tool uniquely contributes to other available health data to support national and local discussions about how to improve health, health policy and healthcare practice in America.

In addition to the BCBS Institute and the BCBS Health Index, individual Plans identify members' social risk factors through outreach and through opportunities that arise when members touch the health system, including:

- **Predictive Analytics.** At least one Plan uses an algorithm developed to predict high risk for future hospitalizations. The algorithm includes social risk factors such as zip codes in its model. If a member is identified as high risk, that member is referred for case management where a case manager will work to identify and address social risk factors.

- **In-home Assessments.** Plans conduct in-home assessments of members during which practitioners visit members to provide a more personalized experience. In addition to clinical care, these providers are inquiring and collecting data on social risk factors (e.g., home safety, financial needs, transportation). This information is used to identify the social risk factors of members and, where possible, connect the members to needed services and supports to address those factors.

- **Acute Health Events.** When members with known chronic conditions have acute events that result in them accessing the healthcare system (e.g., hospital admissions), case managers or care coordinators will typically reach out to understand what caused the event. As part of these conversations, the care managers or care coordinators will work to identify any social risk factors driving the event and work to identify ways to prevent a reoccurrence.

These efforts typically operate across lines of business, identifying members regardless of coverage type (e.g., MA, commercial insurance).

Addressing the needs of beneficiaries with social risk factors

Once a need is identified, there are a variety of ways that Plans are working to improve health outcomes for their members with social risk factors, including value-based arrangements, product design, customized messaging and/or interventions, and community partnership expansion. In addition to these approaches, Plans leverage their case management and care coordination programs to provide additional resources and holistic care. Members with social risk factors often benefit from the additional support that such programs offer, including support during transitions of care for members with specified chronic conditions. For Medicare beneficiaries, the most important risk factors are typically access to transportation and nutritious foods.

- **Blue Cross and Blue Shield of New Mexico (BCBSNM): Addressing Food Security**
Through BCBSNM's support in 2017, more than 2.5 million pounds of food were distributed, impacting more than 73,000 individuals. Key partners working with BCBSNM to increase access to food and educate individuals on healthy eating across the state include:

  o Casa de Peregrinos – The Doña Ana County Rural Food Initiative distributes 50 pounds of nutritious food monthly to approximately 1,000 low-income, largely Hispanic rural colonias – families of southern Doña Ana County, New Mexico.

  o St. Felix Pantry – The Good Eats program provides nutritious food for low-income elementary school students and their families in the Rio Rancho community. Food boxes containing fruits, vegetables and other healthy foods are delivered to the school for distribution to food insecure families.

  o Food Bank of Eastern New Mexico – The food bank supports programs that feed low- to moderate-income individuals, families and homebound persons and students.

  o The Food Depot – The Mobile Food Pantry program provides nutritious food to rural, isolated communities in northern New Mexico where there are high rates of hunger and poverty. This program engages the community by requiring community volunteers to organize and execute the food distribution. The program also serves as an opportunity to develop partnerships with healthcare centers to provide screenings, immunizations and health information to underserved communities.

  o Roadrunner Food Bank – Childhood Hunger Initiative partners with 47 Title I elementary schools, which have a high percentage of students and their families living in poverty. With the funding BCBSNM provided, Roadrunner Food Bank gave significantly more food to families – 1.2 million pounds of food in 2017 compared with 400,000 pounds previously. Through the Senior Hunger Initiative program, fixed and mobile food pantries serve seniors at 18 low-income senior center locations. In 2017, BCBSNM funded food pantries at eight elementary schools and two senior centers as part of Roadrunner's programs.

- **Highmark Foundation: Basic Cardiopulmonary Resuscitation (CPR) and First Aid Training for Transportation Personnel**
The Highmark Foundation awarded a $2,400 grant to In Touch and Concerned, an organization that provides door-to-door transportation to non-emergency medical appointments and reassurance to the elderly, individuals with disabilities and low-income members to support basic CPR and first aid training for transportation personnel. The goal of the project is to provide training to transportation personnel from 30-35 nonprofits in Monongalia County, indirectly benefitting approximately 3,000 individuals receiving transportation services.

- **Blue Cross and Blue Shield of Minnesota (BCBSMN): Lifeworks Employees**
Lifeworks, a nonprofit that serves people with disabilities, helps connect people with jobs that give them a sense of purpose, a way to contribute and the ability to live an ordinary life. BCBSMN has partnered with Lifeworks for over 30 years and contracts 12 associates with special needs and developmental disabilities for general clerical work.

- **Anthem Foundation: American Lung Association – Smoking Cessation for Low-Income Housing Residents**
Building on the organizations' longstanding relationship, the Anthem Foundation has developed a two-year, nearly $900K partnership with the American Lung Association (ALA) to deliver smoking

cessation programming in low-income housing units across 14 states. Reducing the use of tobacco and its harmful effects on consumers – and their families and neighbors – builds on Anthem Foundation's mission to create a healthier generation of Americans through strategic philanthropy. Near the end of 2016, the U.S. Department of Housing and Urban Development (HUD) announced a nationwide smoking ban in public housing that would go into effect July 31, 2018. HUD called for local public housing authorities to provide support services and programs to help residents comply with the ban by the deadline, but, unfortunately, not all facilities were able to provide such measures for their tenants. To address this gap, and what continues to be the nation's number one most preventable cause of death, Anthem Foundation's support mobilized the industry-recognized "Gold Standard" of smoking cessation programs – Freedom from Smoking.

- **Blue Cross and Blue Shield of Kansas (BCBSKS): Pathways to a Healthy Kansas**
BCBSKS' Pathways to a Healthy Kansas is a major community grant program that provides community coalitions with the tools and resources needed to remove barriers and engage their communities in ways that enable healthy eating and tobacco-free, active living to become a way of life. Sixteen communities across the state have been awarded a three-year, $100,000 coordination grant, along with a variety of technical assistance and support. In addition, each community has the opportunity to earn supplemental grants of up to $400,000 per community. In all, each Pathways community may receive up to $500,000 in grants. These coalitions are working within their communities on implementing health strategies across the sectors - or pathways - of community policy, resident/community well-being, the food retail sector, healthcare, restaurants, schools and worksites. More than 360,000 Kansans have the opportunities to live healthier lifestyles through the Pathways initiative. The first round of communities funded include the counties of Atchison, Bourbon, Crawford, Franklin, northern Barton, Kearny, Reno and Seward as well as the city of Hoisington. The second round of communities receiving grants are the counties of Cowley, Dickinson, Geary, Harvey and Lyon. The city of Chanute and the Northwest Collaborative (cities of Atwood, Bird City, Colby and St. Francis) were also round two grant recipients.

- **Blue Cross and Blue Shield of Minnesota (BCBSMN): Willmar Community Initiative**
The face of Minnesota is changing — and Willmar is a city that's ahead of that trend. Home to growing Latino and Somali populations, Willmar is a vibrant and ethnically diverse community. Through its Corporate Social Responsibility initiative, BCBSMN partnered with the community and has committed up to $2 million through 2018 to improve the health of all residents of Willmar. Willmar, Minnesota, located 100 miles west of the Twin Cities metro area, is a community of approximately 20,000 people that continues to experience significant transformations, including rapid growth with increasingly diverse and aging populations. Within the community, many are facing considerable barriers to health.

- **Blue Cross and Blue Shield of Nebraska (BCBSNE): Heart Ministry Center**
Heart Ministry Center provides food, clothing, healthcare and supportive services to individuals impacted by poverty in North Omaha. The organization's programs include a food pantry, clothing closet, urgent care and dental clinic, legal services, job skills and training and social work services. BCBSNE funding supported the Center's "choice" food pantry, which gives clients the dignity of selecting food to feed their families in a grocery store-style environment. Because the food selection process is more intensive and interactive, staff have the opportunity to connect with clients and provide wrap-around services and additional resources to improve every aspect of their life.

- **Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Foundation: Looking at Health from All Sides**
  Good health starts long before patients enter the doctor's office. Therefore, the Blue Cross NC Foundation is committed to addressing the social, environmental and economic factors that are at the root of poor health and health disparities and investing in – and supporting – North Carolina individuals, organizations and communities that act on those factors. In 2017, this included continued investments in clinical-community collaborations in Asheville, Gastonia and Greensboro through the Community-Centered Health Initiative; joining both national and local funders in supporting the BUILD Health Challenge; and funding a partnership between Legal Aid North Carolina and medical providers in Eastern North Carolina to address legal issues that are barriers to good health.

- **Wellmark Blue Cross and Blue Shield: Healthy Hometown^{SM} Powered by Wellmark**
  When it comes to health, ZIP Code may be more important than genetic code. Think about how surroundings can affect a person's health. Is processed food easier to fit into a hectic schedule than a healthy meal? Is driving to the store easier than walking? Healthy Hometown^{SM} Powered by Wellmark was created in 2017 to help communities change their environments and positively impact social behaviors. This initiative is designed to improve overall well-being by making the healthy choice the easy choice. Healthy Hometown offers proven tools and techniques, available in the public domain, that have shown to be effective in terms of creating healthier communities and individuals. Communities, schools and worksites can complete an online self-assessment that provides insight into not only what they can do to make the healthy choice the easy choice — but also how to do it. Those communities wanting to take a broader approach can receive expert consultation and assistance. Healthy Hometown is free and available to all Iowa communities willing to do the work.

- **Anthem Blue Cross and Blue Shield in Colorado (BCBSCO): Double Up Food Bucks Colorado**
  Through a $50,000 grant to LiveWell Colorado, Anthem BCBSCO's parent company foundation is helping increase access to, and affordability of, healthy produce for low-income families in Colorado. The Double Up program helps families make the most of their Supplemental Nutrition Assistance Program (SNAP) funding, increase consumption of fruits and vegetables, and promote healthy eating behaviors.

- **Arkansas Blue & You Foundation: Addressing Hunger and Good Nutrition**
  Helping to feed the hungry and provide better nutrition for those in need is the focus of five grants from the Arkansas Blue & You Foundation in 2017. These include backpack meals for students in the Fort Smith and Berryville school districts; a mobile food pantry in Little Rock, gardening classes in Nashville; and a food bank in Little Rock for Hispanic immigrants.

- **Blue Cross Blue Shield of Arizona (BCBSAZ): Fresh Express**
  BCBSAZ is one of several businesses that are partnering with the Discovery Triangle Development Corporation to offer Farm Express, a mobile food initiative. Fresh Express travels to underserved neighborhoods to sell affordable fresh fruits and vegetables at convenient, nearby locations. Fresh Express also features onboard health resources such as nutrition education, healthy food demonstrations and health screenings. Residents can pay with cash, debit/credit cards and even SNAP cards.

- **Blue Cross and Blue Shield of Illinois (BCBSIL): Addressing Food Insecurity**
  In 2017, BCBSIL worked with key partners and various food banks to increase access to food and educate individuals on healthy food consumption across Illinois. Over 62,000 pounds of food were distributed, impacting more than 11,000 individuals.

- **Blue Cross and Blue Shield of Minnesota (BCBSMN): Giving Garden**
  The community giving garden came to life ten years ago and continues to flourish today. Planted on BCSBMN corporate property, the giving garden is completely maintained by employee volunteers. The main goal of the garden is to grow and give fresh, healthy produce to families in need. Providing employees with an opportunity to include physical activity into their workday and reducing its corporate carbon footprint are welcomed bonuses of this project. Over the years, the garden has doubled in size, seen well over 500 different volunteers, delivered over 7,000 pounds of produce to local food shelves and added another food shelf to its donation list. During the 2017 growing season, the giving garden harvested and delivered over 500 pounds of produce. Garden volunteers held 11 events for employees to come out and get their hands dirty and hosted seven teams of employees who wanted to volunteer their time as a group.

- **Blue Cross and Blue Shield of North Carolina (Blue Cross NC): Increasing Access to Healthy Nutritious Food**
  Blue Cross NC partnered with four food banks across the state. By supporting MANNA Food Bank in Asheville, Charlotte's Second Harvest Food Bank of Metrolina, Central & Eastern North Carolina Food Bank and Second Harvest of NWNC, Blue Cross NC enabled each food bank to purchase new refrigeration equipment or refrigerated trucks for distribution, reducing waste and increasing the volume of healthy foods — meats, dairy, fruits and vegetables — that reached their partner agencies. Gifts to these four food banks impacted food assistance programs in 82 of North Carolina's 100 counties through more than 2,100 partner agencies.

- **Blue Cross and Blue Shield of North Carolina (Blue Cross NC): Nourishing North Carolina**
  Research shows that when communities have access to fresh fruits and vegetables, they eat them – and they're healthier for it, having lower rates of obesity, diabetes and other diet-related diseases. To address this, Blue Cross NC and the North Carolina Recreation & Park Association (NCRPA) have joined forces to establish community gardens throughout North Carolina. Through this partnership, Blue Cross NC has established or enhanced community gardens in all 100 North Carolina counties.

- **Blue Cross Blue Shield of Arizona (BCBSAZ): Nourishing Arizona**
  Research shows a staggering one in three Arizonans is considered "working poor," and families with limited incomes are often forced to make food choices based on price or convenience alone. Building upon BCBSAZ's strong community ties and ongoing commitment to health and wellness, the program highlights four main focus areas: 1) raising awareness of food insecurity and food deserts, 2) educating Arizonans on making better food choices, 3) directing people to resources and access to help, and 4) maintaining healthy habits learned and sharing learnings.

- **Blue Cross and Blue Shield of Oklahoma (BCBSOK): Addressing Food Security**
  Providing access to healthy and nutritious food is a core focus of BCBSOK's work within its communities. Without access to consistent food, individuals, especially children, are not able to lead healthy and productive lives. Through BCBSOK's support in 2017, 392,242 pounds of food were distributed through two food bank partners – the Community Food Bank of Eastern Oklahoma and Regional Food Bank of Oklahoma – impacting 2,971 individuals. Food as medicine is a key priority for BCBSOK and their work with their food bank partners has focused

on ensuring individuals with health challenges have access to appropriate foods for their conditions and that all clients have access to fresh and healthy food options.

- **Regence BlueShield (Regence): Idaho Foodbank**
  Regence and the Idaho Foodbank have partnered to increase the awareness of the crucial community support for the more than 240,000 Idahoans – or one in seven Idahoans - who are living at risk of hunger. Of those at risk are at least 80,000 children who are food insecure. Aiming to promote healthy families and communities, Regence invested in four direct focus areas within the Foodbank's Nutrition Services program.

- **Regence BlueShield (Regence): Second Harvest**
  Second Harvest, with Regence's support, launched a new volunteer center to increase the capacity of food sorting, leverage larger groups of volunteers more frequently and accommodate processing more fresh fruits and vegetables to help people in need. Second Harvest combats hunger by bringing community resources together to feed the hungry in eastern Washington and northern Idaho with its partnership of more than 250 neighborhood food banks and meal centers. The partnership has also advanced Second Harvest's Feeding Children and Healthy Eating initiatives, also increasing its capacity to deliver fresh, nutritious food where it is most needed.

- **Blue Shield of California: Shield Cares: Solutions to Homelessness in San Francisco**
  The commitment to service in San Francisco is evidenced in Blue Shield of California's annual participation in Project Homeless Connect (PHC), which brings nonprofit medical and social service organizations together to offer comprehensive, holistic services to the city's homeless population. Blue Shield of California has contributed more than $250,000 to the project since 2004, with more than 600 employees offering their time and support. An estimated 6,000-12,000 people are homeless on any given night in San Francisco, and 20 percent are chronically homeless. In 2004, the San Francisco Department of Public Health created PHC as a way to bring necessary services to this population. Today, more than 1,000 community volunteers partner with government agencies, nonprofits, and the private sector every two months to provide a single location with comprehensive health and human services for homeless San Franciscans. During PHC's events, participants are able to accomplish in one day what might normally take eight months.

- **Excellus BlueCross BlueShield (Excellus BCBS): Dual Recovery/Rapid Engagement Homeless Assistance Team**
  Excellus BCBS and Upstate Cerebral Palsy Inc. partnered for the Dual Recovery/Rapid Engagement Homeless Assistance Team (REHAT). Through the REHAT program, homeless and housing vulnerable individuals in Oneida County with documented mental illness and/or substance use issues are provided stabilization services using the "housing first" model. REHAT works with clients to develop a service/treatment plan, which addresses medication adherence, and mental health treatment.

- **Regence BlueCross BlueShield of Oregon (Regence BCBSO): Building Community Alongside Habitat for Humanity Portland Metro**
  To create healthier living situations for those in need, Regence BCBSO has regularly partnered with Habitat for Humanity Portland Metro since 2013 to address the pressing issues of affordable housing and inadequate, substandard housing. In addition to significant funding, over 100 employees have participated in homebuilding activities.

- **Health Care Service Corporation (HCSC): Feeding America**
  Families facing food insecurity often experience stress, limited income and diet-related chronic illness, which negatively affects health. According to the U.S. Department of Agriculture, 40 million people are food insecure. HCSC works with Feeding America®, the nation's largest hunger-relief organization, to address the complex and often overlapping challenges that increase families' risk of food insecurity, the lack of consistent access to enough food for an active, healthy life. Through a $1.2 million grant to Feeding America® over two years across its five health plan states, including Illinois, Montana, New Mexico, Oklahoma and Texas, HCSC is driving toward a whole-person approach that empowers families with employment skills training and the knowledge to sustain healthy eating behaviors. HCSC selected 26 food banks to implement Feeding America's nutrition education and intervention strategies, including:

  o Nudges in food pantries: Recommended on-site changes, such as placing fresh produce, dairy and protein in areas with high-visibility near the entrance and using signage to encourage healthy selection

  o Community kitchens: 10- to 16-week culinary job training programs that prepare adults in-need for jobs in the food service industry

  o Nutrition policy: Nutrition guidelines that help food pantries identify healthful foods and beverages as they shift toward nutrition-focused food banking

- **Hawaii Medical Service Association (HMSA): Federally Qualified Health Center (FQHC) Community Grant Program**
  The Federally Qualified Health Center (FQHC) Community Grant Program is a two-year grant which aims to address medical and non-medical health needs within communities. All 14 FQHCs across the state were awarded funds to support community-driven solutions that include: lifestyle change programs, cultural practices, integration of community health workers, and programs that address social determinants of health such as transportation, education, housing, medical legal, and social support. HMSA plans to work aside these FQHCs to incorporate community perspectives into their understandings of health and to inform our strategies overall. The Community Grant Program is expected to be complete by October 2019.

Investing in the health and well-being of our communities has been a long-standing tradition of BCBS companies for nearly 90 years. We are proud to be a part of the great work taking place in the communities where our members live and work. By supporting these efforts, we can make progress toward reducing health disparities and achieving healthier outcomes for every American across the country and for future generations. For more information on what BCBS Plans are doing to address these issues, visit www.bcbsprogresshealth.com.

We appreciate your consideration of our comments on how BCBS companies are working to identify needs and improve health outcomes for all members with social risk factors and what the federal government can do to move these efforts forward. We look forward to continuing to work with ASPE on this topic as BCBS companies are committed to improving the health and well-being of all their members. If you have questions, please contact Jane Galvin at 202.626.8651 or Jane.Galvin@bcbsa.com.

Sincerely,

Kris Haltmeyer
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association

Below please find Blue Shield of California's responses to the first two bullets points:

How plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors
- HOS and CAHPS - Collects some of the SDoH data (e.g., household income, education, low-income status, gender, race) and the results are provided in the annual survey results.
- Optum CAHPS consumer analytics analysis - Provides SDoH aggregate data for social isolation (SII) and socioeconomic status (SES). However, we only have SI data at the member level. For SES, Optum uses a third-party administrator to provide the data.
- Blue Shield's Health Risk Assessment (HRA) team is working with Heal to perform focused outreach and provide in-home physician wellness assessment visits to some of our Medicare members. Since Heal visits members in the home, they have unique insight and the ability to identify members and improve care for those members. As part of their visits, they often identify patients with social needs and can connect members to other resources as needed.

Approaches plans and providers have used to address the needs of beneficiaries with social risk factors
- Blue Shield is looking to expand transportation services, food security (access and delivery of meals), falls prevention, and possibly isolation and support in 2019.
- Blue Shield has implemented the following quality programs to-date:
  - SI data has been used for our SilverSneakers (fitness) initiatives.
  - Optum CAHPS has been used for an in-home initiative for disabled Medicare members between the ages of 18 and 64.

Thank you,

Kristina Hergot
Sr. Medicare Compliance Analyst, Medicare Compliance
Blue Shield of California
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☎ (818) 228-6042 | ✉ Kristina.Hergot@blueshieldca.com

-----Original Message-----
From: HPMS
Sent: Friday, October 26, 2018 3:12 PM
To: Hergot, Kristina
Subject: ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Blue Shield Security Warning! This email originated outside of Blue Shield. Do not open attachments or click links unless you recognize the sender, are expecting the email, and are confident the content is safe.

ASPE has issued a Request for Information (RFI) related to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 at https://urldefense.proofpoint.com/v2/url?u=https-3A__aspe.hhs.gov_social-2Drisk-2Dfactors-2Dand-2Dmedicares-2Dvalue-2Dbased-2Dpurchasing-2Dprograms-2Drequest-2Dinformation&d=DwIBAg&c=hNAZrKxPkhfPADjr9wUJ4I9GS8ZQPNEcFQu4kKjVcNw&r=gdi6ltFHl7WNYuENru3nco

CZbil6J_BqMkY_8lmXdBE&m=0vL7j8COvYJT66sSPoL4bK-sQCHpSwpZipZgEek_OKo&s=_yMEoQmLaBj36HtRZ5AyTXOd_hMeR78liqKDll38TuI&e=, accepting responses until November 16, 2018 by email at ASPEImpactStudy@hhs.gov. The RFI, entitled IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors, focuses on one aspect of the larger study described below.

Section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 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. The first component of the required work, a 2016 Report to Congress, focused on socioeconomic information currently available in Medicare data. Following up on ASPE's first Report to Congress, HHS is interested in:

. How plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors
. Approaches plans and providers have used to address the needs of beneficiaries with social risk factors
. Evidence regarding the impact of these approaches on quality outcomes and the total cost of care
. Ways in which plans and providers disentangle beneficiaries' social and medical risks and address each
We encourage you to respond to this request for information and to share it with others. The information gathered through this RFI will be valuable to CMS as we continue to examine the impact of social risk factors on health outcomes and how to best address the impact on clinical quality measurement for health and drug plans.

The full request for information is available at https://urldefense.proofpoint.com/v2/url?u=https-3A__aspe.hhs.gov_social-2Drisk-2Dfactors-2Dand-2Dmedicares-2Dvalue-2Dbased-2Dpurchasing-2Dprograms-2Drequest-2Dinformation&d=DwIBAg&c=hNAZrKxPkhfPADjr9wUJ4I9GS8ZQPNEcFQu4kKjVcNw&r=gdi6ltFHl7WNYuENru3ncoCZbil6J_BqMkY_8lmXdBE&m=0vL7j8COvYJT66sSPoL4bK-sQCHpSwpZipZgEek_OKo&s=_yMEoQmLaBj36HtRZ5AyTXOd_hMeR78liqKDll38TuI&e=. Comments will be received until November 16, 2018 by email at ASPEImpactStudy@hhs.gov.

November 16, 2018

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

Dear Dr. Destro,

On behalf of Movement is Life, I am pleased to submit the following response to the Assistant Secretary for Planning and Evaluation (ASPE) in response to ASPE's Request for Information (RFI) titled, IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

Movement is Life (MIL) is a multi-stakeholder organization dedicated to eliminating health disparities and promoting health equity, primarily concerning musculoskeletal conditions. Our membership includes healthcare providers, attorneys, academicians, and other partners. MIL facilitates community-based programs to help at-risk patients and convenes an annual conference in Washington, D.C. called the Movement is Life Caucus that brings together a diverse set of attendees who share our mission of promoting health equity and eliminating health disparities.

The MIL Caucus educates attendees about the need for greater health equity and provides a unique perspective on how certain social and medical factors exacerbate musculoskeletal health disparities. MIL's many priorities center around a vicious cycle of factors that affect musculoskeletal health. Many of the elements that make up the vicious cycle disproportionately affect minority populations.

MIL would like to express our support for ASPE's leadership on reducing health disparities and promoting health equity. We strongly support the IMPACT Act's requirements for ASPE's reports on health disparities within the Medicare program. The responses to this RFI will help guide ASPE's second of two reports to Congress which must be completed by October 2019.

Call to Action on Health Equity

ASPE acknowledges "growing recognition that social risk factors – such as income, education, race and ethnicity, employment, housing, food, community resources, and social support – play a major role in health." We believe "growing recognition," while correct, is not the best way to characterize the current environment of studying health disparities. There is indeed widespread acceptance among the entire spectrum of health care providers, researchers, and policymakers that social factors affect health status at both the individual and population level. We strongly support efforts to improve our understanding of the causes and consequences of health disparities. **However, we believe enough evidence exists for CMS to**

immediately take more concrete actions to address this issue. We implore ASPE to include actionable recommendations for how to address health disparities in its report.

As you know, health policy is largely made through the healthcare reimbursement system. Conversely, healthcare reimbursements create incentives that can lead to both intended and unintended consequences. Paying providers more for adopting EHRs incentivized the intended consequence of higher EHR utilization but also had the unintended consequence of EHR systems not being able to communicate with each other.

Health inequity poses particular challenges to new value-based health care systems. According to the RFI, ASPE believes, "In many ways, beneficiaries with social risk factors may benefit the most from value-based purchasing programs and other delivery system reform efforts, since improved care coordination and provider cooperation will be of the highest utility to the most complex beneficiaries with the most care needs." We agree that complex patients stand to benefit from the care delivery improvements sought through value-based payments. However, CMS must recognize that payment incentives within value-based payment models could hinder access to care for complex patients.

The root of the issue is how to define "quality" and "value." Most value-based payment models establish a benchmark for what is considered good quality or value. Providers who perform well against the benchmark typically earn a financial reward while those who perform below the benchmark receive a financial penalty. Models usually do not account for the fact that some providers treat a high number of complex patients compared to their peers. This could result in providers seeking to change their patient mix for a given performance period to improve their ability to achieve a better performance score. Absent an adequate mechanism to risk adjust for medical and social complexity or a redesign of how benchmarks are calculated, providers will continue to be financially incentivized to avoid patients who fall on the wrong side of the benchmark.

It is important to recognize that social risk factors play a role in health status. The next step is to determine how we hold providers accountable for the impact these risk factors have on provider performance within value-based payment models that require providers to bear financial risk. The healthcare system is not designed to empower physicians and other healthcare providers to address many of the social issues that contribute to health complexities. **To achieve health equity, policy must recognize that patients with social risk factors often require additional resources and additional time to achieve an equitable care outcome.**

The failure to adequately account for social risk factors means many patients cannot benefit from the innovations of a value-based payment environment because they are being avoided. Major improvements to how we hold providers accountable under value-based payments are needed to make sure patients are not avoided out of fear that a complex patient will hurt a provider's bottom line.

At what point will HHS feel it has enough data to take additional action? Continuing to delay action means patients will continue to experience impediments to accessing equitable care. Every payment model that is offered as an alternative to fee-for-service must include a plan for ensuring health equity. We also hope this report helps guide new payment models to better incorporate social risk factors into how providers are reimbursed.

Defining Social Risk

We agree with ASPE's use of the National Academies of Science, Engineering, and Medicine (NASEM) definition of social risk:

1. Socioeconomic position (income, wealth, insurance status, education, occupation, food insecurity)
2. Race, ethnicity, and community context (race and ethnicity, language, nativity, acculturation)
3. Gender (gender identity, sexual orientation)
4. Social relationships (marital/partnership status, living alone, social support)
5. Residential and community context (physical environment, housing, and social environment)

All of these factors can affect health status. CMS should incorporate a risk adjustment methodology that accounts for how every element of this definition can impact quality and cost performance. There is no standard way to incorporate such a risk adjustment mechanism due to the wide variety of payment models. However, this definition should serve as the foundation on top of which all risk adjustment methodologies are built.

Using the Comprehensive Joint Replacement (CJR) program as an example, how should a patient's social risk status, according to the NASEM definition, factor into a hospital's target price? How should each element of the NASEM definition be weighted to impact risk adjustment of the target price? **We believe this definition should be the basis of a Risk Adjustment Factor (RAF) that would directly apply a risk adjustment based on a patient's social risk factors.**

To date, CMS has used dual-eligible status as a proxy measure for social risk. Relying on dual-eligible status is a crude approach, but we acknowledge it can be effective. It is certainly better than nothing. **MIL believes the use of dual-eligible status as a representation of social risk must be an interim approach until a more refined risk adjustment mechanism that incorporates all elements of the NASEM definition of social risk.**

Accepting this definition will identify the social risk factors CMS believes impact health status. This is a meaningful first step towards a robust risk adjustment framework.

Response to ASPE's Questions

HHS is interested in how plans and providers serving Medicare beneficiaries:

> **Identify** beneficiaries with social risk factors;
> **Approaches** plans and providers have used to address the needs of beneficiaries with social risk factors;
> **Evidence** regarding the impact of these approaches on quality outcomes and the total cost of care; and
> **Disentangle** beneficiaries' social and medical risks and address each.

Identify Beneficiaries with Social Risk Factors

MIL agrees that identifying beneficiaries with social risk factors is a challenge that must be addressed. We believe that the best approach to collecting this data is to leverage existing government resources. The federal government already has much of this information in various silos. Better communication between government agencies is the most effective way to collect the information needed to account for social risk factors. For example, the Social Security Administration (SSA) likely has much of the data on social status that the Medicare program hopes to use to risk adjust payment models. Perhaps the Department of Housing and Urban Development (HUD) can help identify Medicare beneficiaries who rely on public housing assistance.

Government agencies will be most effective at collecting static information such as race, ethnicity, gender and education. However, many social, such as income, social relationships, and housing situation, can change over time. We believe that providers can play a role in capturing information on social risk factors at the point of care but we caution against an overreliance on providers to capture this information.

We have concerns about the ability of providers to collect social risk information at the point of care without additional resources being made available. Collecting this information this will require additional time and resources on the part of the provider's office to collect this information. Further, recent studies have shown that patients are often reluctant to provide this information to their provider.[1]

A standardized EHR element will be helpful in simplifying how this information is collected. However, Medicare must incentivize the added time and resources necessary to overcome the hesitance of patients to provide this information.

Social factors such as English proficiency already increase the length of a typical visit. The only effective way to incentivize this information collection is to create an additional payment to providers for collecting this information from patients. This incentive must account for both general patient hesitancy and the fact that the presence of social risks already leads to longer visits. CMS can also consider collecting social risk factor information during the initial Medicare visit for new Medicare beneficiaries.

Providers can be used to supplement or support data collection efforts. However, we urge ASPE to recommend that the federal government leverage existing data sources before placing the data collection responsibility on providers. **We urge ASPE and CMS to study how the federal government can leverage its own resources to compile information on social risk factors across federal agencies. CMS should also continue to study how to incentivize providers to collect this information.**

Approaches Providers Have Used to Address the Needs of Beneficiaries with Social Risk Factors, and Evidence Regarding the Impact of These Approaches on Quality Outcomes and the Total Cost of Care

Measuring for quality and value in healthcare is a relatively new field. The Medicare program has been a leader in this arena, but we believe more leadership is needed to improve how we define value in healthcare. **CMS must reform how it financially rewards and penalizes healthcare providers for value-based payment program performance to better incentivize the treatment of complex patients.** Failure to do so will result in the continuation of financial incentives for healthcare providers to avoid patients with greater social and medical complexity.

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[1] http://www.annfammed.org/content/16/5/399.full.pdf+html

CMS maintains one standard for "value" within each program with limited risk adjustment mechanisms if any at all to account for health equity. Under these programs, the less complex the patient, the easier it is to achieve the required quality or cost performance score. An article published in March by Karen E. Joynt Maddox, M.D., M.P.H. in the New England Journal of Medicine[2] highlights how the current "all or nothing" approach to quality measurement can be improved.

> "APMs could reward quality improvements proportionally rather than taking an all-or-nothing approach. Currently, a primary care doctor who helps a patient with uncomplicated hypertension to reduce her systolic blood pressure from 145 to 140 mm Hg would achieve the quality metric of "blood pressure under control," but a doctor who helps a patient with chronic kidney disease and diabetes reduce his blood pressure from 190 to 145 mm Hg — an accomplishment with much more profound clinical consequences — would receive no credit. Under a proportional-improvement–based method, clinicians would have incentives to focus on patients whose conditions had the most room for improvement. Such a system would require a more sophisticated approach to quality measurement, but as we increasingly attend to population health and capture more data electronically, it is an essential and increasingly feasible proposition."

Changing the way we define "value" will help us better account for the social risk factors that contribute to health disparities. Value-based payment programs must be designed in a way that rewards providers for caring for the most complex patients. Unfortunately, our current systems incentivize avoidance of complex patients because of the all or nothing definition of value. **Factoring improvement into value-based payment models can help rebalance these incentives to better reward providers for treating complex patients.**

CMS has historically opposed changes to this definition of value fearing such a policy could create a two-tiered system of quality. CMS believes that all patients should be entitled to the same definition of quality.

CMS has recognized the need for risk adjustment and implemented improvements to several value-based payment programs to account for social and medical risk. For example, CMS will begin grouping hospitals in the Hospital Readmission Reduction Program (HRRP) into five groups based on the number of dual-eligible patients the hospital treats. This policy does not change the definition of quality. Rather, it creates a more level playing field that allows hospitals to compete against hospitals with similar patient population risk profiles as opposed to having every hospital compete against each other.

We are confident that ASPE will hear from many providers describing a plethora of practices they use to address the needs of patients with social risk factors. The key to the success of these efforts is a reimbursement system that incentivizes health equity by recognizing that it takes different amounts of resources to provide an equitable health outcome for different patients.

Disentangle Beneficiaries' Social and Medical Risks and Address Each.

Medicare value-based payment models must not disentangle social and medical risks. CMS must recognize and account for the fact that social risks exacerbate medical risks. When developing new payment models and updating existing models, CMS must only hold providers accountable for what they

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[2] http://www.nejm.org/doi/full/10.1056/NEJMp1715455

are empowered to control. Returning to the CJR model as an example, a hospital cannot control if a patient who needs a knee replacement lives on the fourth floor of a building with no elevator. Such a scenario would require an inpatient rehabilitation stay that increases the hospital's expenditure on that patient for the episode of care. Models that fail to account for these scenarios could lead to a provider delaying or not recommending knee replacement surgery for that patient.

There is only so much that can be done to separate social risk factors from health status. In many cases, nothing can be done because many social risk factors can have a direct impact on health status. **It is therefore essential that payment models include mechanisms to reimburse providers for the additional resources required to address patients with medical complexities that are exacerbated by social risk factors.**

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

We are certain that ASPE will receive many responses from health plans and providers highlighting the commendable work they are doing to help socially at-risk patients. We feel it would be more beneficial for CMS to ask providers and health plans what additional resources they need to more effectively meet the needs of socially at-risk patients and to achieve an equitable health outcome. ASPE's report should identify gaps and recommend policy solutions that fill those gaps.

Conclusion

Health equity means that some patients require additional resources to achieve an equitable care outcome as other patients. Many social risk factors can only be addressed outside of the exam room. Value-based payment models are increasingly holding providers accountable for factors beyond their control. The U.S. healthcare system cannot unilaterally solve income, education or language disparities. Healthcare providers who serve a disproportionately at-risk patient population should have their performance in value-based payment models adjusted to account for the added resources it will require to care for their patient population.

If ASPE has any questions regarding our comments or wishes to discuss our recommendations in more detail, please do not hesitate to contact Bill Finerfrock (bf@capitolassociates.com) or Matt Reiter (reiterm@capitolassociates.com).

Sincerely,

Mary I. O'Connor, M.D.
Chair
Movement is Life
www.movementislifecaucus.com

A Passionate Voice for Compassionate Care

November 5, 2018

The Department of Health and Human Services
Attn: Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Washington, DC
ASPEImpactStudy@hhs.gov

RE: Comments from the Catholic Health Association of the United States regarding ASPE's *Request for Information (RFI): IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors*

The Catholic Health Association of the United States (CHA) is pleased to submit comments in response to the Assistant Secretary for Planning and Evaluation (ASPE)'s *Request for Information: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors*.

CHA is pleased that ASPE is examining the role of individuals' socioeconomic status on the Medicare program and its beneficiaries because there is a growing recognition that social risk factors play a key role in health. For the past year, CHA has studied how social risk factors (also known as social determinants of health) influence the health and well-being of low-income individuals and their communities and the role of hospitals in addressing these factors. As health care providers, we know that health does not occur in a vacuum. In addition to access to health care, biology and behaviors, the health of all individuals, including Medicare beneficiaries, is shaped by their physical environment, social and economic conditions. While these risk factors are defined in several ways, our work focused on these categories:

- **Social and community context**, including social cohesion, discrimination, community engagement
- **Education,** including literacy and language
- **Neighborhood and built environment,** including safety from crime and violence, transportation, clean air and water
- **Economic stability,** Including housing and food security and income.

The Role of the Healthcare System
While the health care system cannot solve problems related to social risk factors alone, hospitals and other health care organizations have a responsibility to address these factors within their organizations and communities. CHA recommends that our members engage these issues at three levels: in the clinical encounter, in community relationships, and in organizational structures and processes.

The clinical level

Many hospitals are screening Medicare beneficiaries in their emergency rooms and primary care settings for food and housing security as well as other determinants of health. When problems are identified, such as running out of food by the end of the month, not having access to healthy food or living in housing that is unsafe, patients and their families are referred to community agencies when possible. If community resources do not exist, hospitals work with community organizations to help develop needed resources. Our members have found that when problems related to social needs can be resolved, patient outcomes improve, and unnecessary, costly admissions can be prevented.

The community level

Having a network of community partners enables hospitals to be part of community-wide solutions to serious problems and to have access to a cadre of community resources for patient referrals. Hospitals work with community partners to conduct their health community health needs assessment which identify health needs and the root cause of these needs which often include social risk factors. Dealing with problems such as food and housing insecurity requires coordinated effort by health care, public agencies and community partners to promote access to healthy food and affordable housing and to advocate for policies addressing such needs.

The organization level

Poverty is at the root of many social risk factors. To address communities' economic conditions, healthcare organizations can and should consider community wellbeing in their operations. For example, when hiring, they can focus on community members including persons who might be disadvantaged in the job market because of disability or discrimination. When they contract or invest, they can look to local and minority vendors and businesses, thereby supporting the economies of their communities.

Screening for Social Needs

Our members tell us that the most frequently identified needs they are uncovering are food security, transportation, and financial stress. Patients often report they are skipping medications to save money, which certainly impacts the effectiveness of prescribed treatments. Screening also reveals practical needs including eyeglasses, dentures, help with managing healthcare bills, resources for caregiver supports, access to prescription assistance, and assistance with maintaining their homes.

Food insecurity is a frequently identified need and some patients must choose between buying food and taking care of other needs. These patients are referred to food banks and agencies that can provide on-going nutritional support.

Here is an example of a patient helped through screening for social risk factors:

"Sharon" is low functioning and is unable to read or write. With the help of hospice, she is taking care of her husband who has dementia. She identified the need for food security and was immediately set up with food banks in the area. She also had outstanding medical bills and the hospital helped her process financial aid applications. She also needed assistance with managing funds so that she could afford the co-pays on her prescriptions.

Sharon needed new dentures because what she had no longer fit and she had problems when eating. The hospital staff helped her fill out an application for new dentures and she was approved through a local foundation for ongoing dental care.

Because she heats her trailer with chopped wood, the hospital helped her to reach out to Habitat for Humanity for aid in upgrading her heat source from chopped wood and to do a home inspection for improved insulation and door and window repairs.

Below is the screening instrument used to help Sharon and other patients seen by her hospital.

		Circle One
	In the last 12 months, were you worried that your food would run out before you got money to buy more?	YES NO
	Are you worried or concerned that in the next 2 months, you may not have stable housing that you own, rent, or stay in as a part of a household?	YES NO
	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	YES NO
	In the last 12 months, did you skip medications to save money?	YES NO
	In the past 12 months, has lack of transportation kept you from the doctor, work, or from meeting other needs?	YES NO
	Are you worried about your physical or emotional safety where you currently live?	YES NO
	Do you ever need help reading medical materials?	YES NO
	Would you like to receive help with any of these needs?	YES NO
	Are any of your needs urgent? *For example: I don't have food tonight, I don't have a place to sleep tonight*	YES NO

Many hospitals use the screening tool designed for Centers for Medicare and Medicaid Innovation Center's Accountable Health Community Model. This model calls for screening for social needs and referring for needed services.

One of CHA member hospitals using the model reported to us:

> "If patients are high-risk, they receive a Community Health Worker/Advocate to assist them. They are interviewed for face to face screening and a home visit occurs. The key things we see is lack of caregiver support, transportation needs (on-going not only to appointments but for day to day needs), food insecurity, utility assistance, medication and durable medical equipment assistance, inadequate health and social supports by family, lack of financial resources, housing insecurity and/or inadequate housing or safe housing. We see elder abuse as well, which continues to be a huge problem. We are also seeing an increase in aging homeless individuals. The last one that I got a call on was for a 91 year old whose family just "dropped him off" and indicated, he is your problem now. He ended up in our hospital and eventually passed away in Hospice."

Loneliness and Social Isolation

A need frequently identified by our members among older patients is related to loneliness and social isolation. The *Archives of Internal Medicine* has reported that 20-43 % of adults age 60 or older experience frequent or intense loneliness (https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1188033). AARP's Public Policy Institute reports that not only is social isolation a serious risk factor, contributing to poor health and even premature death, but is also a significant cost to Medicare. A recent study by the AARP Policy Institute found that a lack of social contacts among older adults is associated with an estimated $6.7 billion in additional Medicare spending annually. According to AARP, Medicare spends an additional $1608 annually for each socially isolated older adult, even more than for arthritis. (https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf) Clearly, this is a need that should be screened and addressed. Many of our member hospitals and other hospitals and health care organizations are working with faith communities (parishes, synagogues, mosques) and other community and volunteer organizations to provide home visits and opportunities for social interaction to address loneliness and isolation. (See: https://www.chausa.org/docs/default-source/eldercare/improving-the-lives-of-older-adults-through-faith-community-partnerships_final-oct-192016.pdf?sfvrsn=0)

Conclusion

While in these comments we have focused on the role and experience of hospitals, we also recognize, as does ASPE, the role of managed care plans and Medicare Advantage organizations. They can help

Medicare beneficiaries and their care givers by recognizing the importance of social risk factors and the need for screening. They can also support community organizations in investing in needed support services to address these needs.

Thank you for allowing the opportunity for the Catholic Health Association to provide these comments. For any questions related to them, please contact Julie Trocchio, CHA Senior Director of Community Benefit and Continuing Care, at 202-721-6320 or email Jtrocchio@chausa.org.

<u>Center for Health Care Strategies' Response to HHS SDOH RFI (11/15/18)</u>

HHS has issued a [request for information (RFI)](#) to *better understand how healthcare providers and plans identify and manage Medicare patients who have social risk* factors. HHS will be using the information it gathers from the RFI to produce a report requested by Congress. The report will examine factors such as income, education, race, employment, housing, etc.

With the recognition that social determinants of health (SDOH) can account for up to 40 percent of individual health outcomes[1], particularly among dual eligible populations, their providers are increasingly focused on strategies to address patients' unmet social needs (e.g., food insecurity, housing, transportation, etc.). With support from the Robert Wood Johnson Foundation, the *Partnership for Healthy Outcomes* brought together Nonprofit Finance Fund, the Center for Health Care Strategies, and the Alliance for Strong Families and Communities to capture insights on partnerships between community-based organizations and health care organizations, particularly those serving low-income and vulnerable populations. Insights from one of the partnerships profiled, Eastern Virginia Care Transitions Partnership, can help to inform future efforts to address social needs among dual eligible populations, as noted in the responses below.

Background on EVCTP: In 2012, in response to a funding opportunity from the Centers for Medicare & Medicaid Services (CMS) Innovation Center's Community-Based Care Transitions Program (CCTP), Bay Aging — an Area Agency on Aging (AAA) serving the southeastern region of Virginia — teamed up with five health systems to form the Eastern Virginia Care Transitions Partnership (EVCTP). The partnership is designed to reduce hospital readmissions and improve quality of care among older adults and those with complex illness through an evidence-based care transition model and in-home assessments. This unique collaborative effort is a largescale partnership including Bay Aging and four other AAAs, four health systems, three managed care organizations (MCOs), and other health care and human service providers. Since then, EVCTP's success in helping consumers transition from hospital (or another care setting) to home and reducing hospital and nursing home readmissions has led to the formation of a statewide coalition of 25 AAAs, known as VAAACares. The program serves as a one-contract, one-stop entity for comprehensive care coordination, care transitions, and other community-based services for Virginia's dually eligible Medicare and Medicaid beneficiaries[2].

The specific questions HHS are interested in include:

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

In the EVCTP example, in preparation for the CCTP funding opportunity, which charged awardees with reducing avoidable 30-day all-cause hospital readmissions by 20 percent, EVCTP conducted a root cause analysis to identify clinical diagnoses linked to the highest volume of readmissions within the aging

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[1] B.C. Booske, J.K. Athens, D.A. Kindig, H. Park, and P.L. Remington. "Different Perspectives for Assigning Weights to Determinants of Health." University of Wisconsin Population Health Institute, 2010.
[2] D. Kozick. "Collaborating to Reduce Hospital Readmissions for Older Adults with Complex Needs: Eastern Virginia Care Transitions Partnership   ." Partnership for Healthy Outcomes, 2017.

population. Based on this data, EVCTP defined its target group for CCTP as Medicare and dual eligible beneficiaries with at least one of the following diagnoses: (1) congestive heart failure, (2) chronic obstructive pulmonary disease, (3) acute myocardial infarction, (4) pneumonia, and (5) septicemia. Additionally, upon discharge, EVCTP coordinates in-home and community-based supports for Medicare and dual-eligible individuals across the state. Following a hospital discharge, a coach from the local Area Agency on Aging (AAAs) conducts in-home assessments and virtual check-ins to further assess social risks. Eligible patients, based on screening results, are linked to a dedicated coach who then connects them to services based on their specific social service needs, including: transportation to medical appointments, home-delivered meals, and home repair to facilitate independent living.

- **Are there especially promising strategies for improving care for patients with social risk?**

Promising strategies for improving care for patients with social risk (from the EVCTP partnership example) include meeting the patients where they are – meaning, connecting them with a dedicated coach in the hospital, prior to discharge, to ensure that timely linkages are made with the social service providers who can address needs that prevent future avoidable admissions. Dedicated and experienced coaches also conduct in-home and virtual check-ins to further assess and monitor patients' social risk needs, recognizing the evolving nature of the target population's needs over time. The EVCTP partnership also models the potential benefits of a collaborative approach to improving care for patients with social risk by bringing together the expertise of health care professionals with established community-based social service providers (in this case, Area Agencies on Aging), well-versed, culturally sensitive, and experienced in identifying and addressing the social risk issues that present in dually eligible populations. Tapping into the network of AAAs also helped the partnership successfully scale its operations across the state of Virginia.

- **How are costs for targeting and providing those services evaluated?**

There are inherent challenges to evaluating the costs of related services provided to patients with social risk, some of which are particularly difficult to quantify. In addition to the direct costs of providing the services in question, there are also administrative costs related to the staffing/training for assigned coaches to outreach to and coordinate care for targeted patients. There are also costs associated with maintaining the infrastructure that supports ongoing administrative activities including data collection and reporting processes and maintaining electronic data sharing platforms to support the exchange and compilation of relevant measures to manage ongoing provider activities.

- **What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)?**

N/A

- **What is the return on investment in improved outcomes or reduced healthcare costs?**

While ROI is often difficult to measure given the challenges in assessing costs (and related savings) of social services provided, as noted above, some providers have been able to measure some returns in recent years, particularly in terms of reductions in avoidable ED/inpatient admissions. As an example, the EVCTP partnership, which was originally formed as part of the CCTP program through CMS, with a

specific goal of reducing avoidable admissions by 20 percent (within 2 years), reduced 30 day readmission rates from 18.2 to 8.9 (from Feb. 2013 - Jan. 2015), resulting in an estimated savings of $17M through on 1,804 avoided readmissions.

Another CHCS project, Promoting Integrated Care for Dual Eligibles (PRIDE), is a national initiative made possible by The Commonwealth Fund that is focused on advancing high-quality integrated care for dually eligible beneficiaries. This learning collaborative of nine leading integrated Medicare-Medicaid health plans that are locally based and have special expertise in serving this population, have developed various approaches to delivering targeted, value-added services to meet their members' social service needs. The plans are not paid to provide value-added services described in this brief (i.e., value-added services are not included in rate-setting calculations), but the plans often offer them because they anticipate that doing so will improve health and cost outcomes. PRIDE plans described several challenges with assessing the return-on-investment of value-added services, including:

- Lack of specific methodologies and consistent data to understand the impact of offering services to different members in an ad hoc manner;
- Assessment of "intangible" factors to measuring overall member well-being, such as improved quality of life by living at home;
- The impact of cost avoidance, rather than actual spending, as appropriate. For example, it is difficult to measure how many people could be admitted to a nursing facility without these value-added services;
- General internal capacity to conduct the resource-intensive analyses needed to determine a return-on-investment; and
- Difficulty in projecting additional demand for value-added services.

- **What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?**

One promising approach to referring beneficiaries to relevant social service organizations is to link them to a dedicated coach (with community ties) who can help navigate the patient through the various resources available and prioritize the various services offered to improve patients' health. Also, maintaining a shared database for the care team to share relevant data in real-time seems to further support addressing social risk factors effectively.

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

Some lessons from our EVCTP case include:

1. **Involving active champions in the design and implementation of care models that address patient issues**. For EVCTP, the president of the Bay Aging, the leading AAA, and the vice president of clinical integration for Riverside Medical System, not only encouraged other AAAs and hospitals to participate, but were able to address early concerns from AAAs and health systems. These champions were able to activate meaningful participation from provider partners/community stakeholders. Both acknowledged that the partnership would not have been successful without strong representation from each.

2. **Building in flexibility into Service Models** – Designing and implementing a nimble service model that can evolve with the needs of its target populations is vital to ensure that care continues to be responsive to changing patient needs. Partnerships should adapt their service models based on community feedback, outcomes data, and changes in the local/federal political and regulatory environment. The patient community has and should continue to play a particularly active role in identifying unmet needs and making suggestions for program design.

3. **Making time for upfront relationship-building**. CBO and health care partners build trust with one another through shared governance, contributions of in-kind services, and sharing patient data — with each contributing distinct and complementary areas of expertise. This relationship-building process also extends to patients becoming more engaged in their own care as the partnerships support a more person-centered approach.

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

We noted significant barriers to providing care to patients with social risk factors, particularly in terms of ongoing capacity-building needs of providers who care for them. As such, some ways these barriers can be addressed include making available:

1. Advice on **financing and potential funding models** to support activities – challenges remain around securing sustainable funding to support infrastructure and services for patients with social risk factors.
2. Support for providers with planning for and building appropriate capacity, including **estimating the costs** related to providing specific partnership services.
3. Guidance on **measurement approaches for collecting and communicating data across partners** and making informed decisions based on this data.
4. Assistance with more **formal evaluations of outcomes and cost savings** to supplement the largely anecdotal findings that have been tracked to date.

- **For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?**

Patients' disability further substantiates the need for support to prioritize the various resources available to patients, as well as individual priorities to ensure a person-centered approach to their care. Furthermore, the ability to screen patients in their homes and provide services at home or virtually helps to promote effective care for patients for whom travel is challenging.

- **Which social risk factors are most important to capture?**

N/A

- **Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected**

consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)?

Identifying program metrics that resonate across all provider partners and reaching consensus on an effective outcomes-reporting process are time-intensive and complex for partnerships, yet vital to their ongoing success. The CBOs and health care partners interviewed are working toward more formal evaluations of cost savings realized through partnership, which to date have generally been tracked anecdotally.

Most partnerships we have explored have data-sharing systems in place, though these vary in complexity and sophistication. For some partnerships, data shared between partners has evolved from basic utilization measures, which were simplest to vet with the group at first, to more sophisticated trend analyses and quality improvement indicators, through a "learn-as-you-go" approach. Many share patient-level data as part of service delivery, while some share data to communicate progress toward partnership goals internally and/or externally.

- **What are the burdens of this data collection on plans, providers, and beneficiaries? · Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?**

Data collection is burdensome for providers and MCOs as illustrated by the EVCTP case study, where the hub AAA received pushback initially in terms of time and resources to support data collection and has since dedicated significant staff time to refine reporting to support the partnership's activities. Standardized data elements for EHRs could help stakeholders with data collection and also facilitate the analysis and review of data by other stakeholders, including state representatives interested in scaling the model. It is also important to note that many, if not most, of community-based, local organizations and home-and community-based provider agencies that provide personal care and other Medicaid LTSS have limited data management infrastructure and capital to invest in expanding this capacity. As traditional Medicare providers and plans consider how to partner with these organizations, they might think about how to support investments and educate these organizations about how to use new systems to collect, analyze and report data.

CHANGE HEALTHCARE

Date November 16, 2018

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

Dear Deputy Assistant Secretary Destro,

On behalf of Change Healthcare, I am pleased to submit comments addressing the recently published RFI – A Study of Social Risk Factors and Medicare's Value-based Purchasing Programs.

Change Healthcare is inspiring a better healthcare system. Working alongside its customers and partners, Change Healthcare leverages its software and analytics, network solutions and technology-enabled services to help providers and payers improve efficiency, reduce costs, increase cash flow and more effectively manage complex workflows. Together, Change Healthcare is accelerating the healthcare journey toward improved lives and healthier communities.

Change Healthcare is a key catalyst of a value-based healthcare system, working with our customers and partners to accelerate the journey toward improved lives and healthier communities. While the point of care delivery is the most visible measure of quality and value, Change Healthcare is a healthcare technology solutions company that uniquely champions the improvement of all the points before, after and in between care episodes. Change Healthcare occupies a uniquely interconnected position at the center of healthcare, serving providers, payers, and consumers. As an independent healthcare IT company, we work with multiple platforms to address diverse needs.

Identifying beneficiaries with social risk factors and approaches we use to address the needs of Medicare beneficiaries with social risk factors

Change Healthcare's Member Engagement products combat social determinants of health and enable better outcomes by:

- Helping to improve member satisfaction and loyalty, by enrolling them in programs that can enhance their quality of life;
- Enabling increased retention in the member's health plan, promoting continuity of care;

- Facilitating financial security for members, helping them find and enroll in programs that provide economic assistance; and
- Encouraging better health with added benefits that enable members to seek care and manage their chronic conditions

Change Healthcare offers several solutions to address the needs of Medicare beneficiaries with social risk factors.

Dual Enrollment Advocate™

Change Healthcare's Dual Enrollment Advocate™ solution blends artificial intelligence and behavioral science to help solve the challenge of Medicare Advantage (MA) dual-eligibility identification and enrollment. This new technology helps health plans more accurately identify, engage, and enroll MA members who are eligible for both Medicare and Medicaid.

There are 58.5 million Medicare beneficiaries today[1], and 34% of them live at or below the Federal Poverty Level[2], indicating many might be eligible for Medicaid. Meanwhile, only about 10.6 million of 19 million Medicare Advantage members are dual-enrolled, representing a significant opportunity for Medicare Advantage plans[3]. The Change Healthcare Dual Enrollment Advocate uses artificial intelligence to pinpoint, with up to 93%* accuracy, those individuals with the highest likelihood to qualify for Medicaid. The result is that Medicare Advantage plans can quickly engage with this population and potentially enroll more of them faster.

Health plans traditionally have identified dual-eligible candidates using systems that require manual programming, continual updating, and are limited by small data sets and legacy technology. Dual Enrollment Advocate enables the rapid analysis of massive amounts of data in a fraction of the time otherwise required to identify optimal targets' dual-eligible status.

Change Healthcare's proprietary technology is deployed in concert with our member engagement teams, which apply behavioral science that uses intelligence gathered through consumer and expert interviews, focus groups, in-home immersions, and by engaging with

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[1] Source: CMS Fast Facts, January 2018: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html

[2] Source: Kaiser Family Foundation: https://www.kff.org/medicare/state-indicator/medicare-beneficiaries-byfpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[3] Source: CMS: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources.html

beneficiaries. The engagement teams use live advocates, targeted mailings, and other outreach methods to more effectively engage members and support them through the enrollment process.

Recert Complete™
Change Healthcare ensures dual eligible status is retained by engaging and guiding members through the state's annual renewal process.

Part D Complete™
Change Healthcare assists members apply for Low-Income Subsidy (LIS) also known as "Extra Help". Enrollment in LIS facilitates higher member compliance with prescription treatment plans through enhanced member Rx benefits.

Community Advocate™
Our Community Advocate™ product helps our contracted Medicare Advantage plans to address their members' socio-economic needs. We have a robust database of more than 15,000 public and privately-sponsored community programs for which we assist our members to enroll. Change Healthcare helps plans' low-income enrollees secure approximately $150 million in financial benefits through Community Advocate annually.

Supplemental Nutrition Assistance Program (SNAP) Education
All of the members that we assist to apply for Medicaid and/or the Medicare Savings Programs receive written information about the federal Supplemental Nutrition Assistance Program (SNAP) and how to enroll. Change Healthcare recognizes the impact SNAP can have on improving the health and wellbeing of elderly and disabled adults. Seniors and persons with disabilities can be particularly vulnerable to food insecurity, due to challenges that can include decreased mobility, limited shopping and cooking ability and health concerns.

Evidence regarding the impact of these approaches on qualify outcomes and the total cost of care
Evidence of the positive impact of Change Healthcare's assistance to low-income Medicare beneficiaries is the impact on plan tenure. On average, members we assist to enroll into Medicaid remain with their plan an additional 13.2 months, which represents a 46.6% increase in member retention. MA low-income beneficiaries stay more loyal to their plan when their socio-economic challenges are addressed. Additionally, these members express more satisfaction with their plan through a multitude of surveys that impact the plan's qualify-based bonus payments.

Change Healthcare is deeply committed to ensuring that Medicare beneficiaries have access to affordable medical coverage and the resources they need to address their socio-economic challenges. We strongly encourage CMS to incentivize health plans and providers to meet the socio-economic challenges of their low-income beneficiaries through qualify measures, program incentives or value-based care programs. Change Healthcare's experience has shown that its interventions with these members have been linked to higher quality care, improved health and lower costs.

Change Healthcare appreciates the opportunity to comment on the RFI. Please contact me if you have any questions or would like to arrange a follow-up meeting to discuss any of these issues in further detail. I can be reached by phone at 847-224-9468 or by email at terry.ward@changehealthcare.com.

Sincerely,

Terry Ward
Vice President, Product Management, Reporting and Analysis

David Schwartz
Head of Global Policy
Public Policy and Federal Government Affairs

November 16, 2018

VIA ELECTRONIC SUBMISSION TO ASPEImpactStudy@hhs.gov

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

Dear Ms. DeLew:

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

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

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

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

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

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

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

*   *   *

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

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

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

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

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

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

Delivery of Services

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

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

HealthSpring[1] days
To ensure that our members are able to access needed preventive services, we periodically bring together multiple vendors offering health screenings together at primary care physician (PCP) offices. Members can receive eye exams, blood pressure checks, mammograms, and osteoarthritis screenings in a single visit, and receive additional information and referrals to care management programs as needed. Some provider partners will make their offices available after hours or on Saturdays to conduct these events because they know they are important to their patients, but also because their caregivers or family members may not be available to accompany them during work hours.

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

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

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[1] Cigna-HealthSpring is the name of Cigna's wholly owned subsidiary offering MA and Part D plans.
[2] Cigna no longer owns the Living Well Centers in Philadelphia, but continues to partner with the clinics to offer services to our members in the area.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Data

Cigna data collection tool

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

Social Determinants of Health   10/18/2018

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

Family Dynamics/Support Systems

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

Primary caregiver: _____
Power of Attorney: _____ ☐ Same as primary caregiver.
Other Caregivers: _____

Access to Care

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

Home Environment

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

Barriers to Medication Adherence

Are there barriers to medication adherence? ○ Yes ● No

If yes, check all that apply:
- ☐ Cannot afford medication
- ☐ Does not understand instructions.
- ☐ Prefers not to take.
- ☐ Cannot swallow/administer

Other: _____

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

Readiness to Change

Is patient/family engaged in aging process? ○ Yes ○ No

If yes, check where they are in readiness to change:
- ☐ Precontemplation
- ☐ Contemplation
- ☐ Preparation
- ☐ Action
- ☐ Maintenance

Challenges to Engagement:
_____

Other Concerns:
_____

○ Yes	◉ No	Inadequate food quality.
○ Yes	◉ No	Substance abuse in home environment.
○ Yes	◉ No	Uses assistive device.

☐ Walker ☐ Wheelchair
☐ Hospital Bed ☐ Hoyer Lift ☐ Oxygen or other respiratory device

○ Yes	◉ No	Inadequate home environment for medical needs.
○ Yes	◉ No	Dysfunctionality barrier to health care.
○ Yes	◉ No	Mental health challenges in the home environment
○ Yes	◉ No	Does not feel safe in home/community

Personal

○ Yes	◉ No	Inadequate coping skills.
○ Yes	◉ No	Inadequate organization skills.
○ Yes	◉ No	Inadequate compliance.
○ Yes	◉ No	Language barriers (English as a second language).
○ Yes	◉ No	Work setting difficulties (inability to leave work for appts).
○ Yes	◉ No	Recent loss of significant person in patient's life

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

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

○ Yes ○ No Adult Protective Services contacted
Date Contacted [/ /]
Notes: [   ]

[Save & Close]

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

Barriers to data collection

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

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

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

Data analytics

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

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

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

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

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

Summary

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

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

Respectfully,

David Schwartz

November 16, 2018

To: The ASPE Impact Study at ASPEImpactStudy@hhs.gov

Re: RFI on Social Risk Factors

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this RFI about ways to improve Medicare, particularly for those living with advanced illness.

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those living with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high- quality, person- and family-centered care that is consistent with their goals and values, honors their dignity, and supports their family caregivers. C-TAC is made up of over 140 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving advanced illness care in the U.S.

C-TAC's definition of advanced illness is when one or more conditions becomes serious enough that general health and functioning begin to decline, treatment may no longer lead to preferred outcomes, and care oriented toward comfort may take precedence over attempts to cure – a process that extends to the end of life and that for some individuals and their families may lead to transition to hospice.

We appreciate the opportunity to respond to this RFI as those with advanced illness are often "medically complex" and have social risk factors that affect their health, quality of life, and the burden on their family caregivers. Below are our responses to your questions:

How do plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors?

Because many individuals with advanced illness have social risk factors, programs developed uniquely for them, including advanced illness management (AIM) and palliative care programs, regularly identify and address such risk factors.

Participants for AIM and palliative care are initially identified through a combination of medical, utilization, and, when available, functional information[i]. This is then augmented by a comprehensive assessment of the beneficiary's physical, emotional, social, and spiritual needs along with the needs of their family caregiver[ii]. This assessment is systematically done and captured by an interdisciplinary team. Through this highly personalized process,

the unique social risk factors of each beneficiary are revealed. These risk factors can be financial, social isolation and transportation challenges, low health literacy, poor nutritional access, etc.

Recommendation: That such a comprehensive, and ideally interdisciplinary, approach be adopted for all Medicare beneficiaries with advanced illness to better identify and address their needs and unique social risk factors**.**

What approaches plans and providers have used to address the needs of beneficiaries with social risk factors?

Whatever a beneficiary's social risk factors, any issues identified through the AIM or palliative care comprehensive interdisciplinary assessment are then addressed in a care plan based on that beneficiary's personal goals and values. This is a highly customized and effective way of addressing the range of needs that someone living with advanced illness has, including any social risk factors. This is also where opportunities for social supports and services are identified, both for the beneficiary and their family caregiver. In addition, another hallmark of AIM and palliative care programs is care coordination, as this is particularly needed for those with social risk factors who have complex medical situations and lives.

Beyond this, Secretary Azar's recent remarks[iii] about caring for the "total person" are exactly the right perspective. Encouragingly, some health systems[iv] and payers are starting to work with their local communities to better understand what resources are available there including identifying any barriers, such as long waiting lists to receive home nutrition support.   Instead of just adjusting for social risk factors, it is more helpful to figure out how to mitigate social risks for those with advanced illness at the local level. Health plans and providers can and should better understand the capabilities of the social supports in the communities where they provide services. They should participate in setting the community's priorities and mitigating any shortcomings in their local areas. They should know the capacity of local services and help support those agencies to meet the community's needs. Health payers and providers are and should be involved in understanding and addressing housing and transportation issues and participating with their local community-based services to enhance the workforce and to enable more family caregiving support. In short, they need to develop corporate citizenship in the communities where they are making their living. They should move beyond addressing individual beneficiary issues to helping build communities where these issues are monitored and managed*.*

Recommendations
1. That Medicare move to encourage and then require comprehensive care plans including social and family supports based on the personal goals of Medicare beneficiaries with advanced illness.
2. That systemic and systematic advance care planning and goals of care conversations be the vehicle to determine and update these personal goals and care plans. Respecting Choices [v]is an acknowledged leader in training people to have these

conversations.
3. That care coordination be an integral part of care for these beneficiaries.
4. That health plans and providers be encouraged to become more participatory members of their communities, better aware of available services or needs, and responsible for improving the quality of life for all with advanced illness beyond just providing medical care.

What is the evidence regarding the impact of these approaches on quality outcomes and the total cost of care?

The literature is now very consistent that AIM and palliative care approaches increase the quality of life for beneficiaries with advanced illness and their family caregivers[vi] and reduce cost[vii] by reducing unnecessary and unwanted utilization.

How does one disentangle beneficiaries' social and medical risks and address each?

With all due respect, this is the wrong approach. It is impossible to disentangle beneficiaries' social and medical risks and address them individually since they are inherently intertwined. Poor health literacy leads to difficulty managing medications and care instructions, which leads to poorer health. Lack of adequate nutrition works against medical treatment as it undermines peoples' ability to heal, maintain function, and avoid health crises. Our health care system has for decades only addressed peoples' medical issues and the gap between what they truly need and receive is growing, along with unsustainable health care costs. A more holistic approach, as Sec. Azar said[viii], is what is urgently needed.

Recommendation- That instead of separating social and medical risk, Medicare take a more holistic care approach for beneficiaries with advanced illness that is focused on quality of life for them and their family caregivers. An additional benefit of this approach is that it will address any social risk factors that also affect their health.

Is value-based purchasing a tool to address social risk factors?

We agree that beneficiaries with social risk factors could benefit from such alternate payment models. However, that is only if providers in such financial arrangements are able and rewarded for gathering the right information, e.g. functionality, quality of life, family caregiver burden, etc., providing holistic care, and are not penalized for caring for people with high needs and historically high cost.

For instance, a recent Government Accountability Office (GAO) report[ix] confirmed that the current Medicare Advantage (MA) risk adjustment calculation understates the effort and cost of caring for those with poor functionality. This is problematic, as it makes it financially less desirable to care for such patients, many of whom also have social risk factors. Yet functional information is not gathered as part of MA risk adjustment methodology and is therefore unable to be factored into that calculation.

Recommendations

1. That functional assessment be added to all Medicare programs. One option would be to add the functional assessment and additional social determinant elements to the standardized data to the Annual Wellness Visit. This will ensure these elements are included in the primary care plan of care and that EHRs will be required to accommodate it. Another option is exploring third party assessors, as per GAO report, should adding these assessments be too administratively burdensome on providers.
2. That value-based purchasing formulas be adjusted so as to promote the care of beneficiaries with poor function, high social needs/risk factors, etc.
3. That Medicare additionally explore adding assessments of quality of life and family caregiver burden for those beneficiaries with advanced illness.

What are barriers to collecting data about social risk? How can these barriers be overcome?

As noted above, a key barrier is that functionality, quality of life, social risk factors, and family caregiver assessments are not required inputs for Medicare programs or providers.

Recommendations
1. Shift payment incentives to promote capturing and acting upon this more comprehensive data.
2. Consider requiring federal CEHRT changes and providing funding to promote expanding medical records to include functionality and key social and family caregiver issues identified through comprehensive assessments.

In conclusion, we strongly urge Medicare to shift to truly person-centered care driven by patient goals and values, at least for those beneficiaries living with advanced illness, when "what matters" varies enormously. More comprehensive assessments and personalized care plans that address areas beyond medical issues will also identify and address any social risk factors. The result will be healthier beneficiaries, more supported family caregivers, and less unnecessary and unwanted medical care.

Thank you for the opportunity to provide these recommendations. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at 443-742-8872 or mgrant@thectac.org.

Sincerely,

Marian Grant

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[iii] https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html

[iv] https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly-hospitals/age-friendly-health-systems-initiative

[v] https://respectingchoices.org , https://altarum.org/publications/medicaring-communities-getting-what-we-want-and-need-frail-old-age-affordable-cost

[vi] vi Kavalieratos D, Corbelli J, Zhang D, et al. Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis. *JAMA*. 2016;316(20):2104-2114. doi:10.1001/jama.2016.16840

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[viii] https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html

[ix] https://www.gao.gov/products/GAO-18-588

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 succesful

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 beahavioral 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 indivuals. 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 to 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 comprenshive 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.[1] In this pilot, a seclect 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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[1] 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 behavorial 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 or by phone at 617-426-0600.

Tuesday, November 6th, 2018

Dear Assistant Secretary for Planning and Evaluation,

I am responding to the Request For Information recently issues by your office: ASPE Request for Information: IMPACT ACT Research Study – Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors.

I am an emergency physician based in Seattle Washington. Over the last decade I have been evolving community alternatives of care for individuals who frequent emergency departments for their care needs. My organization – Community Based Coordination Solutions, LLC – specializes in community resource management for frequent emergency department utilizers. My work over the last decade has exposed me to many of the issues you are seeking feedback on in the aforementioned RFI. I hope you and your team may find some of my feedback here of value in seeking solutions for this important issue.

Why base enrollment on emergency department visits? Emergency departments (EDs) serve individuals in crisis, but they are also the 'safety net' point of entry for individuals that can't access care elsewhere, be it due to lack of coverage, poor access to care, or even poor insight into how best to navigate the health care system. The threshold for access to care through emergency departments is often much easier for clients, even if said care is not the most appropriate option for their needs. As a cohort frequent ED utilizers are certainly experiencing social crisis. Amongst this patient cohort:

- 30% of patients are homeless

- 40% of patients suffer from a primary mental health disorder

- 50% of patients suffer from some form of substance addiction

- Over 60% of patients are Medicaid funded

Frequent emergency department visits are certainly not the only important social determinant of health, but as a metric it arguably identifies those clients in highest crisis and those most costly to our healthcare system. I have found that addressing this issues provides a valuable approach to development of community systems of care. Frequent ED utilization is the only metric we recommend for enrollment into our program (specifically, we target individuals with 5 or more ED visits within the last 12 months). The community systems approach we subsequently implement can then address diverse client needs, irrespective of their medical, social, or financial nature.

We have identified 7 factors that should be prioritized in establishing effective community systems of care to address the needs of frequent ED utilizers:

1. Direct patient engagement – Staff present within the community that can provide direct patient engagement

2. Customized Care Plans – Individualized care plans created through direct involvement with patients, providers and community resources

3. IT Solutions – Communities need a "common language" via which to exchange basic information. Several community solutions exist; we are strong proponents of Collective Medical Technologies' Emergency Department Information Exchange and PreManage tools, which provide HIPPA compliant information sharing across various community EMRS, monitors ED visits and state prescribing data in real time, and provides a portal for immediate community care plan access (please note, CBCS has no fiduciary relationship with CMT)

4. Community Resource Engagement – Clients' needs will be met most effectively when community resources are all engaged in a common plan of care for them. Resources that I advocate be engaged across the community of care include emergency department personnel, hospitalist and hospital resources (discharge planners and social workers), community providers (primary care and specialists), Emergency Medical Services and law enforcement personnel, jail programs, court advocacy programs, community behavioral health and chemical dependency resources, housing entities, community protective services (child and adult) and community transportation services, amongst others. Community resource engagement typically is most helpful at time of client enrollment and care plan development, although there is also tremendous value in bringing together said resources on a regular basis (we typically host a monthly community resource meeting) to discuss community issues of care.

5. Immediate Access Fund – Program staff need access to a pool of monies that are immediately available to provide for target client needs. Our staff typically use said funds to help with immediate housing and transportation needs, meals, clothing, phones, and medications, amongst other items.

6. Telemedicine – Can be very helpful in providing immediate "bridge" access until local provider access can be obtained.

7. At-risk reimbursement model – I have found payers to be much more interested in our product by providing at-risk (or pay-for-performance) contracts, which I am very comfortable doing. I typically base our contracts on a guaranteed ED visit reduction of 30% within first year of patient enrollment.

I have been very successful with this approach in programs across Washington state and Alaska. Our most recent launch in Mat-Su, Alaska showed over 45% reduction in ED visits, over 25% reduction in controlled substance pills provided (opioids and benzodiazepines), and over $3 million in costs savings within the first year of program implementation (70+ clients enrolled). Recently I have begun engaging state Medicaid agencies, as well as health and community-based organizations (e.g. Accountable Communities of Health, Community Care Organizations, and/or Managed Care Organizations) across the country. I feel this model of care is ideally suited for communities with high Medicaid enrollments (recall that over 60% of frequent utilizers across the country are Medicaid insured), and particularly valuable for communities with capitated or "at-risk" models of health management such as the aforementioned ACHs, CCOs and MCOs.

I hope you and your team find this information of some value. I would be more than willing to participate in further discussions at your request.

Sincerely,

Enrique Enguidanos, MD, FACEP, MBA

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Cell (206) 849-6713

REQUEST FOR INFORMATION
IMPACT ACT Research Study: Provider and Health Plan Approaches to Improve Care for Medicare
Beneficiaries with Social Risk Factors
November 16, 2018
Submitted by: Community Health Network Foundation
7240 Shadeland Station
Indianapolis, IN 46256

Karen Lightbourne
John Kunzer, MD
Marth Henn

Delivery of Services

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

- CMS grant collects social risk data on food access, transportation, housing, utilities, social and emotional isolation and safety, which is used to target the appropriate community-based partners to deliver services for our beneficiaries. We identify our beneficiaries initially by grant-defined eligibility criteria of geography (zip code) and Medicare/Medicaid qualified.

Are there especially promising strategies for improving care for patients with social risk?

- Our patients are screened for social risk factors upon entry to a clinical site, which is a promising strategy. It is part of the initial registration process. This promising innovation that could be easily, effectively and widely deployed.
- Screening results are entered into patient EHRs.
- CMS grant supports tracking on all individuals across the life of the grant, for some longitudinal data.
- Interventions for social risk factors need to become the standard of care for high-risk patients.

How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

- Our grant has not progressed far enough to have cost data to evaluate, but the intention is to have before and after cost comparison data for Medicare/Medicaid usage. It is in the intention of the grant to reduce these costs to our east Indianapolis population.
- Given that our grant is still in its earlier stages, the return on investment we forecast right now is not based on cost data but on the value of identified best practices in building the foundation for and the next iterative layer of the grant and our larger eastside population health and community development project, Community Collaborations.
- Initial data indicates that the top social risk factors in our area are 1) food access, 2) safe housing and 3) transportation. We also see large numbers of patients without a primary care provider, so connecting them to care is a top ambition of the program.

- Data about social risk factors garnered from initial screening and then subsequent interviews allows us to target on behalf of the patient the community-based organizations likely to be of the greatest benefit.
- Technology is a best practice for referrals of beneficiaries for social service organizations that can help to address social risk factors. Our Community Health Advocates (CHAs) have an independently funded pilot in place with our local United Way agencies that allows our CHAs to refer patients directly into the United way's Efforts to Outcomes program for services and tracking.
- The CHAs currently have about 200 people for whom they are providing navigation services. About 75% cannot be reached subsequent to initial contacts; CHAs use phone numbers as listed in EHRs. Partner organizations report similar challenges to reaching clients for follow-up so there is a clear opportunity to develop best practices for effective and ongoing communication.

What lessons have been learned about providing care for patients with social risk factors?
- Especially in emergency departments, our best lesson has been the value of asking questions about social risk at the critical moment of high need. Patients may not be used to being asked these kinds of questions or interacting with an advocate, but they will and do share about their lives. Our grant staff typically screen clients in clinical settings before they speak with any medical personnel. We are asking them about their lives, not their medical conditions, and get generally very candid and useful responses.
- While the initial screening is a window of opportunity, follow-through remains a challenge. We continue to revise and tweak standard operating procedures, searching for better follow-up results.

What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?
- Our greatest barrier to tailoring services is to achieve ongoing communication, beyond the initial screening. Phone follow-up is proving to be difficult; it could be linked to caller IDs showing a hospital or health network is the caller. One group of CHAs tried texting and we hope to develop some comparison results as to whether texting is a better mechanism for follow-up outreach.
- Time factors can be a barrier, as to how much time is possible for initial screening. Then when advocates are able to schedule and conduct follow-up interviews and development of healthcare access plans, initial projection of needs typically gets complicated by a host of additional challenges that are uncovered. Ex: referral for food sources reveals a transportation challenge. More time at initial screening may reveal a more complete initial picture.

For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?
- If a patient enters the emergency department with a disability, a functional challenge or frailty, they typically have a higher acuity level, which means on a practical level that those patients screenings are often delayed until after admission or discharge. If CHAs can reach the client at all, these are phone screens, which present diminished effectiveness in comparison to in-person screenings.
- Even when these individuals screen for transportation needs, there are few truly helpful solutions that either the CHAs or other community-based organizations have to offer.

Data

⏱**Which social risk factors are most important to capture?**
- Food, transportation, housing, economic situation and primary care status are the social risk factors most critical to capture.

⏱ **Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?**
- When a patient presents to a primary care office or the emergency department (ED), a Community Health Advocate or Front Desk Staff will check for Medicaid/Medicare status and zip code. A staff member will then give patient a screener tablet device, or paper, and have the patient complete a screening that collects data on social risk factors. Staff will tabulate screener and provide relevant resource information to the patient. In addition, some patients who have presented in ED twice within the past 12 months will be able to utilize a CHA.
- Data is collected from identified beneficiaries several times a year.
- Our program does consistent and universal screening of Medicare/Medicaid patients at different locations.
- There are different workflows at different locations that can burden providers and affect the willingness of providers to screen, including that staff must be trained. Sometimes staff are unaware of resources to assist patients.

⏱ **Would standardized data elements for EHRs help you to collect social risk data? Yes If so, how could these data elements be standardized?**
- Our EHR does contain some standardized data elements for at least some social risk factors. The challenge is to convince more providers to screen for these elements, but providers need to have solutions at hand to present to patients before they are willing to ask social risk factor questions.

⏱**What are barriers to collecting data about social risk? How can these barriers be overcome?**
- Barriers to collecting data about social risk include staffing, limited time with patients, buy-in from staff and technology challenges.

⏱ **What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**
- Promising opportunities for improved data collection include EHR integration and a greater quantity of data reflecting the importance of social determinants of health would allow for more tailoring of services.

From:	compliance@constellationhealth.com
Sent:	Friday, November 16, 2018 4:23 PM
To:	ASPE SES IMPACT Study (OS/ASPE)
Cc:	Patricia Saldana
Subject:	ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Good afternoon,

We include our comments related to Improve Care for Medicare Beneficiaries with Social Risk Factors.

Social Risk factors have become a substantial barrier to address the disadvantaged population's health needs and goals. At Constellation Health, we understand the importance to target such barriers and create effective care coordination programs to produce meaningful outcomes. Approximately fifty (50%) of our membership are dual eligible, increasing the vulnerability to social risk factors.

Part of Constellation Health Plan approaches to target social risk factors include the care management team interventions through telephone calls, interdisciplinary care team discussions and the Community Outreach Program assessments and interventions, focal groups and the integration of service providers within the decision making process and other service coordination approaches. All of these interventions produce meaningful information regarding social risk factors and other barriers of the social determinants of the population we serve. This information in used for the development of products that address these barriers and fulfill the needs that could impede reaching the individualized care plan goals. Some examples of these initiatives include, the benefit of transportation to medical appointments, caregiver services, health services provided within the beneficiary's home setting and other coordination provided through health plan providers or other community services. We have other Care management programs that include health condition electronic monitoring to grant direct access to care management teams for members with certain chronic conditions. This program include an onsite nutritional, social and clinical evaluation process with an interdisciplinary team that target to better the health status outcome, reduce readmissions and create engagement with the member and their support group.

Our Community Outreach Team has also become a proactive way of assessing, documenting and addressing from a qualified professional the beneficiaries health and functional status, support group issues, socioeconomic position, transportation barriers, physical environment or any other risk factor that may reduce or impede a positive outcome within their healthcare status. This team include social workers and other professionals that visit the beneficiaries and asses all these aspects with a comprehensive documenting tool. This information is discussed with the Clinical Affairs Team and can be used to produce service coordinations, ICT discussions, Care Management Interventions and other initiatives to target the issues identified by the Community Outreach Team and address all the social risk factors as observed. This has become the best way to identify social risk with the professionalism and sensitivity point of view. The receptivity of the beneficiaries is great, they become part of the process and the intervention's scope, may include the immediate family members or those that become part of the support group. On the other hand, it helps to promptly identify members that lack a support group or that may be in danger due to the present living conditions. It is in our best interest that we could continue to increase resources to this program and extend the scope and the interventions they perform. We will continue to improve and move towards higher standards to identify, asses and address social risk factors within our entire membership.

Thank You,

Regulatory Affairs Department

Constellation Health, LLC
PO Box 364547
San Juan PR, 00936-4547
e. compliance@constellationhealth.com

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November 16, 2018

Brenda Destro, PhD
Deputy Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

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

Dear Deputy Assistant Destro,

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. We greatly appreciate the opportunity to comment to the Office of the Assistant Secretary for Planning and Evaluation, HHS (ASPE) on the above referenced Request for Information (RFI).

The FAH commends ASPE's efforts to understand and address the challenges related to the effect of an individual's socioeconomic status (SES) on quality measures and measures of resource use within the Medicare payment programs. In particular, the FAH commends ASPE's recognition that researchers, hospitals and others have been examining the degree to which SES impacts patients, and we appreciate the agency reaching out to the community to learn what may have been discovered through the research.

Hospitals have undertaken a wide variety of efforts to improve health outcomes through the mitigation of social risk factors, and those efforts demonstrate wide variation across communities and hospital systems. There is no one mitigation strategy that has proven to be the panacea for every community. This wide variation across communities poses significant challenges to enterprise-wide efforts to reduce the impact of social risk factors and meaningful initiatives tend to be localized ones. In addition, challenges are constant and arise from varying incentives, burden of implementation including staffing and cost, and challenges to data collection.

Efforts for improving health outcomes for Medicare 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?

Do you routinely and systematically collect data about social risk? Who collects this data? When
is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected
consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients
receiving specific services, etc.)? What are the burdens of this data collection on plans,
providers, and beneficiaries?

Our members focus on bolstering social risk factor mitigation through efforts to reduce readmissions, within bundle programs, and in engagements with public health departments and community coalitions. Generally, these efforts are performed through individual local hospital initiatives on a case-by-case basis rather than at the enterprise level. In other words, our hospitals work with their communities to address the problems of greatest need within those communities. In particular, a number of FAH hospitals leverage social risk factor data as one of the factors in developing patient discharge plans. Within certain hospitals, the intensity of discharge planning has increased due to a growing recognition that a particular community's social risk factors need to be addressed to remediate readmission rates in their local community. The determination by hospitals to invest in these efforts is often made as a function of knowledge of and access to local services that will help mitigate the risk factors, higher rates of readmissions at the hospital level relative to national averages, or enrollment in a bundle or value-based payment program. Hospitals generally will collect data only if it is within the hospital's sphere of influence to mitigate. As such, these efforts vary greatly and are only meaningful at a local hospital level. Our members have found it challenging to apply a program working within one community to a distinct separate community, sometimes in a different state. Local factors play a significant role in the success of social risk factor mitigation.

Challenges to addressing social risk factors

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

Our member health systems interested in moving towards centralized discharge planning or enterprise-level risk factor mitigation initiatives face substantial hurdles. At the local hospital level, the burden of identifying social services to which the hospital can effectively refer, the investment required to extend risk factor information gathering, and overcoming regulatory hurdles to address risk factors are among some of the barriers hospitals encounter.

The enterprise-wide sustainability of social risk factor mitigation efforts rests on the alignment of appropriate financial incentives and the moderation of current regulatory frameworks. Family discharge liaisons, social workers and the development of a social services bench requires a substantial up front investment which hospitals must weigh and balance against limited resources and competing priorities such as among improvement efforts, or necessary capital investment in, for example, health information technology and life-saving equipment. This makes it very challenging for hospitals to devote the resources needed to mitigate risk factors. While in some instances hospitals participate in state Medicaid programs' efforts to coordinate a response to address SES, no such national, coordinated effort exists for Medicare beneficiaries. Some hospitals are turning to 'social determinant' vendors in efforts to devise mechanisms for efficient, cost-effective data collection at an enterprise level. Finally, developing tighter links between hospitals and primary care

physicians and also with post-acute care setting providers would help mitigate some of these barriers.

The scarcity of data to identify patients and monitor progress further challenges the development and implementation of strategies for improving care for patients with social risk factors. Without real-time data there is no way to identify or monitor progress. There is a dearth of aggregate level data that is standardized at a national level and easily accessible.

The acquisition of patient level data presents another level of complexity due to the sensitive nature of the data being collected as well as cultural or social apprehensions on the part of patients. This type of data is not something patients may be willing to reveal. For example, a patient experiencing the need to make a tradeoff between paying for food or medications may be reluctant to acknowledge that. Another example is the lack of comfort some patients elicit with letting home health agencies into their homes for the purpose of assessing social risk factors. The FAH encourages ASPE to develop suggested strategies for improving risk factor data collection. It would be helpful to hospitals for ASPE to articulate promising future opportunities for improving data collection and for using existing or future data to tailor services.

Suggested strategies for improving data collection of risk factors

The lack of standardization of data elements makes it challenging to use risk factor data because this adds to the burden of collecting the data as well as providing limitations in the ability to monitor progress of programs. However, beyond data standardization, the qualitative nuance of the data that needs to be gathered requires best practices education and training. Many of these questions are not satisfied with basic" yes/no" answers. For instance, in order to identify an adequate caregiver, it is not sufficient to ask the patient if he/she has a caregiver. There needs to be an assessment of competence and access to the caregiver as a function of the level of need of the patient. The same is true for transportation; the quality and nature of the access to transportation needs to be assessed as a function of the patient's needs. Discharge or Enrollment liaisons would benefit from standardized questions that have been developed with consideration of the qualitative nuances required. Liaisons responsible for gathering this data at an individual level should also have cultural competency training and be familiar with techniques for eliciting data of a sensitive nature.

A promising future opportunity lies in the development of a strategy for assessing appropriate organisms for data collection and sharing. Such a mechanism will become important to assess the best sources and organizations for the collection of data. Certain data is more easily accessible to payors versus acute hospitals versus post-acute facilities. Upstream data dependencies across the care continuum will need to be evaluated. For instance, acute care hospitals would benefit from payors making some of this social risk data available to them. In the same vein, rehabilitation hospitals rely on acute care hospitals to provide information upon discharge related to behavioral health, symptoms of spousal or familial abuse, etc.

Potential sources of data include hospitals (acute versus rehabilitation or post-acute), Medicare or Medicaid as the vehicle to assist with social determinants of health gathering, payors, and public health offices. Looking at outcomes that public health agencies have gathered will help identify opportunities. Medicaid could be seen as a vehicle to assist with social determinants of health. Traditional Medicare could play a role in delivering data and

resources to support beneficiaries. There is access to a lot of state level data at a federal data level and this could be leveraged to tap into state-level data.

What Data is important to collect

Which social risk factors are most important to capture?

The FAH provides the items below with the social risk factors that are important to capture at an individual level with some examples of the types of questions used to capture them:

- Educational level of the patient
- Health literacy of the patient
- Patient Activation Measure
- Health behaviors
- Payor status (What is covered by the patient's insurance? Can the patient afford the care they need?)
- Caregiver (Does the patient have an adequate care giver who is able to support the patient in the way she needs?)
- Home Environment and Housing Insecurity (Is the patient in a supportive and safe home environment? Does the patient have safe and comfortable housing?)
- Community Environment (Is the patient in a safe and supportive community?)
- Transportation (Does the patient have adequate and reliable means of transportation to get to follow-up appointments or to acquire medications? Does the patient live in a location where transportation is not easily accessible?)
- Food (How far away from the patient's house is the nearest grocery store? Does the patient have access to the nutrition he needs to get better? Does the patient have dietary problems?)
- Barriers to social support services
- Financial (What financial trade-offs must the patient consider against purchasing prescribed drugs?)
- Frailty/Functional Status/Disability
- Domestic or spousal abuse symptoms

The FAH appreciates the opportunity to respond to the RFI and to offer these suggestions for improving data collection and the use of social risk factor data for improving patient care. If you have any questions about our comments or need further information, please contact the FAH staff at (202) 624-1500.

Sincerely,

Claudia Salzberg, PhD
Vice President, Quality

GREATER NEW YORK HOSPITAL ASSOCIATION

November
Sixteen
2 0 1 8

VIA EMAIL: ASPEImpactStudy@hhs.gov

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Request for Information on Provider and Health Plan Approaches to Improve Care for
        Medicare Beneficiaries with Social Risk Factors

Dear Ms. Destro:

Greater New York Hospital Association (GNYHA) is pleased to respond to the U. S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation's (ASPE's) request for information on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

GNYHA is a trade organization representing more than 160 hospitals and health systems across New York, New Jersey, Connecticut and Rhode Island. Through work across the membership, and particularly our New York members, GNYHA has had the opportunity to learn how social determinants of health are being assessed and addressed. We have done this as part of our ongoing support of our hospital-sponsored primary care practices and, more recently and more broadly, hospital-led organizations implementing New York's Delivery System Reform Incentive Payment (DSRIP) program. A key DSRIP component has been to assess what social risk factors contribute to poor health outcomes and how they may be addressed to reduce avoidable hospitalizations and emergency department use. A parallel component of New York's DSRIP program has been for the State to move Medicaid managed care contracts to higher levels of value-based arrangements. While DSRIP is targeted to Medicaid beneficiaries (a subset of whom are dual-eligibles), we believe that the lessons learned from this experience would also benefit the development of a general approach for Medicare beneficiaries and Medicare Advantage plans entering into value-based payment arrangements.

GNYHA's response will summarize ongoing efforts, best practices, and challenges to (1) screening patients for social risk factors; (2) addressing social determinants of health; (3) data collection; (4) and evaluating interventions. [1]

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[1] Within this response, we use the terms "social risk factors" and "social determinants of health" interchangeably.

GNYHA

Screening Patients for Social Risk Factors
In a recent survey conducted by the New York State Department of Health's Bureau of Social Determinants of Health, fewer than half of the 260 responding providers—which included hospitals, community-based practitioners, and federally qualified health centers—routinely screen patients for social needs. The survey results are consistent with GNYHA's experience with member hospitals, which are in various stages of implementing screening tools and workflows to assess patients for social determinants of health.

New York hospitals are also in the early stages in considering how they might use patient demographic information to address social risk factors and health disparities. GNYHA has begun to work on this issue in the context of CMS's Partnership for Patients (PfP) initiative. GNYHA is co-leading a Hospital Innovation Improvement Network for approximately 175 New York hospitals, and as part of that effort, we surveyed PfP participating hospitals regarding collection of demographic, race, and ethnicity information. Forty-six hospitals responded indicating that they regularly collect this information as part of admissions and outpatient registration. While this data collection is a promising start, there is work to be done to use it for effective interventions and to integrate it with separately gathered data based on screening patients.

Selecting a Screening Tool
In assessing social risk factors, an initial challenge that GNYHA members have encountered is selecting a screening tool. There are numerous screening tools available, some validated and others developed more informally based on provider and social worker experiences in treating their patients. Some tools include questions on several social determinants, while others focus on one or two key social needs. The Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) project requires a specific screening tool and GNYHA members participating in the AHC project are working with that tool. GNYHA hospitals not participating in the AHC project have spent a considerable amount of time reviewing and assessing existing tools. In some cases, hospitals determined that none were right for them and created their own tool by pulling questions from existing tools, rewording questions to better meet their needs, and adding questions that they did not find in any tool.

To assist member hospitals that have not yet selected a screening tool, GNYHA is creating a repository that will be available on its website shortly. We believe that having screening tools and questions available in one place will help GNYHA members accelerate the selection process. As more hospitals and practitioners begin using and validating screening tools, we expect that there will be more clarity on which work best within different settings and under different circumstances. A similar effort to create a national repository of screening tools may be something that HHS or another agency may want to undertake.

Implementing Screening Workflows
Another challenge that GNYHA members have encountered is developing a workflow that supports effective screening without being overly burdensome. Most GNYHA members with whom we have discussed screening tools are conducting screenings annually. GNYHA members, for the most part, have not yet developed best practices in screening; instead, they are continuing to test different screening workflows and administration modalities (e.g., paper-based, using tablets). Related to this, hospitals must determine who should perform the screening. Some tools are designed to be self-administered by the patient or a family member and others are

administered by staff, particularly if the screening tool is not available in the patient's preferred language. From our discussions with GNYHA members, the typical staff members who administer social determinants of health screenings are patient navigators, community health workers, health coaches, social workers, and volunteers. A positive screen (i.e., a finding that a patient has a significant social need) is typically forwarded to a social worker who can conduct a more thorough assessment and begin interventions. Hospitals must then consider how screening results can be communicated to the health care practitioner and what – if anything – the practitioner is expected to do with the information.

One of the screening workflow issues being explored is whether screenings should be for all patients or targeted to a subset of patients. We understand that some vendors are marketing a product whereby publicly and commercially available data sets can be analyzed with the goal of targeting screening efforts towards particular individuals, communities, and populations. In discussions with GNYHA members, the concept and overall approach may be of interest as they think about how to best utilize resources.

Ambulatory Care Experience with Social Risk Factors
Over the last 10 years, New York's primary care practices (e.g., hospital-affiliated, community health centers, physician practices) have been engaged in a significant effort to incorporate behavioral health screenings for depression, anxiety, and substance use disorder into their workflows. Much of this work has been done as part of efforts to achieve patient-centered medical home (PCMH) recognition by the National Committee for Quality Assurance. In our experience working with GNYHA members, there is sometimes a disconnect between the ambulatory experience and new efforts being considered for inpatient settings. The significant communication and tracking workflow experience developed for these screening tools in the ambulatory settings could potentially be leveraged to assess social risk factors for Medicare beneficiaries in hospital inpatient settings and other parts of the health care continuum (e.g., skilled nursing facilities).

Addressing Social Determinants of Health
Screening for social determinants of health has been coupled with promising strategies to implement interventions to address identified needs. GNYHA members have undertaken some of this intervention work themselves, but what is emerging more commonly are efforts to partner with community-based organizations (CBOs) that provide social services.

Hospitals Addressing Social Determinants of Health
GNYHA member hospitals, and particularly their ambulatory care departments, have added new roles to help ensure that patients with complex needs attend appointments and adhere to medication and self-care regiments. These care manager, care coordinators, health coaches, and community health workers employed by the hospital are often called upon to help address social needs which contribute to exacerbation of chronic diseases. Medicaid beneficiaries with two or more chronic health conditions are also referred to one of New York's Medicaid Health Homes. The Health Home program provides reimbursement for care management services for enrolled patients, and care managers often help patients navigate both their medical and social needs. These staff roles have been critical to addressing these needs and in reducing potentially avoidable hospitalizations.

As part of their efforts to address social determinants of health, hospitals have also begun to educate practitioners and other clinical staff on social risk factors to help them understand the impact of these issues on patients and how it may impact their treatment adherence and health outcomes. In response to graduate medical education accreditation requirements and more public awareness of social risk factors, New York's teaching hospitals have started to focus on ensuring that medical residents are aware of these issues as part of their education. GNYHA recently completed a project working with 15 member teaching hospitals in New York where the residency programs were partnered with local CBOs (e.g., food banks, senior centers) and primary care residents were educated regarding how the CBOs assisted their clients. The residents reported appreciating the opportunity to learn about some of the services available in the community to help their patients with their social needs, and the CBOs expressed appreciation at being able to work more closely with their local hospitals for the benefit of their mutual clients.

CBOs Addressing Social Determinants of Health
GNYHA members recognize that New York's CBOs provide critical services to address social determinants of health and many of these organizations have a long history of providing critical support to their communities. In particular, GNYHA member hospitals have reported that they are impressed at how CBOs are trusted entities whose staff understand the local landscape and cultural concerns. While hospitals and health systems seek to collaborate with CBOs whenever possible to address patients' social needs, there are some challenges that have emerged to navigating successful hospital-CBO partnerships. These challenges are detailed in a publicly available research report sponsored by GNYHA and the New York Academy of Medicine, entitled *Partnerships Between New York City Health Care Institutions and Community Based Organizations: A Qualitative Study on Process, Outcomes, Facilitators and Barriers to Effective Collaboration*.

Based on the research, keys to successful partnerships include invested leadership from both partners; appropriate consideration of the financial needs of the CBO; systematized workflows for the two organizations; routine communication between the two entities; and a clear set of metrics to define successful outcomes. Partnerships with these elements have resulted in improved care for high-risk patients, and this has been documented in data collected by GNYHA members that have implemented these interventions. The major challenge associated with CBO partners is related to sustaining the projects, programs, and related staffing that comprise partnership activities. As part of their DSRIP participation, New York CBOs have provided services to address social needs, including patient outreach, cultural competency trainings, community health worker services, and chronic disease management education. With DSRIP funding slated to end in March 2020, hospitals and CBOs are discussing how to financially support partnerships that are becoming well-established and more integrated into patient care.

As social risk factors are identified and CBO partnerships are developed, a need has emerged to improve connectivity between hospitals and CBOs to facilitate referrals and ongoing communication about shared patients. Many GNYHA members have adopted technology to assist in this effort and GNYHA has been a forerunner in supporting this effort through its Health Improvement Tool for Empowerment (HITE), which was developed 20 years ago. HITE, which is publicly available at www.hitesite.org, allows users to search thousands of free and low-cost social service resources in their community. HITE, along with other technology, allows staff

from hospitals and social service organizations to search for services related to needs identified in a social determinant of health screening. Other technology solutions that can send referral notices to CBOs that can provide those services are also being tested.

Efforts are also underway to use technology to "close the loop" on social needs referrals, which mirrors work that has been done for PCMH where providers are encouraged to follow up on referrals to specialty providers. Implementation of these tools is ongoing, and GNYHA views this as a promising strategy to encourage connectivity between organizations that otherwise lack a communication infrastructure. While the focus for much of this effort has been Medicaid beneficiaries with complex needs and limited resources, the approach could be tailored to meet the needs of Medicare beneficiaries also.

Data Collection
A benefit of the screenings being conducted by hospitals and the technology tools being implemented is that more robust data is being collected on individual social needs. The experience with these screenings should be useful for those considering how data on social risk factors might be collected for Medicare beneficiaries. GNYHA hospitals are experimenting with modifications to their electronic health records (EHRs), such as embedding the screening tool, creating structured fields, and interfacing the EHR with the aforementioned search and referral technologies. However, because screening tools vary and EHRs are customizable, it is difficult at this time to standardize screening results and related data, or even aggregate data in a standardized way across providers and communities.

Based on information from GNYHA members that routinely screen for social needs, the issues arising most often are around housing stability (homelessness, risk of homelessness or eviction); housing quality (mold, pests); and food insecurity. GNYHA members believe that these factors are those where providers can most easily track services, provide referrals, and make the greatest impact. While this is a promising list, because most organizations are still in the early stages of reviewing and exploring different screening tools and connecting results to health outcomes, GNYHA believes it may be premature to specify exactly which social risk factors should be captured for Medicare beneficiaries.

Utilizing Z-Codes to Standardize Data Collection
Several GNYHA member hospitals are beginning to utilize "z-codes" to capture information regarding social risk factors. Z-codes are contained within the ICD-10 classification system and categorized as "persons with potential health hazards related to socioeconomic and psychosocial circumstances" (Z55 to Z65). Using these codes effectively, however, is challenging.

One difficulty that has arisen for GNYHA member hospitals with regard to using z-codes is with finding the right code for specific social risk factors. GNYHA members report that not all social conditions are included in the available codes. For example, there are no z-codes that indicate a lack of or difficulty with transportation. On the other hand, in cases where there are codes available for a social condition, providers can become confused about exactly which one to select, and this can lead to data quality concerns. For example, there are 10 codes under Z59, the housing and economic circumstances category. They include "homelessness," "inadequate housing," "other problems related to housing and economic circumstances," and "unspecified problems related to housing and economic circumstances." GNYHA believes that there is an

opportunity to review existing screening tools and make meaningful recommendations for the ICD-10 manual so that information can be collected in a standardized way.

According to GNYHA members, another challenge related to data collection and coding is that the usual workflow for screening and addressing social risk factors does not currently lend itself to successfully integrated documentation. This is particularly the case in the ambulatory care setting where practitioners, not trained professional coders, typically do the coding. For example, during a visit, a patient might be seen by a medical assistant, a nurse, and a doctor. These activities would be documented in the visit note and then finalized and coded by the doctor before the visit is closed. Encounters with social workers or care managers are often separate and are documented in a separate note within the patient's medical record. It is in these social work or care manager encounters where patients will have the most robust discussions about social risk factors. However, in most ambulatory care settings, the social work encounter is not billable and would not generate a z-code or any other ICD-10 code. This means that in order for a z-code to be included on an outpatient claim, the practitioner would need to be apprised of the separate encounter and record it in the "main" note. This complexity makes the consistent capturing of z-codes difficult.

GNYHA members are discussing these issues and working on operational and communication workflows. Regardless of these challenges, GNYHA believes that consistent and correct use of z-codes would be the best way to collect social risk factor data for Medicare beneficiaries.

Evaluating Interventions
It has been extremely challenging for GNYHA member hospitals to demonstrate a clear return on investment from addressing social determinants of health. Hospitals report that what makes this calculation difficult is that it is hard to truly separate out the effects of the social and clinical interventions. As New York hospitals have implemented certain social interventions, they have started to see improvement in certain health care measures, but, again, it is harder to isolate the effect of the social risk factor intervention.

As part of New York's DSRIP program, hospitals have funded "innovation projects" whereby CBOs could partner with a health care provider to address a specific social need and evaluate the effects. This effort is intended to provide hospitals with information on the value and return on investment for specific interventions. These innovation projects are underway, and GNYHA should have more information on these efforts in mid-2019.

Contact Information
Thank you for the opportunity to share this information. We look forward to any future opportunities to participate in your work. Should HHS require additional information, please feel free to contact either me (tjohnson@gnyha.org) or Carla Nelson (cnelson@gnyha.org).

Sincerely,

Tim Johnson

Tim Johnson
Senior Vice President

From:	Ben.Trumbull <Ben.Trumbull@healthalliance.org>
Sent:	Friday, November 16, 2018 9:16 AM
To:	ASPE SES IMPACT Study (OS/ASPE)
Cc:	Hollie.Wilson; Sarah.Harbin
Subject:	ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors
Attachments:	ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Good morning! Below are comments from Health Alliance in response to the ASPE RFI. The four bullet points below correspond with the bulleted items on the webpage at https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs-request-information. Thank you.

- **Identify beneficiaries with social risk factors**
  - o Comprehensive health assessments are completed with all beneficiaries engaged in care coordination, and social risk factors are taken into account when developing the plan of care. Beneficiaries are enrolled in care coordination based on high-risk diagnoses, predicted risk scores, provider referral, self-referral, multi-disciplinary team member referrals and proprietary identification and stratification methods. Utilization management nurses involved in reviewing medical records for coverage determinations may also refer beneficiaries to care coordination when social risk factors are identified.

- **Approaches plans and providers have used to address the needs of beneficiaries with social risk factors**
  - o When beneficiaries or providers alert the health plan about social risk factors, a multidisciplinary team of registered nurses, social workers, physicians, and pharmacists work together to identify community resources and/or covered benefits that may help minimize the impact of those risk factors. Face-to-face intervention efforts have been particularly successful, and these include providing care coordination program fliers with pictures of the nursing staff to patients while they are admitted in the hospital and completing home visits with high risk beneficiaries.
  - o From a cost and utilization perspective, a recent approach has involved evaluating the coverage criteria for home-based supports to see if the accessibility of intermittent skilled services can be increased. Another method reviewed the cost of potentially covering custodial care or non-emergency transportation for high risk members in care coordination programs, and this investigation is still

underway. For members with concomitant medical needs, revised preauthorization processes have resulted in a 40% reduction in wait times for medical necessity decisions to be reached.

- **Evidence regarding the impact of these approaches on quality outcomes and the total cost of care**
  - o Social risk factors can have a significant impact on physical and mental wellbeing, but it can be challenging to directly measure their impact on quality outcomes and health care costs. To work around the measurement limitations, the Medical Management leadership team reviews the effectiveness of care coordination efforts via monthly dashboards. These dashboards include a variety of data points, such as Medicare Stars performance, cost saving values assigned by care coordinators to respective interventions completed, the percentage of beneficiaries receiving preventive care, health care utilization patterns, readmission rates, and how the cost of care compares to benchmarks.
  - o Optimizations to the health plan's Medical Management program in 2017 resulted in several successes in 2018, including faster access to services for beneficiaries and 6% reduction in the medical loss ratio for the health plan.

- **Disentangle beneficiaries' social and medical risks and address each**
  - o Following Maslow's hierarchy of needs, the health plan care coordinators inquire about and immediately address social issues such as inadequate housing, lack of access to food, or risk of harm. These needs are assessed both at initial comprehensive assessment with the beneficiary as well as during follow up conversations with beneficiaries. The next stage of care planning involves gathering a detailed history of social risks and medical needs to critically evaluate the relationship between the two. A beneficiary-centric care plan is developed to address modifiable risk factors that are in alignment with beneficiaries' state of readiness for change. Care coordinators partner with providers and community agencies to wrap services around the beneficiaries and promote sustainable progress.

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November 16, 2018

Brenda Destro
Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services (HHS)
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Re: IMPACT Act Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Dear Ms. Destro:

On behalf of the Healthcare Association of New York State's (HANYS) member not-for-profit and public hospitals, nursing homes, home care agencies and other healthcare provider organizations, thank you for the opportunity to submit comments in response to the following research question:

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

HANYS appreciates that HHS is turning to the field to solicit recommendations for improving care for Medicare beneficiaries. We are pleased to participate in this national conversation about the healthcare delivery system.

General Comments

HANYS appreciates HHS' growing recognition that social risk factors—such as income, education, race and ethnicity, employment, community resources and social support—play a major role in health, and significant gaps remain in health and life expectancy based on income, race, ethnicity and community environment.

As the healthcare system moves toward value-based or alternative payment models that tie payment to the quality and efficiency of care, we appreciate the additional focus on understanding the relationships between social risk and performance on these programs. HANYS strongly believes that providers should not be penalized for variables outside of their control.

HANYS members' experience validates the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) findings in its first report to Congress:

- Beneficiaries with social risk factors had worse outcomes on many quality measures, regardless of the providers they saw, and dual enrollment status is a powerful predictor of poor outcomes.[i]

- Providers that disproportionately served beneficiaries with social risk factors tend to have worse performance on quality measures, even after accounting for their beneficiary mix. Under all five value-based purchasing programs in which penalties are currently assessed, these providers experience somewhat higher penalties than did providers serving fewer beneficiaries with social risk factors.[ii]

HANYS supports the study of social risk factors and their impact on patient outcomes and resource use in the Medicare program. HANYS has long advocated for refining the hospital readmission adjustment methodology to take into account socio-demographic factors. Failure to recognize the effect of socio-demographic factors on hospital readmission rates can unfairly penalize these hospitals. While hospitals should do all within their power to care for and assist patients in challenging circumstances, they should not suffer financial penalties due to gaps in the community's healthcare infrastructure.

HANYS supported enactment of the provision in the 21st Century Cures Act intended to address this problem. It directs the HHS Secretary to implement a methodology beginning in federal fiscal year 2019 that assigns hospitals to peer groups based on their proportion of full-benefit, dual-eligible individuals, and to provide separate comparisons of hospitals within groups in determining a hospital's adjustment factor.

We believe this is a reasonable first step toward providing a socio-demographic adjustment for the hospital readmissions program. However, it is vital that the methodology to implement the mandated adjustment be carefully designed to provide adequate relief for those hospitals that serve a high proportion of poor and disadvantaged patients. The necessity of socio-economic status adjustment has been confirmed by national leading organizations in healthcare outcome and measures, such as the National Academy of Sciences, Engineering, Medicine[iii] (National Academy of Medicine, ASPE contractor) and National Quality Forum.[iv]

Recommendation: While the Centers for Medicare and Medicaid Services' (CMS) risk stratification by dual-eligible status is directionally correct, more study is required to ensure the methodology is expanded to more accurately reflect the differences in population (which are beyond a hospital's control) that affect outcomes. We encourage HHS, CMS and others to expand their look beyond the readmission measures, as social risk factors are a large driver of healthcare utilization and patient outcomes across the continuum of care. In addition, we encourage study of the advantages/disadvantages of adjusting for social risk factors at the patient/case level, which may provide a more accurate and meaningful adjustment, rather than at the hospital (aggregate) level.

Delivery of Services
New York State is currently engaged in a Delivery System Reform Incentive Payment (DSRIP) program, which is redesigning the way care is delivered to Medicaid beneficiaries. The statewide goal of New York's DSRIP program is to reduce avoidable hospital use by 25 percent over five

years. To achieve this significant improvement, New York's healthcare community is transforming how care is delivered, with a particular emphasis on social risk factors. While this program is focused on the Medicaid program, lessons learned can be translated to the Medicare population. DSRIP is also driving the transition from volume to value within the Medicaid program. To qualify for a Value-Based Payment (VBP) contract, contractors in New York State are required to address at least one social determinant of health.

Promising practices[v] include:

- care management to address social and medical needs;
- integration of behavioral health and primary care;
- working with certified patient educators (asthma, diabetes, etc.);
- real-time connections to healthcare providers for time-sensitive issues via telehealth;
- nutrition services; and
- support to ensure housing security.

In addition, hospitals and health systems are working with a broader range of partners across their organizations and in their communities to identify and address health needs impacted by income, ethnicity, education, housing, food insecurity and other social determinants. These efforts typically focus on reducing health disparities and advancing health equity, and are collaborative, focus on specific populations, preventive and evidence-based.

In New York State, much of this work is aligned with the *Prevention Agenda*,[vi] the state's health improvement plan. With the goal of making New York the healthiest state for people of all ages, the *Prevention Agenda* addresses social determinants of health, reducing disparities and improving health equity. Under the *Prevention Agenda*, hospitals and health systems work together with local health departments and partners in the community to identify community health needs and develop, implement and measure initiatives to address those needs. Some of the initiatives focus on social determinants of health. Examples include:

- screening inpatients and outpatients for food insecurity and housing needs, and incorporating these findings into the electronic medical record;

- providing "prescriptions" for food for the food insecure;

- providing outreach and education in barber shops, beauty salons, churches, etc., to engage populations in blood pressure management initiatives; and

- partnering with communities for safe, well-lit, walkable spaces for exercise, recreation and socialization.

Recommendation: HHS should look to programs underway within New York and other states for promising practices related to delivery of services for beneficiaries with social risk factors.

Data
HANYS supports the use of data to drive quality improvement. However, we urge HHS to proceed with caution as it considers new data collection requirements related to social risk factors.

Streamline, Align, and Focus on the Measures that Matter Most for Improving Patient Care
In our *Measures that Matter* report, HANYS notes that while the value of measurement is clear, measurement is also clearly out of control and in need of reform.

While providers, patients, consumer groups, payers (government and commercial), and professional societies are united in their commitment to the provision of high-quality, safe, patient-centered care, they are often divided on what to measure and report, and how. As the American Hospital Association noted, opportunities to make meaningful enhancements in quality and patient safety may be lost because there is a lack of focus and agreement on which measures can help improve patient outcomes.[vii]

The current environment is chaotic. Hospitals and other providers must report on hundreds of measures required by government and commercial payers, accreditation agencies, professional societies and registries. Underlying the collection and reporting of each measure is a complex system of specifications, definitions, data abstraction, analysis and reporting, consuming significant time, expense and drawing from limited clinical, information system and administrative resources.

This has created an imbalance of values as provider practice has shifted to accommodate quality program reporting, undermining patient care. Despite the abundance of existing metrics, new measures are being developed to address the fundamental shifts in how care is paid for (volume to value) and delivered (integrated, preventive care at lower costs).

While many measures evaluate the same focus area or patient population, the measure specifications may be different, requiring providers to understand and implement distinct methodologies and systems. This lack of alignment and coordination, coupled with the sheer volume of quality measures and the limitations of current electronic health record (EHR) technology, has created an environment of measure madness. This madness is further complicated by the fact that EHRs were not designed with clinician input to support the existing workflow. As a result, clinicians are forced to modify current practice to meet electronic documentation requirements, which further displaces and redirects resources from meaningful quality improvement efforts.

Recommendation: We urge HHS to align with the CMS Meaningful Measures Framework, which seeks to focus on the most critical quality improvement areas, while minimizing provider burden.

Transparency to Support Continuous Improvement
As part of an ongoing effort to improve quality, safety and patient outcomes, HANYS and our members are working hard to understand the impact of social risk factor adjustment. We look forward to ASPE's findings and the publication of the second report.

In general, **in advance of implementation, CMS should prioritize social risk factor adjustment methods and data sources that can be transparent.** For example, if CMS develops social factors at the patient level and uses them in the Readmission Reduction Program, those factors should be made available in the Standard Analytic File, Medicare Provider Analysis and Review (MedPAR), and other analytical files. This was not the case with the dual-eligible percent adjustment in the current program; those factors were not available until final adjusted factors were released.

We encourage ASPE to consider the following recommendations:

- **HHS should evaluate differences in the relationship between social risk factors and outcomes among types of conditions, procedures, patients, etc., rather than using a common adjustment across the board.**

- **HHS should make adjustments that can be done consistently across patient populations (i.e., payers) as well as across geographies (state vs. national data).**

- **HHS should analyze how social risk factors vary in different geographic markets (i.e., urban vs. rural access to automobile).**

- **HHS should avoid using data that are selectively reported and are not consistently available for all patients/cases (i.e., ICD 10 social risk factor codes that may not be entered, but would be valid).**

Again, the findings of this study should be made available to providers and other stakeholders to support quality improvement efforts.

Address Significant Electronic Health Record and eCQM Challenges
HANYS supports the long-term vision of using EHRs to streamline quality reporting practices while improving care. Hospitals and health systems in New York State have devoted significant resources and efforts to meet electronic clinical quality measures (eCQM) requirements, yet, challenges such as data mapping, data validation, submission of test and production files, among other issues, continue to hinder the ability of providers to use accurate clinical quality measure information to effectively impact patient care and quality.

That being said, the EHR as it currently exists may not be the most appropriate place for data collection related to social risk factors. Since the EHR is designed to handle an episode of care and social determinants involve daily life, providers need another mechanism and entry point to connect these data fields and integrate the information into the providers' data stores and workflow.

CMS should ensure that the accuracy, reliability and reporting feasibility of eCQMs are fully tested before expanding any eCQM requirements. We believe there is also opportunity for improvement related to the EHR itself, along with vendor certification.

Specific to the EHR, literature indicates that content is not captured or presented in a meaningful way and modifying the EHR to align with workflow would allow for greater efficiencies and improved clinical care. Additionally, the lack of interfacing with systems and technology, such as

monitoring equipment, affects many organizations' ability to deliver effective and efficient care, and achieve eCQM specification requirements.

The HHS Office of the National Coordinator for Health Information Technology (ONC) created vendor certification criteria to address issues such as these. However, the literature indicates that 34 percent of certified vendor reports reviewed did not meet the ONC certification requirement of stating their user-centered design (UCD) process, although certified as having met these requirements (Benda, A, Ratwai, Hettinger, & Fairbanks, 2015). This lack of adherence may be a significant contributing factor regarding poor usability.

Recommendation: HANYS strongly recommends that ONC enforce the current requirements and validate UCD testing.

Again, thank you for the opportunity to submit comments on this important issue. Please contact me if you have questions or need additional information.

Sincerely,

Loretta B. Willis, RN, CPHQ
Vice President, Quality Advocacy, Research, and Innovation

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[i] Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. December 21, 2016. https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs
[ii] Ibid.
[iii] National Academies of Sciences, Engineering, and Medicine. Accounting for social risk factors in Medicare payment. Washington, DC: National Academies Press, 2017.
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[v] Frescatore, D. Medicaid in New York: Fostering Collaboration to Improve Health. United Hospital Fund Conference presentation. July 18, 2018. https://uhfnyc.org/uploads/Files/Presentations/Donna%20Frescatore%20UHF%2007.18.2018.pdf
[vi] New York State Department of Health. *Prevention Agenda* 2013-2018: New York's Health Improvement Plan. https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/
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IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Comments by Healthfirst (Contract #H3359)

Healthfirst is a not-for-profit, provider-sponsored plan serving New York City and Nassau, Suffolk, and Westchester counties. Our model promotes population health at the provider level by transferring most financial risk to our hospital system sponsors who, with their community-based partners, work with us to align incentives and ensure quality, member satisfaction, and efficiency. We are the largest Medicaid managed care plan in downstate New York and the #1 Medicaid plan for quality in the State.

We serve about 150,000 Medicare Advantage members. Approximately 60% are dually eligible for Medicare and Medicaid, and 75% receive the Low Income Subsidy (LIS). Close to 30% of our Medicare members have 3+ chronic conditions and take 8+ Part D Drugs. As a primarily low income plan, Healthfirst observes that the 25% of our membership that does not receive the low income subsidy (non-LIS) is remarkably similar to the 75% of our membership that receives the LIS. Our LIS/non-LIS members reside in the same neighborhoods and have the same challenges related to social determinants of health like education, health literacy, and cultural norms.

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

Healthfirst recognizes the impact that social adversities play in many of our members' health outcomes and has taken the first fundamental steps in identifying and addressing social risk factors outside of traditional healthcare needs. We currently don't use "social risk data" for identifying, targeting / outreaching members. However, we are focused on developing sound approaches to proactively address and impact social determinants of health in the future.

Current Approaches:
- Stratify/target high-risk populations for outreach / interventions based on utilization patterns (e.g. frequent ED visits, hospitalizations)
- Connect members to social service vendor (Altegra/Community Link). Members are connected by our member-facing staff (Member Services, Care Management, Sales, etc.) based on the needs/ challenges identified during conversations / interactions with members. Community Link is responsible for assessing social risk factors and connecting members to appropriate community-based resources.
- Identify barriers/ needs and address social risk factors via our field-based care teams, serving as our eyes/ears in the community for our care management teams (Community Health Workers, Nurses, Patient Care Aides, etc.)

- Identify and remove barriers through telephone outreach via Care Management and Pharmacy teams by connecting members to social supports/services (transportation, appointment scheduling, housing insecurity, legal needs, etc.). Handbooks of community-based resources by NYC borough were created and are used by our Care Management teams.

Future Approaches (In-development):

- Standardize the questions we ask members about social determinants, where possible, drawing on the CMS Accountable Health Communities Health-Related Social Needs Screening Tool.
- Improve data collection of social risk data and timely referrals of social services by partnering with a vendor that provides a search engine of an up-to-date directory of comprehensive community resources and a web-based referral tool.
- Develop algorithms using machine learning to proactively identify and intervene with members that are at risk / predicted to be impacted by social risk factors.

2. **Are there especially promising strategies for improving care for patients with social risk?**

We believe the best and most powerful strategy for improving care for our members with social risk is to partner with providers and community-based organizations to help us identify members impacted by social risk factors and provide access to timely and needed supports/resources by using standardized data collection, referral and tracking tools.

Other promising strategies include:

- Shift care management of members from telephonic support to in-house / community-based visits – meeting members where they are and building trust face to face.
- Provide member-facing staff with access to an up-to-date "bank of community resources" and web-based referral / tracking tool.
- Extend the aforementioned screening and program software tools to health plan partners (e.g., providers, vendors, and community-based organizations).
- Leverage technology (i.e. machine learning) to proactively identify "social risk", stratify and facilitate programs that address not only medical but the social needs of our members.

We are in the early stages of implementing some of these approaches.

3. **How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?**

It is difficult /challenging to quantify the impact on health outcomes based on social services provided solely. Instead, we conduct ROIs to measure improved outcomes / reduced costs based on both care and social services provided using outcome measure indicators such as ER and inpatient utilization. In

our most recent pilot study, we found that our Community Health Workers helped to statistically significantly (p value <0.05) reduce ER and inpatient utilization among the intervention vs. control group.

What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

While reviewing published literature and best practices elsewhere, and engaging our clinical stakeholders, we identified two best practices for identifying and referring beneficiaries to social service organizations.

- Enable your member-facing workforce to assess for social risk factors by providing them with the technology to assess members' risk, access a comprehensive directory of local social services and a referral platform. Additionally, integrate "social risk data" into the 360 degree view of the member – to ensure issues / barriers are addressed and removed for members.
- Build capacity in the community to identify and refer members to social services by partnering with community-based organizations, provider groups and care management field staff.

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

Every patient / member has a unique set of challenges and needs. It's important to assess social risk factors for each member and direct care and resources appropriately. Often times, this requires the health plan to go above and beyond to ensure the most important actions are taken to address the immediate needs and overall wellness of our members.

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

- The lack of a standardized social determinants of health (SDH) assessment tool is one of the biggest barriers to capture data related to SDH, and this makes tailoring targeted interventions and services for those with SDH even more difficult. Furthermore, there is an underutilization of ICD-10 codes related to such SDH, this presents a challenge to Population Health initiatives aimed at reducing such disparities.
- Health care providers often do not have the time and/or lack capacity to screen patients for SDH, making it difficult to connect patients to needed services in the community. Additionally, health care providers are often unaware of Community Based Organizations and/or services that are available to meet needs of patients with social risk factors.
- Members "near poor" (i.e., just over the federal poverty level and who don't qualify for Medicaid) have the biggest barriers and don't qualify for the following:
  a. Personal care/home attendant services and often cannot afford to pay out of pocket for the help they need with their ADLs.
  b. Long term custodial SNF care – even if they reach a point where 24/7 care is necessary.
  c. Bathroom DME as they are aging and becoming more frail (i.e., shower chair, grab bars, essentials for tub safety/fall prevention).

- Social service agencies that are best suited to address member social needs are often not prepared to work with health plans and may not have invested in the infrastructure to do so (technology platforms, expertise/capability around billing, security and compliance safeguards, reporting and communication.

Members can and do change to different health plans. Long term investments in addressing some of the most pervasive and difficult social determinants (i.e. housing) may not accrue to the health plan.

6. For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?

Functional status, disability and frailty play a critical role on a patient's ability to engage in care. Often these patients are isolated and are unable to seek services, making it even more difficult to remove SDH related barriers. If members are unable to physically get to their doctor appointments, they are not able to benefit from any interventions aimed at reducing such barriers.

7. Which social risk factors are most important to capture?

- **Housing insecurities.** Housing stability is a key indicator of socioeconomic status and is the single greatest monthly expense. Members with low income spend a larger proportion of earnings on securing housing. Those in urban areas are also facing high rent due to higher housing demands. Unstable housing is a stressor and can present problems with properly storing medications, accessing educational and healthcare services.
- **English language proficiency and cultural understanding**. Most healthcare services are rendered in the English language while our population is becoming more and more culturally diverse.
- **Health literacy and educational level**. This helps us understand members' ability to obtain, process, and understand basic health information needed to make appropriate health decisions such as managing chronic conditions.
- **Food insecurities**. Inability to access healthy foods increases malnutrition and obesity and decreases the ability to properly manage certain high prevalence diagnoses such as heart failure and diabetes.
- **Transportation.** Members who are frail or live alone can have challenges in taking public transportation or driving to appointments. Private car service can be costly.

8. Do you routinely and systematically collect data about social risk?

We collect some social risk data, but not consistently and systematically for all members. Currently, social risk data is collected by our care management teams, which are typically during interactions with high-risk members. Data is used to inform care planning at an individual level.

In 2019, we will embark on a standardized approach for collecting social risk data by providing a social determinants screening and referral web-based tool to member-facing staff. In addition, we will be using machine learning (as described in our response to question 1 above) to help us predict /estimate "social risk" for our population. In the future, we hope to work with our providers to standardize data

collection efforts in EMRs and the Health Information Exchange, along with our vendor partners who support members in the home in order to incorporate social risk into the members' care plan.

9b. Who collects this data?

See Q8.

9c. When is it collected? Is it collected only once or multiple times for a beneficiary?

Currently, it is collected during initial and ongoing assessments while members are supported by care management. In the future, we hope all of our member-facing staff (telephonic and field-based staff) will be able to screen, collect, and act on social determinants of health data.

9d. Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)?

Currently, SDH data is not collected consistently across our Medicare population. Only high-risk members and members with high behavioral health needs are assessed for social determinants of health.

9e. What are the burdens of this data collection on plans, providers, and beneficiaries?

See Q10.

9. Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

Yes. We recommend that standard definitions / data elements for social needs be established. In addition, there is a lack of provider coding for Z-codes. We recommend that there be alignment between Z-codes and standard definitions / elements.

10. What are barriers to collecting data about social risk? How can these barriers be overcome?

There are a number of barriers to collecting social risk data:
- Limited available social risk data; underutilization of ICD-10 / Z- codes related SDH
- The lack of a standardized SDH assessment tool
- Difficulty in measuring/quantifying the impact of social risk factors and their contribution to health outcomes
- Under-representation of social risk factors due to sensitivity and/or very personal information
- Highly confidential data and the consequences of breaches in data security
- Members unengaged with the health plan and providers – very difficult / challenging to collect data for members that are homeless, transient, don't have a working phone number, etc.
- Health care providers often do not have the time and/or lack capacity to screen patients for SDH.

In order to overcome these barriers, providers will need to understand the importance of collecting and coding this data. They will also need education on the impact of social determinants on health outcomes and how to use Z-codes related to social determinants.

Incentives to support the identification and "treatment" of social determinants should be considered.

11. What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

CMS could incorporate SDH-related measures into provider quality programs, first by measuring the degree to which SDH data is collected by providers, by conclusively mapping Z-codes to SDH risk factors, and eventually by introducing an expectation that providers address social risk factors.

Additionally, a further promising opportunity is to define and use a metric for 'overall wellbeing', which can be incorporated into provider data collection and reporting. A uniform, high-validity metric would enable health plans and providers to support their members and patients in a holistic, person-centered way, and we would welcome the leadership of CMS in this regard.

November 16, 2018

Brenda Destro, Deputy Assistant Secretary for Planning and Evaluation (ASPE)
United States Department of Health and Human Services (HHS)
7500 Security Boulevard, Baltimore, MD 21244–1850
Submitted electronically to ASPEImpactStudy@hhs.gov

RE: Request for Information: IMPACT Act Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Dear Deputy Assistant Secretary Destro:

This letter is in response to the Request for Information: IMPACT Act Research Study. Humana thanks ASPE for the opportunity to provide our comments on the importance of improving care for Medicare beneficiaries with social risk factors.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. As one of the nation's top contractors for Medicare Advantage (MA) with approximately 3.1 million members we are distinguished by an over 30-year, long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend on the Medicare Advantage program as their safety net and many in underserved areas – receive integrated, coordinated, quality, and affordable care through our plans.

Addressing social risk factors, including food insecurity and social isolation, is a growing priority for many health plans. Humana has been working for many years on addressing the social determinants that are impacting the health of our members and their communities through our Bold Goal initiative. Through this initiative we are continuing to learn about the impact social risk factors have on the health of our Medicare beneficiaries and about best practices for addressing them. Humana is encouraged by HHS's focus on this issue and we look forward to working together to better address the needs of all Medicare beneficiaries.

As always, we value this opportunity to provide comments and are pleased to answer any questions you may have with respect to the comments below. We hope that you consider our comments as constructive feedback aimed at ensuring that together we continue to advance

our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to Medicare beneficiaries, focused on improving their total health care experience.

Sincerely,

Mark A. Newsom
Vice President, Public Policy
mnewsom@humana.com

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

Many factors contributing to an individual's overall health cannot be directly linked to medical services or treatments and it is estimated that approximately half of factors influencing health are attributable to social and environmental factors.[1] For many years, Humana has been working to address the social determinants that are impacting the health of our members and their communities. Humana launched its Bold Goal initiative in 2015, with the objective of improving the health of the communities we serve by 20 percent. Through this initiative, Humana partners with nonprofits, businesses, and local governments as well as physicians and other medical providers within communities to develop innovative programs designed to improve the clinical health outcomes of individuals by addressing social needs. Humana's Bold Goal has chosen to address loneliness and social isolation as well as food insecurity as top priorities given the research demonstrating that these are two of the biggest social factors negatively impacting the health of older Americans. Recent studies have found that socially isolated adults have a 29% increased likelihood of mortality than those who are more socially connected and older adults experiencing loneliness are 3.4 times more likely to suffer from depression.[2,3] Loneliness in older adults is also associated with an increased risk of late-life dementia.[4] Research on the impact of food insecurity on older adults has found that it is as strong of a predictor of later declines in health as heart disease, cancer, stroke, diabetes, or pulmonary disease.[5] Food insecure seniors have also been found to be 78% more likely to experience depression, 55% more likely to experience asthma, 40% more likely to experience chest pain, 21% more likely to have limitations in activity, and are 10% more likely to experience high blood pressure.[6] Because of the Bold Goal pursuit, Humana has gained a deeper understanding of the need for addressing social determinants of health (SDOH) to improve clinical health, has gained experience in implementing programs and partnerships to do this, and has a greater appreciation for the importance of this work.[7]

How plans and providers serving Medicare beneficiaries:
- *Identify beneficiaries with social risk factors*

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[1] McGinnis JM, Williams-Russo P, Knickman JR. The Case for More Active Policy Attention to Health Promotion. *Health Affairs*. 2002 Mar-Apr; 21(2): 78-93.

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[5] Alley, Dawn E et al. "Material resources and population health: disadvantages in health care, housing, and food among adults over 50 years of age" American journal of public health vol. 99 Suppl 3, (2009): S693-701.

[6] See https://www.feedingamerica.org/sites/default/files/research/senior-hunger-research/senior-hunger-infographic.pdf

[7] See http://populationhealth.humana.com/wp-content/uploads/2017/03/Humana_BoldGoal_2017_ProgressReport-v2.pdf

- *Disentangle beneficiaries' social and medical risks and address each*

Humana has employed a number of methods to identify beneficiaries with social risk factors, focusing particularly on food insecurity and loneliness and social isolation. First, we have worked to integrate SDOH screening and referral protocols for social and community services in primary care clinics. In a pilot program undertaken by Humana in partnership with Feeding America and Feeding South Florida, a food insecurity screening and a health-related quality of life (HRQOL) survey were administered to patients at primary care clinics in south Florida, with those screening positive for food insecurity being provided food resources onsite and receiving referrals to additional community resources. The program used the Centers for Disease Control (CDC)-developed Healthy Days measure to examine HRQOL and The Hunger Vital Sign™ food insecurity screening tool.[8] In other clinics, Humana has partnered with providers to screen patients for loneliness using the UCLA Loneliness Scale.[9] In both cases, Humana has provided toolkits, resource guides, and technical support for how to conduct screenings and refer to community and public resources to address needs.

We are also working to integrate SDOH screening and referral into Humana clinical programing, with the goal of treating social needs as clinical gaps in care. Screenings have been incorporated into the workflow of several care teams who work directly with our members. Humana's chronic care management nurses screen members for a variety of social risks as they complete clinical assessments and create care plans to help members reach their health goals. This is a component of their National Committee for Quality Assurance (NCQA) care management accreditation. Humana Pharmacy case management teams have also begun screening members for food insecurity to help address root causes of non-adherence to medications.

Additionally, we have developed SDOH predictive models in order to proactively identify members with the highest risk in order to develop care plans to support their needs. In screening thousands of beneficiaries for social risks, Humana has learned a great deal about the association of loneliness and social isolation with worsening HRQOL, increased mortality, and other poor health outcomes.[10,11,12] With these insights, in addition to claims and laboratory data, electronic medical records, and consumer information, we have developed a predictive analytic model to predict loneliness in individuals enrolled in a MA health plan. Identifying individuals at risk for loneliness and related outcomes allows us to estimate their healthcare needs and establish appropriate preventive strategies to support their health and wellbeing. We are currently undertaking a similar process for predicting food insecurity.

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[8] McGrath E, Renda A, Eaker E, Glasheen WP, Cordier T, Dobbins J, Prendergast K, Vatske S, Hernandez Y, Connolly C. Measuring food insecurity and Healthy Days in a primary care setting. Poster presentation at: 2017 Art & Science of Health Promotion Conference. March 27-31, 2017. Colorado Springs, CO.

[9] UCLA Loneliness Scale

[10] Hawkley L, Cacioppo J. Loneliness matters: A theoretical and empirical review of consequences and mechanisms. *Annals of Behavioral Medicine*. 2010; 40: 218–227.

[11] Segrin C, Passalacqua S. Functions of loneliness, social support, health behaviors, and stress in association with poor health. Health Communication. 2010; 25(4): 312-322.

[12] Luo Y, Hawkley L, Waite L, Cacioppo J. Loneliness, health, and mortality in old age: A national longitudinal study. *Social Science & Medicine*. 2012; 74(6): 907-914.

In addition to predictive modeling to identify Humana members with SDOH in need of addressing, Humana identifies low-income MA members who may benefit from dual enrollment in Medicare and Medicaid and acts as an authorized representative to assist them in applying to the appropriate state Medicaid agency. Humana's predictive modeling begins with identifying those that are the most likely to be eligible for but not enrolled in Medicaid. Humana then conducts direct outreach to those likely Medicaid-eligible members and assists them in applying to their Medicaid agency. Through internal surveys, Humana has found high levels of satisfaction with this initiative.

Humana believes that the analytic powers of predictive modeling offer promising opportunities for both data collection and the tailoring of services. As CMS continues its efforts to improve the care of Medicare beneficiaries with social risk factors, efforts such as CMS's Blue Button 2.0 and other data sharing projects that could provide MA plans with critical data should remain a priority. Data sharing opportunities allowing MA plans access to data about beneficiaries from before they become plan members – prior claims data or even clinical, social need, or health risk assessments completed by previous providers – would allow us to run our SDOH predictive model for members sooner. Rather than having to wait for new claims, Humana could quickly and preemptively implement an individualized care plan for a member, potentially preventing future health issues and costs.

Finally, Humana understands that a person's physical and social environment play a strong role in their health. That is why Humana has built [zoom in](TM) (zoomin.humana.com), a data visualization tool that identifies population health risks at a local level by aggregating public health data with key SDOH to provide a more comprehensive view of patient and community social health needs. This tool is intended to enable a place-based, collaborative approach to care by Humana's clinicians, community nonprofit organizations, other health care professionals and local government leaders. Piloted in San Antonio, Texas and Broward County, Florida, two of our Bold Goal communities, Humana is expanding zoom in[TM] to communities nationwide in 2019.

- *Approaches plans and providers have used to address the needs of beneficiaries with social risk factors*
- *What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?*

Humana has designed our MA supplemental benefit offerings to directly address the needs of beneficiaries with social risk factors, to the extent allowed, including: non-emergency medical transportation, respite care, post-hospital discharge meals, and companionship. Despite the innovative work in this area by Humana and others, MA regulations and guidance have historically stipulated that plan sponsors can only offer narrowly defined supplemental benefits that are primarily health services related in the traditional medical model. In the 2019 MA Call Letter and in subsequent guidance, CMS reinterprets the definition of "primarily health related"

to include additional services but the agency's guidance explicitly prohibits coverage of items or services primarily intended to address SDOH.[13]

Humana has urged and will continue to encourage CMS to consider extending benefit and cost sharing flexibility to supplemental benefits targeted at addressing SDOH. The literature clearly demonstrates that health is influenced by more than just medical-specific factors.[14] Allowing Medicare Advantage Organizations (MAOs) to expand supplemental benefits will have positive impacts on social and environmental deterrents and ensures a holistic approach is taken to enhance health outcomes for the Medicare population. Specifically, Humana has prioritized addressing food insecurity and social isolation because an analysis of our MA population demonstrated that these are the key SDOH impacting the lives and health of older adults.

While we know food insecurity is correlated with a number of chronic conditions, such as diabetes, hypertension and cardiovascular disease,[15]regulations generally prohibit social factors, on their own, from qualifying an MA enrollee for meal services.[16] Humana has urged CMS to work with MAOs to design policies allowing plans to address food insecurity and recommended targeted modifications of the Medicare Managed Care Manual. For enrollees eligible for Supplemental Nutrition Assistance Program (SNAP), MAOs should be able to coordinate and include meal services as a benefit to ensure that members have enough nutritious food to last throughout each month.

One of the biggest risk factors for social isolation is lack of access to transportation. Seniors without access to transportation or who have retired from driving are often unable to participate in community activities and therefore to connect in-person with others. Humana has recommended to CMS that transportation should be an eligible supplemental benefit to be offered to MA members who are socially isolated to the point where that isolation is a root cause for clinical depression or other behavioral health issues. Lack of transportation may also exacerbate food insecurity, as vulnerable seniors may be unable to travel to grocery stores with healthier foods, and instead may have to rely on more easily accessible fast food options located closer to their homes. As such, CMS should allow MAOs the flexibility to provide non-

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[13] See CMS April 27, 2018 HPMS memo.

[14] Alley, D. E., Asomugha, C. N., Conway, P. H., & Sanghavi, D. M. (2016). Accountable health communities—addressing social needs through Medicare and Medicaid. *N Engl J Med*, *374*(1), 8-11; Adler, Nancy E., et al. *Addressing Social Determinants of Health and Health Disparities*. Discussion Paper, Vital Directions for Health and Health Care Series. National Academy of Medicine, Washington, DC. https://nam. edu/wp-content/uploads/2016/09/addressing-social-determinantsof-health-and-health-disparities; Braveman, Paula, and Laura Gottlieb. "The social determinants of health: it's time to consider the causes of the causes." *Public Health Reports* 129.1_suppl2 (2014): 19-31; and Meddings, Jennifer, et al. "The impact of disability and social determinants of health on condition-specific readmissions beyond Medicare risk adjustments: A cohort study." *Journal of general internal medicine* 32.1 (2017): 71-80.

[15] Berkowitz, S. e. (2017). Food Insecurity and Health Care Expenditure in the United States, 2011-2013. Health Services Research, 10.1111/1475-6773.12730

[16] Chapter 4, Medicare Managed Care Manual, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf

medical transportation services as a supplemental benefit if transportation is deemed a barrier to accessing healthy food.

Collaboration with community partners is imperative to helping address the social risks facing our members and is key to our Bold Goal initiative. After identifying at-risk members, we connect them to community resources in a variety of ways. For our food insecurity interventions in the clinical setting, we have a formal partnership with Feeding America and Feeding South Florida to provide food resources onsite and referral to appropriate community resources. We have also developed a loneliness tool kit that can be provided directly to a member or to a patient by their physician that both describes the health risks associated with loneliness and social isolation and suggests resources in their community to help, including community centers, volunteer opportunities, and Humana in Your Neighborhood locations that offer programs and activities such as Silver Sneakers, designed to connect members with others in their communities. Humana care managers also connect members to community-based organizations that can help address health related social needs by leveraging an internally developed and maintained community resource directory.

We believe that providers are key to address the needs of beneficiaries with social risk factors. They know their patients intimately and care for all their traditional health-related needs. That is why so many of our interventions are located in the physician's office and why we have developed numerous tools to make it as easy as possible for the care team to identify and address social risks. We have created a Continuing Education Unit for physicians, nurses, pharmacists, and social workers on the SDOH and HRQOL. This not only provides Humana's clinicians with an opportunity to build their skills in this area, but we are also sponsoring trainings for clinicians in the community for a broader impact.

- *Evidence regarding the impact of these approaches on quality outcomes and the total cost of care*

While we do not yet have causal evidence that the interventions we have implemented to address social risks have an impact on quality outcomes and the total cost of care, we have seen correlations in the literature and our own studies. For instance, a recent study found that food insecure seniors are 65 percent more likely to be diabetic, twice as likely to report fair or poor health, 19 percent more likely to have high blood pressure, 57 percent more likely to have congestive heart failure, 66 percent more likely to have experienced a heart attack, and 2.3 times more likely to suffer from depression.[17] Two peer-reviewed studies of 54,000 Maryland residents on both Medicare and Medicaid found that SNAP participation reduced their odds of nursing home admission by 23 percent and of hospitalization by 14 percent. Based on this

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[17] Gundersen C, Ziliak J. The Health Consequences of Senior Hunger in the United States. 2014.

research, it is estimated that enrolling eligible people ages 65 and older in SNAP could reduce annual healthcare costs by $2,120 per person. [18,19]

We also know that social isolation, loneliness, and the availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities can play an important role in patient health.[20] According to research from the AARP Foundation, 17 percent of adults age 65 and older are isolated, leading to a 26 percent increased risk of death due to the subjective feeling of loneliness.[21]

Humana measures Healthy Days, a HRQOL measure developed and validated by the CDC, to measure the population health of the communities we serve and as a leading indicator for the impact of social risk interventions on an individual's health and well-being. Because Healthy Days captures broad dimensions of health from the individual's perspective, it is a simple way to holistically measure the health and well-being of a population and its trend over time, and there is a strong evidence base correlating Healthy Days to chronic disease conditions.[22] Results from Humana's pilot screening for food insecurity in primary care clinics found that food insecure individuals had nearly twice as many physically unhealthy days per month as food secure individuals (13.68 days versus 7.44) as well as more than twice as many mentally unhealthy days per month (12.91 days versus 6.10).[23] Knowing this, Humana believes we can significantly improve a beneficiary's HRQOL by addressing their food insecurity. We have a randomized control test underway to measure food insecurity's impact on quality outcomes and the total cost of care. The outcomes of this study will require a longer timeframe to measure and results will be available in 2019.

In addition, Humana's Bold Goal work has shown improvement in the number of Healthy Days in our targeted Bold Goal communities. For example, in 2017, San Antonio, TX experienced an overall 3.5% improvement in Health Days and a 5.1% improvement for members living with diabetes. In Knoxville, TN, Healthy Days increased by 5.4% overall and there was an improvement of 9.7% for seniors living with diabetes. The senior populations of Baton Rouge and New Orleans, LA experienced an improvement in Healthy Days of 4.1% and 3.9%, respectively in 2017.[24] These positive outcomes in improved Healthy Days lead not only to better health outcomes for members but also to lower costs, as a recent study found increased

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[18] Zielinskie G, Samuel L, Szanton S, Betley C, Cahill R. Access to Public Benefits among Dual Eligible Seniors Reduces Risk of Nursing Home and Hospital Admission and Cuts Costs. July 2018.

[19] Samuel L, Szanton S, Cahill R, Wolff J, Ong P, Zielinskie G, Betley C. Does the Supplemental Nutrition Assistance Program Affect Hospital Utilization Among Older Adults? The Case of Maryland. *Population Health Management*. Apr 2018; 21(2): 88:95.

[20] HHS, "Healthy People 2020 and Social Determinants of Health," available at https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

[21] See https://connect2affect.org/

[22] Slabaugh S, Shah M, Zack M, Happe L, Cordier T, Havens E, Davidson E, Miao M, Prewitt T, Jia H. Leveraging Health-Related Quality of Life in Population Health Management: The Case for Healthy Days. *Population Health Management*. 2017 Feb; 20(1):13-22.

[23] See http://apps.humana.com/marketing/documents.asp?file=3105791

[24] See http://populationhealth.humana.com/documents/Humana_BoldGoal_2018_ProgressReport.pdf

medical costs of $15.64 per person per month associated with just one additional Unhealthy Day.[25]

- *Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?*
- *Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?*
- *What are barriers to collecting data about social risk? How can these barriers be overcome?*
- *What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?*

Beginning in 2015, Humana has measured the Healthy Days, a HRQOL measure developed and validated by the CDC, of our members. We conduct an annual survey of a representative sample of members to measure the population health of the communities we serve, including by line of business (i.e. Medicare Advantage and Medicaid) and market (i.e. San Antonio, TX and Knoxville, TN), as well as by certain population segments such as members with disabilities or diabetes. Because Healthy Days captures broad dimensions of health from the individual's perspective, it is a simple way to holistically measure the health and well-being of a population and its trend over time. By segmenting the population, we are able to identify groups who may need more attention or where specific interventions may be having an impact. We also use Healthy Days as a leading indicator for the impact of social risk interventions since other outcomes, such as utilization and lab values take longer to realize. Humana has also incorporated Healthy Days and other HRQOL questions into our Humana at Home and clinical care management screening tools. In fact, Humana at Home telephonic and in-home care management teams screen for Health Days every 90 days while a member is in managed status.

One barrier to collecting social risk data is restrictions on contacting members imposed by the Telephone Consumer Protection Act (TCPA). Due to the complex nature of these regulations, the challenge of collecting and tracking Do Not Call information, and the high cost of violations, considerable effort and expense goes into collecting this information. However, Humana believes this data to be so valuable that we continue with its collection despite these challenges. Insights from our annual Healthy Days survey has, for example, helped us highlight the critical role of providers in value-based relationships to improving HRQOL and the need for special attention to members with disabilities, who experience a substantially higher number of unhealthy days each month.

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[25] Cordier, Tristan, MPH; S. Lane Slabaugh, PharmD; Eric Havens, MA; Jonathan Pena, MS; Gil Haugh, MS; Vipin Gopal, PhD; Andrew Renda, MD; Mona Shah, PhD; and Matthew Zack, MD. A Health Plan's Investigation of Healthy Daysand Chronic Conditions. *Am J Manag Care*. 2017;23(10):e323-e330

Data interoperability is key to achieving continuity of care for beneficiaries as they interact with plans, health providers, and community service organizations and as beneficiaries switch between plans or are covered by both Medicare and Medicaid. Interoperability is also critical to enable patients to receive truly individualized care, as it could allow for all providers to access and share the same information without requiring the patient to repeatedly provide social risk information, some of which may be uncomfortable to discuss. Humana applauds the efforts CMS has taken to achieve the goal of interoperability, such as its Blue Button 2.0 initiative and the adoption of the Fast Healthcare Interoperability Resources (FHIR) standard and encourage continued focus in this area.

Time is often identified by providers as a barrier to collecting data about social risks. That is why Humana is undergoing a methods study to assess the time it takes to screen patients in a clinical setting using both face-to-face and tablet methods. We will also evaluate the validity of assessment based on each modality. We hope to publish the outcomes of this study in 2019 to contribute to the discussion around the best practices of collecting data on and addressing social risks.

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FIGHTING SENIOR POVERTY THROUGH LAW

November 16, 2018

Submitted electronically to ASPEImpactStudy@hhs.gov

Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Department of Health and Human Services
Baltimore, MD 21244-8016

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

Justice in Aging appreciates the opportunity to provide a response to the above-referenced Request for Information (RFI).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

We appreciate the effort of ASPE to identify best practices for serving the needs of beneficiaries with social risk factors. This is critically important work. Based on our experience as advocates for low income older adults, and particularly what we have seen with the Medicare-Medicaid financial alignment demonstration, we suggest some areas where we believe improvements and identification of best practices would be particularly fruitful.

Information on social risks: We appreciate that ASPE is looking at how to capture social risk factors in electronic health records (EHR). One challenge is that non-medical providers (home health aides, social workers, residential service coordinators, etc.) who do not have EHR access are often best situated to learn of issues such as food or housing insecurity or changes in social supports. Best practices for information sharing among all members of the team serving a beneficiary, including those not providing Medicare-covered services, that also respect the privacy interests of the beneficiary, would be very valuable.

Language access: An area where there is much room for improvement is addressing the needs of beneficiaries with limited English proficiency (LEP). A recent evaluation of the Cal MediConnect (CMC) dual eligible demonstration found that half of the non-English speaking CMC beneficiaries reported that they could "never" get a medical interpreter when they needed one. Over 40% reported that it was harder to get an interpreter in 2017 than it had been in 2016.[1] This report is consistent with comments

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[1] UCSF, Assessing the Experiences of Dually Eligible Beneficiaries in Cal MediConnect: Results of a Longitudinal Survey (Sept. 2018), pp. 6, 64 *available at* www.thescanfoundation.org/sites/default/files/assessing_the_experiences_of_dually_eligible_beneficiaries_in_cal_mediconnect_final_091018.pdf?utm_source=9%2F12%2F2018+TSF%3A+CMC+Evaluation%3B+Dr.+Chernof+Perspectives%3B+New+Videos&utm_campaign=9%2F12%2F2018&utm_medium=email

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we hear from advocates that their LEP clients in many cases either do not know of their rights to interpreters or are reluctant to ask; and, when they do express a need for language assistance, LEP individuals have difficulty obtaining language services.

There is a significant need to educate beneficiaries and their families as well as providers on the value of using trained interpreters and on how to obtain them. It is our experience that many beneficiaries do not understand that this is a right. Moreover, many LEP beneficiaries, like their English-proficient counterparts, rely on family members to help them understand information from providers and make important health decisions. It is important for plans and providers to explain that interpreters can support, rather than supplant, that family involvement.

Further, Medicare Advantage plans and financial alignment demonstration plans should have easy-to-follow procedures to facilitate obtaining interpreter services and should be proactively working to ensure that individuals needing interpreter services, for example those with specialist appointments, have those interpreter services lined up in advance of their appointments. We hope that ASPE can explore with plans best practices around these issues.

Care coordination: Care coordination, both in fee-for-service and managed care models, is particularly important for beneficiaries with social risk factors. The UCSF Study found that Cal-MediConnect beneficiaries with a care coordinator were about four times more likely to rate their care favorably compared to those with no care coordinator.[2] Yet progress with consistent provision of care coordination has been mixed. The UCSF Study found that less than a third of CMC beneficiaries reported having a care coordinator. Further only half of beneficiaries reported that they are getting all the help they need with care coordination.[3] A national evaluation of the demonstrations similarly found a wide range of beneficiary experience with care coordination, including complaints about turnover in coordinators.[4] We urge ASPE to look particularly closely at ways to improve this key function.

Identifying resources: To effectively address social risk factors, plan personnel need to have a full understanding of resources in the community that can be leveraged to provide needed help and services. To be effective, plans need comprehensive knowledge of what is available and how their members can access services. It would be useful to see information on strategies plan care coordinators use to systematically identify and establish working relationships with community based organizations that work with individuals with social risks, including food banks, housing advocates, independent living centers, faith-based organizations, senior centers, county and state agencies – like area agencies on aging and county, state departments of aging, and transportation boards.

Best practices would also be helpful around how plans partner with legal services organizations to help ensure that their members are receiving all benefits to which they are entitled and to untangle problems they encounter in maintaining eligibility and accessing benefits. Medical-legal partnerships, which address legal needs when an individual is in a health care setting, could be a model for how plans could partner with legal service providers. For example, the National Center for Medical-Legal Partnership has

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[2] UCSF Study at p. 4

[3] UCSF Study at p. 5

[4] RTI International, Beneficiary Experience, Early Findings From Focus Groups with Enrollees Participating in the Financial Alignment Initiative (Mar. 2017), pp. 20-21 *available at* www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf.

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highlighted data and best practices around how these partnerships can effectively address social risk factors such as homelessness and mental health--including among veterans, transgender health, the opioids crisis, and chronic health conditions.[5] These are issues that plans serving Medicare beneficiaries could similarly address.

LGBTQ Competency: There is need for learnings on how health plans ensure that their networks include LGBTQ providers and that the entire network has received training at every level – from traditional health care providers to community based organizations. The SAGE certification program is one existing resource for plans and providers.[6] We would encourage ASPE to promote this resource and best practices.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

Jennifer Goldberg

Directing Attorney

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[5] *See* The National Center for Medical-Legal Partnership Resources, *available at* https://medical-legalpartnership.org/resources/.
[6] SAGECare certification and LGBT training, *available at* http://sageusa.care/why-sagecare/resources/.

VIA ELECTRONIC SUBMISSION: ASPEImpactStudy@hhs.gov

November 16, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: SCAN Health Plan Comments in Response to ASPE RFI – IMPACT Act Research Study

Dear Secretary Azar:

SCAN Health Plan (SCAN) is pleased to submit comments in response to the Request for Information (RFI) from the Assistant Secretary for Planning and Evaluation (ASPE) on the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. SCAN applauds the U.S. Department of Health & Human Services (HHS) for addressing social risk factors for Medicare beneficiaries, an area that SCAN has been deeply engaged in for many years. The following provides background on SCAN and our responses to the RFI questions.

SCAN Background

Founded in 1977, SCAN is a not-for-profit health plan that serves seniors through Medicare Advantage (MA) plans and institutional, chronic care, and dual eligible special needs plans (SNPs). Approximately 194,000 Medicare beneficiaries are enrolled in SCAN's MA plans in California, making it the third largest not-for-profit MA Prescription Drug (MA-PD) plan in the country. Since 1985, SCAN has specialized in providing comprehensive, high quality care to the most vulnerable Medicare beneficiaries, including those who live with multiple chronic conditions, are eligible for nursing home care, and experience difficulty performing activities of daily living. Members benefit from SCAN's partnerships with health care providers that engage with plan members to provide the right care at the right time, while maximizing beneficiaries' ability to maintain their independence. We are proud that SCAN MA plans have received a 4.5 star rating for plan years 2018 and 2019.

SCAN Responses to RFI Questions

1. Overall Question: How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

SCAN addresses social risk factors affecting Medicare beneficiaries by offering a variety of plans to seniors with different needs. Key strategies for identifying and collecting social risk data include conducting a health risk assessment (HRA), providing comprehensive care management to high need members, and partnering with providers to offer high quality health care. Through our 40+ years of experience, we have learned that in-home culturally sensitive and linguistically appropriate care and services are the keys to addressing social risk factors.

These strategies and others are described in detail in the October 2018 ASPE report, *Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans,*[1] in which SCAN is featured as a case study.

Below are examples of SCAN plans and programs that emphasize social risk factors. High need individuals are included in all of our products, although some of them are more focused on dual eligible members who are eligible for benefits from Medicare and Medicaid (called Medi-Cal in California). (Please refer to SCAN's website for information on all of SCAN's programs.)[2]

- **Dual Eligibles.** Of SCAN's total membership (194,000), our traditional MA plan serves around 40,000 high need beneficiaries, and some have self-selected to enroll in one of our SNPs. These include plans for dual eligibles (D-SNP), in which members enroll in Medicare through SCAN and SCAN coordinates with Medi-Cal to address the needs of those beneficiaries who are dually enrolled for both Medicare and Medicaid benefits. Other SCAN SNPs serve people living in institutions (I-SNP) and those with specific chronic conditions (C-SNP). SCAN's I-SNPs and C-SNPs have a high proportion—around 25 percent—of dually enrolled beneficiaries. Members enrolled in Village Health, one of our C-SNPs, include 85 percent of duals with high needs.

  All of SCAN's duals products address social factors, such as access to care in the home, housing, nutrition, social isolation, and others. However, SCAN's most robust and integrated SNP is the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). SCAN's FIDE SNP serves approximately 13,000 dually enrolled beneficiaries in Los Angeles, Riverside, and San Bernardino counties, and offers two programs for dual eligibles: *Connections*, which coordinates patients' Medicare and Medi-Cal benefits, and *Connections at Home,* which coordinates and manages patients' Medicare, Medi-Cal, and long-term services and supports (LTSS).

  SCAN's FIDE SNP is recognized for providing high quality care to members. It is California's only MA FIDE SNP and rated 4.5 stars by CMS (100 percent of SCAN's FIDE SNP members are in 4.5 Star plans). Additionally, our FIDE SNP model of care achieved a 96.67 percent score for 2018 with no deficiencies; and <u>99 percent of SCAN's dual members live in community settings, even though 20 percent qualify for nursing home level of care.</u>

- **SCAN Plus.** Another SCAN plan that addresses social risk factors for MA members is SCAN Plus, offered in Los Angeles, Riverside, San Bernardino and San Francisco counties. This plan provides dual eligible members with additional benefits that are not offered by Original Medicare. These include prescription drugs, vision, hearing, dental, acupuncture, chiropractic, podiatry services, as well as transportation, health club membership, home-delivered meals, and a personal emergency response system. SCAN Plus provides care navigation to support members' access to care and community resources. The plan also coordinates members' Medicare and Medi-Cal benefits, even though their Medi-Cal benefits are not enrolled through SCAN.

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[1] *Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans.* Retrieved on November 10, 2018 at: https://aspe.hhs.gov/pdf-report/addressing-social-determinants-health-needs-dually-enrolled-beneficiaries-medicare-advantage-plans-findings-interviews-and-case-studies.

[2] Please refer to SCAN's website at: www.scanhealthplan.com for additional information.

In addition to the health plan, SCAN offers a community resource agency that serves vulnerable seniors, called Independence at Home (IAH). IAH provides free community and social services to seniors and their caregivers to support them living independently in the home setting of their choice. Since 1977, IAH has managed the largest Multipurpose Senior Services Program (MSSP) in California, which is a 1915(c) Medicaid waiver program, assisting nursing home eligible seniors with health and social risks that put them at risk for nursing home placement. MSSP provides in-home case management and LTSS to close to 1,000 seniors annually. In addition to the MSSP program, IAH offers a variety of programs that address social risk factors and help to maintain living in the community. These include assistance with resource navigation, health education, at-home medication safety and care management, social supports to prevent social isolation, as well as addressing behavioral health. The Insights program, a part of IAH, provides in-home behavioral health counseling to community-dwelling seniors and caregivers.

In addition to offering health plans and programs, SCAN helps providers coordinate care and link to community benefits for their patients. While more providers are becoming interested in addressing social risk factors, many are inexperienced in dealing with social issues and need assistance from plans and other organizations to meet the nonmedical needs of their patients. SCAN is in a unique position because we have a long history of addressing seniors' social needs and our model is based on partnering with providers.

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

SCAN identifies social risk factors, targets services, and provides outreach to its members. Key strategies include conducting a HRA for new and current plan members and providing comprehensive care management to high need members.

- **Health Risk Assessments.** SCAN identifies multiple social risks for members, at various points in time, using a HRA. Social risk is included in the HRA and questions are based on the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) model.[3] This assessment uses a screening tool to identify an individual's social and health care needs and to inform the plan's targeting of services. The HRA collects information related to functional status, cognitive status, mental health, physical health, chronic conditions, social risk factors (e.g., whether the individual is living alone, food insecurity), and other domains.

  In 2018, SCAN launched an expanded health risk assessment to collect more information related to social risk factors, including education, race, and languages spoken. We also use a modeling approach to identify high-risk individuals for care management activities that integrates pharmacy claims, emergency department utilization, and other relevant information. In addition to HRAs, members' needs are identified through a triggering event such as a hospitalization, outreach to customer service, a physician referral, or self-referral.

- **Comprehensive Care Management.** Another way that SCAN addresses social risk factors is by assessing needs through in-person visits and telephonic care management. Depending on the level of need, as determined by the HRA or other assessments, each SCAN member is assigned a care navigator or a

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[3] Retrieved on November 10, 2018 at: **http://www.nachc.org/research-and-data/prapare/.**

complex care manager. Care navigators and managers assist enrollees in communicating with their physicians, re-ordering medications, completing health screenings, and making connections to community resources. High need members are assigned to a complex care manager, which is usually a nurse, social worker, or counselor, who conducts telephonic and in-home assessments. Dual members may receive additional assessments to determine if they meet state eligibility criteria for LTSS.

In addition, care managers promote patient engagement and self-management. SCAN members receive personalized coaching to improve treatment and plan adherence, self-management of chronic conditions, and communication with clinicians. Case navigators and managers are trained in motivational interviewing to help members identify and articulate goals that are important to them. They also identify resources (e.g., housing, food, and transportation) that are available in the community through the website Aunt Bertha and facilitate access to services as needed.

SCAN also coordinates LTSS for members in the FIDE SNP. SCAN contracts with a range of community-based organizations and vendors to facilitate the provision of LTSS, including in-home personal care (e.g., assistance with bathing, dressing, and housekeeping), adult day care, meal delivery, and transportation.

3. Are there especially promising strategies for improving care for patients with social risk?

SCAN is implementing several promising strategies to improve care for patients with social risk factors. Examples include the Connecting Provider to Home Pilot, the Insights program to manage behavioral health, a pilot addressing social isolation, new supplemental benefits (Home Advantage and Returning to Home) to keep people living in their homes safely, and telehealth services.

- **Connecting Provider to Home Pilot**. One promising strategy to improve care and identify social risk factors is SCAN's pilot Connecting Provider to Home, designed to overcome the disconnect that occurs between functioning at home and the picture presented during an office visit. The pilot focuses on improving physical and mental health by engaging patients in their health care, improving doctor/patient communication, providing education, removing barriers, and connecting patients with resources. Culturally and linguistically appropriate social workers and community health workers partner with primary care physicians and care teams to address social determinants of health. To date, the pilot has served nearly 600 patients and worked with six provider groups. Evaluations show that the pilot is improving patient and provider satisfaction as well as reducing emergency room (ER) visits and hospitalizations. Additional information on outcomes is included later in this letter.

- **Insights.** A second strategy is providing behavioral therapy for depression through the Insights program. Insights uses culturally sensitive and linguistically appropriate licensed social workers to conduct cognitive behavioral therapy in members' homes to address anxiety and depression. The program has served nearly 500 individuals over two years. Evaluations show significant improvements in both anxiety and depression following treatment. Additional information on outcomes is included in a later section.

- **Member2Member Peer Program.** A third strategy is Member2Member, an outreach program conducted by peer advocates (SCAN members who are also employees) who work to increase health outcomes for members by encouraging positive health behavior through strengths-based communications and motivational interviewing. Advocates build rapport with members as peers who

can discuss topics like physical activity, bladder control, mental health, and the risk of falling from the perspective of someone who is facing some of the same concerns. They also help members with accessing community resources. Evaluation results will be available in April, but initial reports are positive.

- **Social Isolation.** A fourth strategy is addressing social isolation among community-based seniors. SCAN deployed a pilot program to address issues of isolation and other health problems. The intervention is focused on engaging members through groups in the community and having them participate in physical activity together. Evaluations are still pending.

- **New Supplemental Benefits.** In 2019, SCAN will offer two new supplemental benefits that address social risk factors: Home Advantage and Returning to Home. Both benefits are part of SCAN's health plan, with no additional cost for members.

  Home Advantage – includes an annual in-home safety assessment conducted by a licensed Occupational Therapist and a plan for identifying risk from falls or injury and potential hazards in the home. Home Advantage is based on learnings from the CAPABLE model,[4] which was developed at the Johns Hopkins School of Nursing for low-income seniors to safely age in place. It also includes a follow-up in-home visit from a SCAN care navigator who helps members implement the safety plan and connects them to resources in the community. This benefit is in addition (not a replacement) to Medicare-covered home health services.

  Returning to Home – is designed to help with personal care services immediately following a discharge from a hospital or skilled nursing facility. A patient, family member, or doctor can request the program within seven days of being discharged. Specific benefits include:
  o   Personal in-home care, which includes up to 4-hour in-home care visits (16 hours total per year) to help with activities of daily living such as, bathing, dressing, laundry, bed linen changing, light housekeeping, caregiver relief, etc.;
  o   Home delivered meals for up to 28 days (84 meals maximum per year);
  o   Instructions for taking prescriptions safely; and
  o   Ongoing personal phone support services from a SCAN care navigator to help with questions about discharge plans, determine what is needed for a safe return home, and coordinate next steps, such as follow-up doctor visits, home health, durable medical equipment, and physical therapy.

- **Telehealth**. SCAN supports telehealth services as a promising strategy for patients and their caregivers who are unable to travel to a doctor's office. However, for telehealth to be a useful tool depends on the patient's ability to use the technology and the type of care needed. In 2019, SCAN is offering a telehealth benefit to its plan members for non-threatening conditions.

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[4] Retrieved November 10, 2018 at: https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html.

4. How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g. transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?

SCAN evaluates all of its programs to determine their quality outcomes, effectiveness, cost, and return on investment. Below are examples of SCAN programs that address social risk factors and show positive health outcomes.

- **Connecting Provider to Home Pilot**. SCAN's evaluation of the Connecting Provider to Home Pilot indicates health improvements and lower costs. Evaluating two rounds of data, including a controlled match, <u>found a statistically significant decrease in ER visits and hospitalizations and a positive return on investment. Additionally, there were improvements in glycated hemoglobin (A1C) with a statically significant reduction in A1C scores for diabetic members in the program.</u> This reduction was especially pronounced for people whose diabetes was uncontrolled. Metrics on patient and provider satisfaction were also positive.

- **Insights.** SCAN evaluated the use of in-home cognitive behavioral therapy provided by social workers to seniors with depression. <u>The program led to members' improvements in depressive symptoms as measured by the PHQ-9 (a depression screening tool).</u> Client depression levels decreased from 11 to 5 in the PHQ-9 while anxiety dropped from a 12 to a 6 in the Geriatric Anxiety Scale. Program results were equally significant across client's race, ethnicity, and preferred language.

- **LTSS/Care Management**. SCAN found that frail seniors in its FIDE SNP who received LTSS had <u>a 20 percent reduction in the hospitalization rates among frail dually enrolled members receiving care management services compared to individuals who were similar in complexity.</u> This evaluation, which includes a pre/post comparison of hospitalizations, emergency department visits, and other outcomes, has consistently found positive effects from care management.

  In addition, SCAN compares scores on HEDIS measures for each plan to scores from other California plans and national averages. From SCAN internal documents, we confirmed that <u>our SNPs performed at or above the national average on measures related to blood pressure control for patients with hypertension (HTN), colorectal cancer screening, medication reconciliation post discharge, and three measures related to care for older adults (assessment for pain, functional status, and medication reconciliation).</u>

5. What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

Several best practices used by SCAN to address social risk factors include:

- **Person-Centered Care Management.** Using a person-centered approach to address high need patients' health and social needs is another SCAN best practice. This means moving beyond the medical model and taking into consideration what matters most to patients, such as supporting their quality of life and function; minimizing the burden on family; addressing concerns about role changes and illness stigma; and acknowledging uncertainty, hopes, fears and spiritual concerns.

Additionally, care managers meet patients in their homes to determine social needs. For example, if a care manager discovers that a patient's main concern is finding affordable housing or getting enough food to eat, then taking care of health concerns may be an afterthought for the patient. SCAN care managers focus on the whole person and connect them to community-based services to help meet their needs. Lastly, care is culturally and linguistically appropriate. Hiring staff from local communities who speak the same language as the patient, who understand the resources available, and who know how to identify and remove barriers in a culturally appropriate manner is key to achieving rapport, trust, and outcomes.

- **Closing the Loop on Care.** Another best practice is that SCAN focuses on closing the care loop by working with high need members to help them put their treatment plans into practice. This is important because many providers write prescriptions and make treatment recommendations for their patients, but are unaware of what happens to them after they leave the office, unless they return for another appointment.

  SCAN's approach is to work with members to develop goals and care plans that include identifying social support and care navigation needs, discussing personalized goals, needs, and preferences matched against personalized treatment options, and adjusting for variables that may impact appropriate treatment selection. Once interventions are implemented, the focus is on efficacy of the intervention and continuous improvement of the plan of care.

  For high need members, regardless of the type of MA contract, SCAN emphasizes the right to self-determination, care management, coaching and navigation on benefits, health care utilization, and community resources. For example, upon enrollment, each dually enrolled member is assigned to a Personal Assistance Line (PAL) navigator, who is bilingual (Spanish and English). The PALs are well-trained in customer service and able to answer questions about Medicaid benefits, identify community resources through the website Aunt Bertha, and make referrals. This person stays with the member as their personal assistant for care to ensure that care is delivered and outcomes are achieved.

- **Health Risk Assessments.** Another SCAN best practice is assessing individuals' health risks, including social risk factors. Using a screening tool to identify an individual's social and health care needs to inform the plan's targeting of services is best practice, especially if the HRAs collects information related to functional status, and social risk factors (e.g., whether the individual is living alone, food insecurity, etc.). This data is difficult to obtain through other means such as diagnosis and procedure codes.

- **Transportation Services.** SCAN provides its members (99 percent) with a transportation benefit to enable them to travel to and from medical appointments.

- **Alternative Pain Management.** SCAN provides its members (over 99 percent) with chiropractic and/or acupuncture benefits to reduce pain and help prevent opioid addiction.

- **Medication Adherence by Telephone.** Through a telephonic program, bilingual care managers provide support to SCAN members and reduce barriers to medication adherence.

- **In-Home Palliative Care.** SCAN uses an in-home palliative care model with an outside organization to provide palliative care for members.

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

Lessons learned, based on SCAN's experience with providing care for patients with social risk factors, include: 1) people with high needs may require a human connection to meet their health goals; 2) people with chronic conditions may not have the coping skills necessary to follow a treatment plan without assistance; and 3) physicians may not have the time to address patients' social risk factors during an appointment, resulting in treatment plans that are based on limited information.

- **Human Connection.** First, many patients with significant health and social needs require a human connection to meet their health goals and treatment plans. For example, providers may ask patients to use specific technology and equipment to help with health conditions (e.g., iPads, iPhones, oxygen tanks, etc.) that they do not understand how to use. Some patients benefit from repeated instructions on how to use technology, and without this, the equipment is not used and health conditions may not improve. In addition, some people will never learn how to use certain technology because of a variety of barriers. Without in-person linguistically and culturally appropriate outreach, these barriers go unnoticed and unaddressed and alternative more appropriate interventions are not implemented.

  An example is Mrs. W., an 85-year-old low-income member with end-stage congestive heart failure who lives alone. Her provider ordered her an electronic scale and a tablet to track her weight. Vision and balance issues make it impossible for her to step onto the scale without assistance of another person and read the scale, plus she does not have a way to keep the tablet charged. After an in-home visit from a social worker and community health worker, she and her care team decided to get a different scale and develop a manual way for her to track her weight and share it with her doctor.

- **Coping Skills.** Second, some patients with social risk factors lack adequate coping skills to successfully navigate the health system and find community-based services on their own. An example is a woman named Sue who enrolled in Insights, which addresses seniors' and caregivers' barriers to accessing mental health care. Sue is a 71-year-old monolingual Korean speaker and the primary caregiver for her younger sister with Alzheimer's. She was experiencing stress due to caregiving and depression from the loss of her adult son. After receiving Insights interventions, including regular cognitive behavioral therapy and coping strategies such as routines, problem-solving, and journaling, her mental outlook improved. Sue felt she had more confidence to handle difficult situations and a better relationship with her sister.

- **Limited Information.** Third, many physicians have limited time to spend with patients and are not able to ask questions about social risk factors. Even when physicians collect data on social risks, they may have limited awareness of the community-services for patient referrals. For example, Mr. E is a senior who was living in a mini RV with no running water, cooking facilities, or electricity. He had multiple ER and hospital admissions due to chronic obstructive pulmonary disease, HTN, cancer, depression, chronic pain, and more. After being connected to community resources that provided housing, behavioral health services, food pantry, personal care, meal prep, and transportation, Mr. E's health greatly improved. He has not had any further ER or hospital visits and now follows a treatment plan.

To alleviate these issues, SCAN recommends that providers use standardized HRAs to capture social risk factors. Providers who are not aware of external resources to make referrals to patients should partner with organizations to help them develop patient-centered care to address social risk factors, rather than focusing

solely on medical issues. For example, it is important that high need seniors are assessed in their homes to identify risk factors and community-based services that can help them.

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

Barriers to tailoring services to patients with social risk factors include a lack of protocols that incorporate social risk identification and interventions, a lack of incentives and reimbursement for providers, and a lack of available community-based support systems. First, as mentioned earlier, providers should use different protocols to target social risk factors for high need populations, such as seniors and people with disabilities. Second, providers are not paid for addressing social risk factors. Additional incentives and reimbursement or a realignment of incentives would encourage physicians to pay more attention to patients' social needs. Third, providers must be aware of, and their systems must enable the use of existing codes available for social risk factors, such as the ICD-10 code for homelessness and CPT II codes for screenings and interventions.

Fourth, providers often do not close the care loop for high need individuals. Providers see patients and make treatment recommendations, but do not know what happens to them afterward. A feedback system would help ensure that individuals receive appropriate community resources and that the services are directed to those most in need. Finally, SCAN is concerned that as large health plans begin using small community organizations to manage social risk factors, it could lead to fewer community-resources available for seniors who are not enrolled in large plans. As community resources become part of the health care ecosystem, they need more support with technology and funding in order to meet the needs of Medicare beneficiaries with social risk factors.

8. For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?

Patients' disability, functional status, and frailty must be considered when addressing social risk factors. Factors such as patient ability, provider practices, and patient trust can affect the provision of services. For example, not every person benefits from digital solutions. Although telehealth must be a part of the solution, digital solutions can be problematic for people who are homebound and do not have anyone to assist them with the technology.

In addition, as mentioned previously, providers should use different protocols to assess various populations and a person-centered approach to determine and address individual social risks. Finally, building relationships and trust with some high need patients may take time before they accept social services. Some high needs individuals may not trust treatment recommendations made to them by physicians, plans, and community organizations, especially if they were promised services in the past that did not materialize.

9. Which social risk factors are most important to capture? Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

The most important social risk factors to capture are data on housing, nutrition, transportation, isolation, living alone, and access to affordable medications and health providers. SCAN has routinely collected data on social risk factors through the HRAs for the SNP programs and now collects this information from the HRAs from all of our programs. In addition to the HRAs, data are collected at point of sale, and at doctors' offices when patients fill out health forms. We recommend that social risk data is collected in partnership with other public data sources like Social Security and local municipalities to have complete information for each patient. However, we understand that current HIPPA rules prevent some data sources from being shared.

Collecting data can be burdensome for providers, patients, and plans. For providers, collecting social risk data can be frustrating if they do not have a clear path for what to do with the information or knowledge of community-based services for patient referrals. Patients are burdened by data collection because they are often asked to provide the same information over and over about their health conditions, and do not know why the data are being collected. For plans, data collection can be difficult because some patients are reluctant to provide personal information because of concerns about privacy and how the data will be used. Integrating data and promoting greater interoperability among health systems would ease some of these burdens.

10. Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

SCAN supports standardized data elements for EHRs to collect social risk data for consistency and accuracy across plans and providers. Specifically, we recommend using the PRAPARE model for standardization. PRAPARE is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. It was informed by research, the experience of existing social risk assessments, and stakeholder engagement. It aligns with national initiatives prioritizing social determinants measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System.[5]

11. What are barriers to collecting data about social risk? How can these barriers be overcome? What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

Barriers to collecting social risk data include: 1) providers are not coding for social risks even when there are codes available, e.g., homelessness; 2) providers are not reimbursed for collecting data on social risk factors; 3) providers do not have a clear path for what to do with the data collected; and 4) members of the public are not often aware of the importance of providing data on health equity factors to providers and plans.

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[5] Text retrieved on November 10, 2018 at: http://www.nachc.org/research-and-data/prapare/.

The current focus on social determinants of health in the medical community, the inclusion of social risk factors in EHRs, the aggregation of community resources in on-line data bases, and the growing interest in community health workers and other in-home care coordination and management are all very promising. Ensuring that laws and regulations allow for appropriate sharing of data and that new data analytic models use social risk factors will greatly improve data collection and the ability to tailor services.

SCAN Health Plan appreciates your interest in addressing social risk factors for Medicare beneficiaries and improving health outcomes for people with complex health conditions. We look forward to partnering with you in the future on this important work.

Sincerely,

Eve Gelb
SVP, Health Care Services
SCAN Health Plan

lyft

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November 16, 2018

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 600E
Washington, DC 20201

RE: Request for Information by the Secretary of the U.S. Department of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation, under Section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

Dear Secretary Azar:

Lyft appreciates the opportunity to comment on this Request for Information. We are a transportation network company (TNC) that introduced peer-to-peer, on-demand ridesharing in 2012. Today, through our ridesharing platform, Lyft's friendly, safe, affordable transportation options are available to more than 96% of Americans and provide over 10 million rides per week. We are committed to leveraging our service to help improve lives, particularly when it comes to addressing the social determinants of health – of which transportation is foundational.

We commend the Department of Health and Human Services (HHS) through the Assistant Secretary for Planning and Evaluation for seeking information on how health plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors and address their specific needs. We share your view that social risk factors – such as transportation, income, education, race and ethnicity, employment, housing, food, community resources, and social support – play a major role in health. In particular, we at Lyft are concerned about the 3.6 million Americans who delay or miss care each year due to transportation issues.[1] Patients who miss appointments due to transportation obstacles cost the health care industry $150 billion in lost revenue annually.[2]

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[1] https://medcitynews.com/2017/01/5-ways-healthcare-transportation-must-change-2017/
[2] https://www.nytimes.com/2018/08/09/business/health-care-transportation.html

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Lyft's non-emergency medical transportation (NEMT) services provide a reliable solution to this gap in transportation for patients. NEMT ensures transportation to and from providers for situations that do not involve immediate threat to the life or health of the beneficiary. Florida State University found that if just one percent of NEMT resulted in the avoidance of an emergency department hospital visit, the payback to the state would be approximately $11.08 for each dollar the state invests in its medical transportation program.[3]

Lyft has been at the forefront of partnering with health plans and providers to provide NEMT services. In 2016, Lyft began its partnership with CareMore Health, a physician-led integrated care delivery system that operates Medicare Advantage plans. CareMore Health and Lyft launched a pilot program in Southern California to assess the impact of Lyft's NEMT services on patient experience and costs. The study found that our partnership reduced transportation wait times by 30 percent and the average cost per-ride fell 32.4 percent from $31.54 to $21.32.[4]

Reducing per-ride costs allowed Lyft and CareMore Health to expand the program system wide throughout the course of 2017. We now offer rides throughout all CareMore Health Medicare Advantage markets, reaching 75,000 patients across California, Nevada, Arizona, and Virginia. By the end of 2017, CareMore Health provided 91 percent of its curb-to-curb, ambulatory rides through Lyft accounting for up to 7,000 rides per month, and a total of 68,993 rides over the course of 2017.[5] The expansion of their NEMT benefit allowed Lyft and CareMore Health to provide an additional 28,000 rides (a 12 percent increase) at no additional cost.[6] Even more importantly, since the expansion of the pilot to the entire CareMore Health system, 96 percent of patients reported in a survey that they felt safe or very safe using Lyft-based rides through CareMore and 98 percent said they were satisfied or very satisfied with Lyft's NEMT services.[7]

Our partnership with CareMore Health also allowed us to address new technological and cultural barriers for seniors. For example, some CareMore Health members felt uncomfortable distinguishing Lyft cars from other cars on the street, so we developed a placard with the Lyft logo and designated wait stations to help riders easily identify their Lyft ride. CareMore Health and Lyft also collaborated on senior sensitivity trainings on a voluntary basis for Lyft's independent contractor drivers to educate them on how to interact with an elderly client base and make them feel more comfortable with Lyft services.

[3] http://www.fdot.gov/ctd/docs/aboutusdocs/roi_final_report_0308.pdf
[4] https://jamanetwork.com/journals/jama/article-abstract/2547765
[5] https://www.healthaffairs.org/do/10.1377/hblog20180907.685440/full/
[6] https://www.healthaffairs.org/do/10.1377/hblog20180907.685440/full/
[7] https://www.ajmc.com/focus-of-the-week/caremore-finds-success-using-lyft-to-transport-medicare-beneficiaries-to-appointments

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In addition to our partnerships with health plans, Lyft also partners with providers to offer NEMT services. In November 2016, as just one example, Lyft collaborated with Denver Health, a large safety net hospital that provides health care for approximately 150,000 individuals, to order transportation services for recently discharged patients and patients in need of transportation to and from outpatient clinical appointments.[8] During the initial three months[9] of our partnership, Denver Health ordered more than 200 rides from Lyft. Prior to the partnership, patient advocates at Denver Health received daily complaints about the lack of adequate transportation. Since the launch of Lyft services, patient advocates have ceased receiving complaints about transportation.[10]

On average, the cost per ride for Denver Health is just $7 and the service is provided freely to patients within a 20-mile radius of the hospital.[11] Denver Health has paid for more than 4,000 rides since the beginning of the program.[12] Furthermore, Denver Health has found that Lyft NEMT services are a great benefit to patients for whom English is a second language and navigating other transportation options can be especially challenging.[13]

Lyft is also working to help people with disabilities increase their mobility. In fact, 75 percent of Lyft passengers who are living with a disability say Lyft has increased their mobility.[14] Our ride sharing service makes running errands, going to doctors appointments and heading to work or class easier for individuals who cannot drive or for whom public transportation poses a challenge. Lyft partners with the National Federation of the Blind and the National Association of the Deaf to expand transportation options for individuals who are blind or low vision and deaf or hard-of-hearing, and to ensure the Lyft app is a usable interface for both. Lyft also partners with the National Down Syndrome Society, helping Americans with intellectual or developmental disabilities enjoy significantly improved transportation options and

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[8] https://www.aha.org/news/insights-and-analysis/2018-03-01-case-study-denver-health-medical-center-collaborates-lyft
[9] https://www.aha.org/news/insights-and-analysis/2018-03-01-case-study-denver-health-medical-center-collaborates-lyft
[10] https://www.aha.org/news/insights-and-analysis/2018-03-01-case-study-denver-health-medical-center-collaborates-lyft
[11] http://www.denverhealthfoundation.org/the-foundation/newsroom/denver-healths-new-program-utilizes-lyft-to-get-patients-home-safely
[12] http://www.denverhealthfoundation.org/the-foundation/newsroom/denver-healths-new-program-utilizes-lyft-to-get-patients-home-safely
[13] https://www.aha.org/news/insights-and-analysis/2018-03-01-case-study-denver-health-medical-center-collaborates-lyft
[14] https://take.lyft.com/economic-impact/

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independence through ridesharing. Lyft is committed to ongoing progress toward better understanding and advancing its ability to improve transportation for people with disabilities.

Additionally, Lyft is concerned with the impact the lack of access to reliable transportation has on social isolation and consequential health effects. According to AARP, more than 8 million adults over the age of 50 are affected by isolation.[15] Isolation can be quantifiably measured using indicators such as the size of one's social network and frequency of social engagement, access to transportation and ability to access resources and information. Furthermore, isolation is often the result of multiple causes such as poor physical and/or mental health, poorly designed communities and lack of resources. AARP has found that the health risks of prolonged isolation are equivalent to smoking 15 cigarettes a day.[16]

The lack of accessible and affordable transportation options and loss of the ability to drive contribute to social isolation. About 21 percent of individuals over 65 do not drive, many for health reasons, and many baby boomers do not have children or spouses to drive them.[17] Furthermore, more than half of the U.S. non-driving population age 65 and over stays home on any given day because they don't have transportation.[18] Lyft allows seniors to retain independence and reduce social isolation through our easy-to-use, on-demand ride services. In addition, we have partnerships with senior living communities such as Brookdale Senior Living, one of the largest operators of senior living facilities in the country and Life Care Services, the third largest manager of full-service senior living communities.

Finally, we are incredibly encouraged by preliminary results of a study conducted by the University of Southern California's 2018 Body Computing Conference found that access to transportation via Lyft rides improve quality of life for seniors by 90 percent. The research was conducted through a partnership between Lyft and the University of Southern California Center for Body Computing in collaboration with UnitedHealthcare and the AARP Foundation. Over a three month period, 150 seniors living with chronic conditions in the Los Angeles area had access to unlimited Lyft rides, with a strong emphasis on doctor's appointments. Most of the participants lived alone and were either retired, unable to work or had a disability. 68 percent

[15] https://connect2affect.org/about-isolation/
[16] http://connect2affect.org/about-isolation/
[17] https://www.nytimes.com/2018/08/09/business/health-care-transportation.html
[18] https://www.aarp.org/content/dam/aarp/livable-communities/learn/transportation/waiting-for-a-ride-transit-access-and-americas-aging-population-aarp.pdf

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of seniors said that Lyft's services made it easier to travel to medical visits and 74 percent said it increased their social visits,[19] drastically decreasing feelings of loneliness and social isolation.

In closing, Lyft appreciates HHS' focus on the social determinants of health and social isolation as a means of confronting other health care issues. Health plans and providers are central in this fight, and we encourage HHS to provide additional flexibility in this space, allowing them to utilize their limited resources in creative, impactful ways including partnering with TNCs. We believe Lyft can play an even greater collaborative role with partners in all corners of health care and across communities to address these costly health risk factors if the appropriate incentives are encouraged throughout the system.

Thank you for the opportunity to comment on the Request for Information. For further questions, please contact Jake Swanton (jswanton@lyft.com) on our federal policy team.

Sincerely,

Lauren Belive
Director of Federal Public Policy

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[19] https://www.fastcompany.com/90244794/how-free-lyft-rides-can-dramatically-improve-life-for-senior-citizens

MAXIM HEALTHCARE SERVICES, INC.

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

Due: November 16, 2018

Submitted by:

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OVERALL QUESTION

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

From Maxim's perspective as an engaged national healthcare partner and provider, we have seen a consistent trend in State health plans and local providers increasingly supporting the integration of Social Determinants of Health (SDoH) data into their strategic program development to support Medicare beneficiaries.

Rather than developing programs that are reactive to the health disparities that arise from the presence of various SDoH and barriers to adherence, Maxim strives to work with various providers and health plans to develop plans that will proactively address the underlying causes of Social Risk Factors. Maxim serves as a healthcare partner and provider of choice to more than 8,000 clients nationwide, including state Managed Care Organizations (MCOs), Care Transformation Organizations (CTOs), Accountable Care Organizations (ACOs), local and federal government agencies and departments, hospitals, correctional facilities, and commercial health plans. We leverage our robust caregiver network, our national presence, and our 30 years of experience in developing comprehensive, community-based programs that address the complex healthcare challenges individuals face on a daily basis.

Maxim believes that to affect lasting change, programs must first address the social barriers to adherence to overcome underlying health disparities, and ultimately improve their health outcomes. Maxim's customized community-based care service offering serves as the natural extension of our core service capability: providing a clinical and non-clinical support network for patients across the continuum of care.

DELIVERY OF SERVICES

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

Yes. In addition to data available from our partners about the socio-economic and health status of the population being supported, Maxim utilizes our proprietary Health Risk Assessment to stratify participants based on their individualized health risk status.

To identify social risk factors, Maxim's proprietary assessment is used to quickly and efficiently assess a patient and their family's status in their home, allow Maxim to assess them in an environment that is both comfortable and a realistic look at their day-to-day lives. This assessment identifies any existing deficits, barriers, or gaps in care.

Our assessment is rooted in the belief that total health and wellbeing hinges on four specific domains: **Medical, Functional, Psychological, and Social**. An example of a clinical assessment for a specific program might be as follows:

- ♦ **Physical/Functional Assessment**
- ♦ **Medication Reconciliation**
- ♦ **Environmental Assessment**
- ♦ **Behavioral/Social Needs Assessment**

Based on the results of our health risk assessments (HRAs) conducted in the home, Maxim develops a personalized Comprehensive Care Plan for each person, tailored to address the participant's unique social risk factors.

2. Are there especially promising strategies for improving care for patients with social risk?

Yes. Maxim has seen significant improvement in both individuals and a total participant population when Maxim is able to fully implement all aspects of our Community-Based Care Management strategies, including but not limited to:

- ♦ **Comprehensive Care Plan:** The results of Maxim's intake assessment drive the development of a customized comprehensive care plan that meets the patient where they currently are, and sets tangible goals based on the patient's long-term needs and goals. Maxim can work collaboratively with customer-specific Case Manager(s) to ensure that the Care Plans Maxim is recommending support existing Case Management treatment plans or health initiatives.

- ♦ A team-based approach to coordination and program management to ensure support across the continuum of care

- ♦ Forging relationships with non-traditional community stakeholders who are familiar with the geographic and socio-economic landscape of a particular region/population. This strategy allows Maxim's programs to address the total health of a population through expanded relationships with providers and practices, and allows entire communities to realize and actualize their health and wellbeing goals.

♦ Data integration with existing member information, HRA results, and other data sources to identify and assess health risks, and serve as a predicative indicator for future population trends.

♦ **Hospital to Home Programs:** Maxim's Hospital to Home Programs are intended to support our customers' more vulnerable populations from the point of discharge from the hospital and their return to their homes.

    o **Transitional Programs:** Members who are at elevated risk for readmission to acute care facilities are linked to the program prior to their discharge. Our Community Health Workers (CHWs) provide assistance in transitioning the member to a post-acute setting. Maxim's goal with these members is to reduce the likelihood of readmission.

    o **Transitional Care Coordination:** Provides transitional care services to bridge the gap between the hospital and home by providing continuity of care across the transition. Maxim's Transitional Care Coordinators are nurses whose role is to establish a relationship with the patient in the hospital, identify needs for a comfortable transition home, and develop a custom transitional care plan for post-hospital services that address these factors while working directly with a local Maxim clinical team to support the transition.

3. **How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?**

While there are fixed costs to some of our services, such as specific vaccination costs, or a per-assessment fee, much of our pricing is subjective depending on the size and scope of the proposed program, the size of the population being supported, and other program-specific components that may impact pricing is structured.

In regards to return on investment, to illustrate the potential impact of our programs, we have included a chart that shows the results of a two-year case study for one of Maxim's Community-Based Care Management programs. It illustrates that the program began with a 25 percent readmission rate for high-risk patients, which was reduced to an 8-12 percent readmission rate over time.
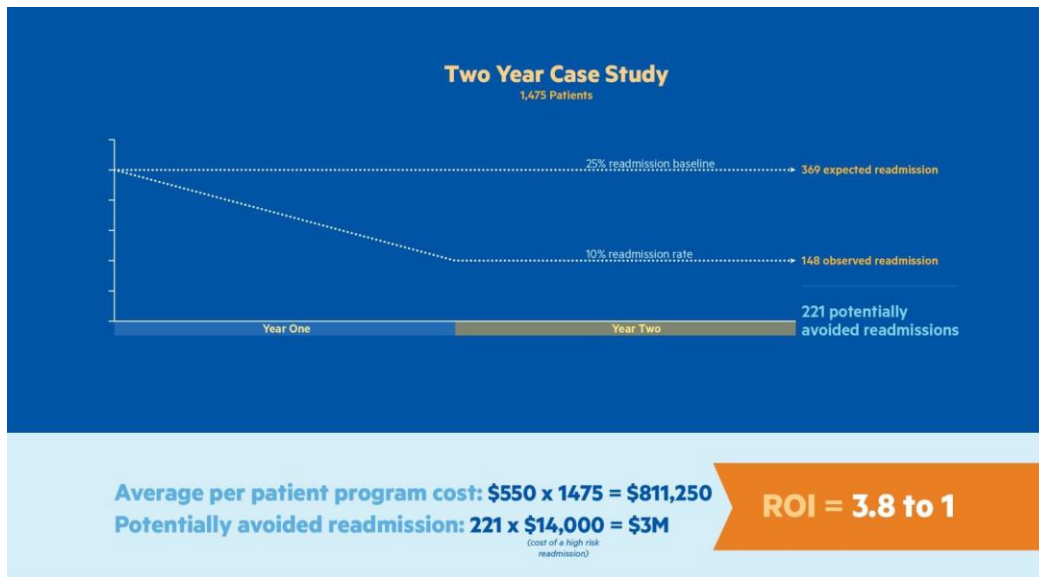
"We began working with the University of Maryland on a program that is very focused on the social determinants side of non-clinical barriers to adherence. We started focusing on readmissions, but quickly realized that for a lot of patients, readmissions are only a symptom of these underlying problems. [Patients are] suffering from socioeconomic challenges that are preventing them from following the care plan you've outlined, so if you can address those, the utilization comes down as a byproduct."

-Andy Friedell, Senior Vice President of Strategic Solutions, Maxim Healthcare

Two Year Case Study
1,475 Patients

25% readmission baseline → 369 expected readmission

10% readmission rate → 148 observed readmission

221 potentially avoided readmissions

Year One | Year Two

Average per patient program cost: $550 x 1475 = $811,250
Potentially avoided readmission: 221 x $14,000 = $3M
(cost of a high risk readmission)

ROI = 3.8 to 1

4. What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

Maxim's Community Health Workers are the core of our Community-Based Care Management programs. Our CHWs are the most critical factor in assessing and supporting participants, as well as linking them to existing community resources to address underlying social risk factors that are negatively impacting their health status or have become a barrier to adhering to their treatment plan. The goal of utilizing CHWs in a particular community is to have the CHW function as a connector between healthcare consumers and existing resources and support systems to promote health among communities that experience barriers to accessible healthcare, as well as elevated risks for specific health issues.

The primary role of a CHW is to develop a relationship with patients and their families based on mutual trust and founded in respect, thus identifying and linking them to the services they need to achieve total wellbeing.

CHWs specialize in care coordination with community resources, including but not limited to medical, behavioral health, rehabilitation, or social services. By engaging patients in a relationship based on mutual trust and respect, and linking them to existing resources in the community, CHWs empower patients and entire communities to manage their health conditions while reducing dependence on unnecessary and high-cost hospital services.

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

Maxim believes that assessing social risk factors concurrently with medical risk factors leads to greater success in developing and delivering care that has long-lasting results, as well as improving the health outcomes of a total population. While of critical importance to the success of community-based care programs, assessing and providing care for patients with social risk factors presents a number of interesting challenges.

We have learned that cooperation and coordination with providers is essential to better integrated care teams, which leads to reductions in gaps in care. We have also learned that supporting these populations requires creative approaches to providing care. To generate a true medical return on investment for patients with significant social risk challenges, Maxim must invest time, energy, and resources into activities that may fall outside of the traditional scope of the healthcare system.

Additionally, these programs require relationships that are less transactional and more continuous in nature, which is why Maxim emphasizes the importance of our Community Health Worker network. Maxim has also learned that program success requires big picture thinking to tackle the concept that you cannot address the issue of high-cost healthcare utilization without first addressing underlying issues that may not be immediately identifiable as a healthcare challenge, such as social isolation, lack of transportation, environmental, or logistical issues.

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

While barriers to tailoring services will vary depending on the cultural and geopolitical landscape of various states and communities, the most general and difficult barrier to overcome is a lack of fiscal and literal resources available to address barriers to adherence. A lack of resources can manifest in different ways – from insufficient transportation and housing to limitations in childcare and unemployment.

Maxim understands that no two programs will be exactly alike, and as such we approach the strategic development of each program in close collaboration with our customers to ensure that we have the framework in place to support the population's unique needs and anticipate the common barriers that may be associated with supporting that specific population. This allows us to preemptively determine care plans that can link participants to a specific community resource.

For example, for a high-risk Medicare population, common barriers to adherence and the community-based resources that could be used to overcome those barriers might be as follows:

Barriers to Adherence	Community-Based Resources
♦ **Social Isolation**	♦ Support Groups ♦ Mental Health Agencies ♦ Community Action Councils
♦ **Lack of Transportation**	♦ State-Sponsored Public Transportation/Ride-Sharing ♦ Expanded Partnerships with Lyft/Uber
♦ **Financial Instability**	♦ Food Banks ♦ Care Coordination ♦ Rental/Utilities Assistance ♦ Transitional Housing

7.   For patients with social risk factors, how does a patient's disability, functional status, or frailty affect the provision of services?

Maxim's Health Risk Assessment does not only measure social risk factors, but also takes into account any physical or medical comorbidities that may influence the level of care that a participant would receive. Maxim has been one of the nation's leading providers of in-home healthcare services for 30 years, which is what makes our Community-Based Care Management services a natural extension of our core service offering. Our programs hinge on the belief that the most effective way to provide treatment is to treat the whole person – this includes any physical disabilities or functional limitations – and create a care plan that addresses *all* measures of health.

The results of the intake assessment will drive the development of a customized comprehensive care plan that meets the patient where they currently are and sets tangible goals based on the patient's long-term needs and goals. Once these assessments are completed and the relevant barriers to care identified, Maxim's EMR system will aide in developing a Comprehensive Care Plan unique to the individual and their specific barriers and challenges.

The plan then outlines barriers/issues, goals, and specific encounters for the team to implement or execute over the course of that phase of the client's time with Maxim. Team members then use the care plan to help clients achieve mutually agreed upon goals. The Care Plan helps guide CHWS and provides a place to document progress toward goals. A participant's functional status and any physical disabilities will be factored into the level of care recommended.

DATA

1.   Which social risk factor are most important to capture?

Maxim considers transportation, nutrition, housing, finances, and social isolation to be the most important social risk factors to capture. These factors have the most measurable impact on improving health outcomes and access to care, as well as generating meaningful, long-term impact on the healthcare costs by reducing potentially-avoidable healthcare utilization.

♦ **Transportation:** A lack of reliable transportation greatly limits a participant's ability to access primary care and specialty appointments on a regular schedule. A lack of transportation also limits a participant's ability to obtain their medications from pharmacies or regularly visit a grocery store, resulting in missed doses and non-adherence to treatment plans, as well as poor dietary habits.

♦ **Nutrition:** Improper nutrition is a major factor in negatively impacting participant health outcomes. Individuals who are not properly educated on the proper nutrition for themselves, or who are unable to access proper nutrition, either due to financial limitations or transportation issues, can experience complications to their existing health issues, resulting in higher long-term and immediate healthcare costs.

♦ **Housing:** Housing – both chronic or occasional homelessness, as well as housing insecurity - are critical risk factors to capture as they dramatically impact a participant's ability to adhere to treatment and receive services. Housing insecurity occurs when an individual spends a disproportionate share of their monthly income on housing (over 50%), leaving fewer resources to spend on

nutrition, medications, transportations, or medical costs for copays and insurance premiums. It is also important to capture environmental factors in the home, such as mold, dust, pollen, or pollution, all of which can exacerbate respiratory conditions and other factors. Community and public safety issues can also have direct health impacts, as well as implications for behavioral and psychological health. There is growing research that indicates that an individual's ZIP code has stronger statistical correlation to health outcomes than an individual's genetic profile.

♦ **Financial Stability:** An individual's financial stability has a number of implications for a person's health. Access to affordable insurance affects a person's ability to and likelihood of obtaining low-cost preventative healthcare services. This can lead to reduced overutilization of Emergency Departments for treatment of manageable conditions. This also impacts a patient's ability to afford medications and food, while having a dramatic impact on psychological issues such as anxiety and depression, which can negatively impact health outcomes. Awareness of and connection to social and community resources that a patient is eligible for (free or reduced cost) can improve engagement with the healthcare system but also connection to other social resources that have long-term impacts on health status.

♦ **Social Isolation**: The absence of family and friends in the home or within a reasonable distance can have a number of ramifications. First, it affects the patient directly by resulting in a loss of hope and increased risk for depression and anxiety. Lacking a support system can impact a person's ability and willingness to engage with the healthcare system. Social Isolation also exacerbates the impact of barriers resulting from cultural or language differences or educational issues like literacy or non-familiarity with technology. Being connected to others can increase these social network connections that serve as a safety net between the patient and the Emergency Department.

While the overall goal is community vitality, it is important to remain focused on those risk factors that have the most concrete and immediate impact on health outcomes without being distracted by any and all social factors.

2. Do you routinely and systematically collect data about social risk?

Yes. Our proprietary Health Risk Assessment is utilized in our Community-Based Care Programs to provide an accurate snapshot of each participant's risk status at that moment in time, and is used to develop the corresponding Care Plan.

3. Who collects the data? When is it collected?

Upon referral to our program a nurse practitioner visits a patient's home and performs the initial health assessment. This creates an opportunity for the patient and their family to discuss with a practitioner the health risks and improvement measures that can be taken to alleviate some of the risks.

4. Is data collected once or multiple times for a beneficiary?

Data is collected at multiple times throughout the program, though the frequency of data collection varies depending upon specific program goals, and can be collected on a weekly, quarterly, monthly, or annual basis per the customer's wishes. Typically, Maxim conducts an Initial Intake Assessment which determines the parameters of the Care Plan. Within the Care Plan, specific goals are set for the participant – if the participant is unable to meet the goals and milestones set in the Care Plan, Maxim will conduct a periodic reassessment and adjust the Care Plan.

5. Is data collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)?

Yes. Maxim's programs collect data across the total population we're supporting with a specific program.

6. What are the burdens of this data collection on plans, providers, and beneficiaries?

Maxim has devoted significant resources to developing an interoperable technology and data systems to ensure our ability to capture all relevant participant data and transmit that data in a timely, accurate fashion. Maxim's programs are structure in a way that the vast majority of the data collection falls primarily on Maxim, and as a result the burden on the plan, provider, and beneficiaries is minimal.

To conduct assessments, Maxim utilizes our **Electronic Medical Records (EMR) System.** This scalable and tablet-friendly system can be used in an online or offline setting and allows caregivers to conduct assessments, develop care plans, and document interventions at the point of care.

Maxim has established data integration formats and processes with over 500 health plans, broker/consultants, data warehouses and wellness companies. We integrate results into electronic health records (EHRs), personal health records (PHRs) and other online health assessments using a variety of secure data formats. We have employed various technologies to link information with our partners.

Sharing solutions has been as simple as a flat file dump transferred over a secured connection such as SFTP, email with encrypted contents via PGP, or more in-depth processes such as SSO (Single Sign On) via the SAML protocol or Web Services via SOAP or REST for reporting and tracking.

7. Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

Yes. Data points on social risk factors are difficult to standardize because, in many cases, these factors are not yet incorporated into EHRs, due to resources and providers being community-based and not yet embedded in the healthcare system. Incorporating non-medical or non-healthcare providers, including entities that provide housing assistance services or nutritional support, like Meals on Wheels, streamlines the application processes for resources and results in benefits being better coordinated with care plans, all of which drives the long-term goal of standardization.

8. What are barriers to collecting data about social risk? How can these barriers be overcome?

Collecting data directly from the participant about their social risk status can provide unique and otherwise unreported insights into patient experiences, allowing our team to better construct a Care Plan that addresses all factors of their health and wellbeing.

However, due to the sensitive manner of this form of data collection, there can be some limitations. The most common barrier to collecting data about social risk directly from a participant is a lack of mutual trust between the participant and the caregiver conducting the risk assessment, which may lead to the reporting of incomplete data from the patients from whom data is most important to collect. These patients are often the most difficult to locate or engage or more resistant to engaging with the healthcare system. It is because of this specific barrier that Maxim utilizes our Community Health Worker (CHW) workforce. By nature of their roles, CHWs are members of the same community as the participant they are supporting, and oftentimes they may have personal experience with many of the same social risk factors that the participant may be experiencing.

Another common barrier to collecting data are the limitations of a participant's health literacy levels, which may mean the participant is unable to fully articulate their risk status. The success of a Community-Based Care Coordination program hinges on the ability to engage participants at any level, regardless of current risk status or health literacy levels.
To ensure that participants who may be resistent to change are receiving support that provides them with realistic goals and tactics for achieving those goals, all Maxim CHWs are trained in conducting **Motivational Interviewing** as well as tools to increase emotional intelligence.

Motivational Interviewing is an evidenced-based approach to help patients suffering from comorbidities drive positive behavioral changes. Motivational interviewing replaces the more traditional method of "advice giving" with "reflective listening". While a CHW or provider may give sound medical advice, the patient, often concurrently, resists the advice. The motivational interviewing process reframes the patient-provider interaction through goal-oriented, patient-focused counseling that challenges patients to address the underlying causes for their issues. The five principles of motviational interviewing are as follows:

- Express and show empathy
- Support and develop discrepancy
- Address resistence and identify root cause
- Support self-efficacy
- Develop skills for autonomy

9. What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

Maxim sees opportunities to improve the quality of data being collected during in the following ways:

- Combining the technology of our tablet-based assessments and Electronic Health Records (EHRs) with our caregiver presence in the home. This allows for a more accurate risk-stratification process, and will provide a more complete picture of the participant's total health and wellbeing status.

♦ The more accurate the data collected, the more comprehensive and customized our care plans will be, resulting in more targeted interventions, more effectively allocated caregiver resources, and improvements in quality of care.

♦ The incorporation of social resources into technology platforms will streamline applications for relevant social and community resources and benefits.

♦ Automatic applications based on eligibility criteria, or even creating a centralized hub or application for various benefits would greatly streamline the application process, and would result in better patient health outcomes.

To support these principles, Maxim recently formed a partnership with Leidos Health. With Leidos support, Maxim intends to leverage available technological resources to engage with our nation-wide network of caregivers in a more strategic manner.

November 13, 2018

Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Ave. SW, Room 600E
Washington, DC 20201

Re: Request for Information (RFI) on IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

To Whom It May Concern,

I greatly appreciate the opportunity to comment on the ASPE's Request for Information regarding the Medicare beneficiaries with social risk factors. I am a health service research fellow at the Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery, Mayo Clinic (Rochester, MN). I completed my PhD training at the Department of Health Policy and Management, the University of North Carolina at Chapel Hill (Chapel Hill, NC) under the advice of Dr. Sally C. Stearns, who also chaired my dissertation, which was titled "Outcomes following hospital discharge: the roles of post-acute care pathway and patient socioeconomic status." This study was focused on the association of socioeconomic status (SES) on the 30-day hospital post-discharge outcomes through different post-acute care pathways including home/self-care, home health agency (HHA), skilled nursing facilities (SNF), and inpatient rehabilitation centers (IRF). The study used data on Fee-for-Service Medicare Current Beneficiary Survey participants with inpatient hospitalizations from 2006 to 2011. This study aimed to help address the disadvantage for safety-net hospitals and to contribute to efforts to ensure access for vulnerable patients with limited resources while promoting high-quality health care and reimbursement commensurate with costs. The study manuscripts are in process, while the details of this study are presented in my dissertation, and can be accessed through Carolina Digital Repository using the following link: https://cdr.lib.unc.edu/record/uuid:b8f75121-0b58-4b15-acf6-cd59244febfb.

Since Medicare short-term (30-day) hospital readmissions are a major financial burden for the Medicare system and post-acute care (PAC) location may also be affected by SES and subsequently affect post-discharge outcomes, this study focused on patients using the four different post-acute pathways after discharged from hospitals. The study findings and implications provided information to this RFI regarding the <u>additional factors that should be considered when tailoring services for Medicare beneficiaries</u>.

First of all, the study results found that dual-eligibility and area deprivation level play important roles in predicting PAC choices. Different PAC types may specialize in patients with different medical complexity. The results suggested that dual-eligible patients were more likely to use SNFs, while patients living in deprived areas were less likely to use SNFs. This finding implies that considering both individual and area dimensions of SES could be important in identifying the effects. This result indicated that policy research examining disparities in care use by SES levels needs to be addressed. To be more specific, studies should examine the extent to which the higher usage among patients with low individual SES is caused by poorer health outcomes and the extent to which the low use among patients with low area SES is due to access to care.

Second, the study results supported the role that dual-eligibility has the most powerful association with the post-discharge outcomes, which was reported in ASPE's first Report to Congress.

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Additional to that, my dissertation study also found that the effects of dual-eligibility differ by the safety-net status of the discharging hospital. When the dual-eligibility status is interacted with the hospital's safety-net status, Dual patients had slightly higher readmission rates in safety-net than in non-safety-net hospitals but hospice/death rates were lower. On the other hand, non-dual eligible patients had higher hospital readmissions compared in safety-net hospitals compared to non-safety-net hospitals. This finding implies that hospitals' performance might be limited by deprived individual-level resources, so that patients with low individual SES had the same poor outcomes regardless of hospital safety-net status. When the individual resources were more sufficient, patients from non-safety-net hospitals had better outcomes.

Third, the study found that PAC location had an effect on the post-discharge outcomes that varied by safety-net status, especially for SNFs and HHAs: For patients discharged to HHAs, those who received care from safety-net hospitals had a similar readmission rate but a lower hospice/death rate; for patients discharged to SNFs, those who received care from safety-net hospitals had higher readmission rates. Overall, patients from safety-net hospitals had a higher readmission rate, and SNFs were the only PAC location that contributed to the higher readmission rate for safety-net patients.

Fourth, the estimations of post-discharge outcomes using three data strategies: 1) using claims data only versus additional variables from surveys or other sources, 2) using dual-eligibility and area deprivation levels as the SES measure rather than also controlling for income and education, and 3) adjusting for hospital safety-net status. Models using claims data only (versus additional survey, hospital, or area measures) seemed to provide estimates greater in magnitude for both PAC use and post-discharge outcomes. Controlling for additional (strategies 2 and 3) increased the explanatory power of the models but did not substantively change the associations. Adding survey information into the models attenuated the estimated effects of SES measures, but the differences did not lead to difference in predicted post-acute outcomes. Therefore, the results suggested that using claims data is sufficient for post-discharge outcome evaluation rather than identifying a need to undertake the time and efforts in survey information collection.

In summary, this study suggested three major concerns in response to this RFI: 1) the effects of SES differ depending on PAC type and safety-net versus non-safety-net hospitals); 2) The outcomes of safety-net hospitals, which serve a high proportion of patients with social risks, may be affected by the type of PAC used; 3) Claims data seem to provide sufficient information for post-discharge outcome evaluation. I appreciate the opportunity to comment on this ASPE's RFI and look forward to the ASPE's Second Report to Congress.

Sincerely,

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MEDICA®

Submitted by Medica   **November 8, 2018**

Request for Information

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

Medica is a non-profit health plan that serves communities in Minnesota, Iowa, Kansas, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin — the heart of America. As a company, we empower communities by listening to their voices, learning about community needs, and devoting time and resources to help.

Our values include:

- Customer Focus
- Excellence
- Stewardship
- Integrity
- Diversity

Medica is fully committed to participating by responding to the request for information for the IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. We recognize the importance of social risk factors in achieving the desired healthcare outcomes for our members.

RFI responses

• Which social risk factors are most important to capture?

- *Access to treatment for substance abuse and mental health co-morbidities*
- *Inability to access or afford health care*
- *Food deserts*
- *Financial distress- level of income*
- *Inadequate or no housing*
- *Frequent appointment no shows*
- *Health literacy*
- *Legal issues*
- *Living alone/ little or inadequate social support*
- *Strength of social support*
- *Transportation barriers*
- *Unstable housing*
- *Access to social services*
- *Safe neighborhoods*

- Do you routinely and systematically collect data about social risk?
  - *Yes*
- Who collects this data*?*
  - *For our Medicare Advantage members data is collected as a part of an annual "Health Risk Assessment" which is voluntary and completed by our members. Currently we have a 10% participation rate. However for 2019 we have engaged a new vendor and methodology which may increase participation. SDoH data is also collected by an RN Case Manager as a part of the assessment process when a member of our Medicare Advantage health plan is enrolled in a case management program. SDoH data is collected as part of the ongoing management and coordination of the case.*
  - *With our DSNP and State Waiver Programs an assessment is done within 30 days of enrollment and the annual assessment process fully evaluates our members for gaps in SDOH. This is reviewed periodically as a part of the care coordination services and on an annual basis.*
- When is it collected?
  - *For Medicare Advantage members, data is collected on an annual basis as part of a voluntary health risk assessment as well as during the course of care when member is followed by a case manager or care coordinator. (see above)*
  - Is it collected only once or multiple times for a beneficiary?
    - *It depends on the needs of the member. Annually, through member responding to a "health risk assessment" or for members identified for case management or care coordination this information is collected on initial assessment and throughout the course of care.*
  - Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)?
    - *Yes, it is collected annually for all the DSNP and "State Waiver" programs and on a voluntary basis or during the course of case management for the Medicare Advantage members.*
  - What are the burdens of this data collection on plans, providers, and beneficiaries?
    - *Burdens of data collection outside the above routine data collection include cost of resources and burden of IT to store information. More emphasis needs to be placed on the standardization of questions. Members may feel that collecting social determinants of health is an intrusion into their personal life's and may not feel comfortable with sharing part of all information. Privacy issues also complicate the collection and "actioning" this. There are immediate concerns when gaps in SDoH are identified but there is no remedy or solution for the individual or population available in the area to actually close the gap.*

- Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized.
    - *Y*es*, as there is benefit from evidence based work flows, enhanced technology on the market and more connected network services especially in underserved or rural areas. Standardized data elements will benefit reporting trends and helping with identification of solutions. It also normalizes the questions helping to de-stigmatize the process of assessment and evaluation. These data elements could be standardized with industry agreement to one set of questions that are used across populations and settings.*

- What are barriers to collecting data about social risk?
  - *Members feeling comfortable with sharing information and questioning or mistrusting how the information may be used to discriminate or reduce healthcare benefits; cost and resources required to upgrade the IT system to collect and store information. Most importantly, ensuring that there are networks in the community and action plans to address the gaps in the SDoH that were identified.*
- How can these barriers be overcome?
  - *Standardizing and prioritizing the questions asked of the public and insuring that there is an adequate response or action that can be provided to remedy the deficits and close the gaps, adjustments to risk payments to account for the resources required to adequately address these gaps and provide solutions.*
- What do you see as promising future opportunities for improving data collection?
  - *More established technology in predicating and stratifying risk around social determinates of health resulting in more developed process flows and evidence based interventions. Increased risk adjustment payments to cover the cost of addressing the gaps and ensuring that adequate action is taken.*
- What opportunities do you see as promising for using existing data to tailor services?
  - *More standardized and consistent data on our members would be helpful in the development and plan designs that could directly address more effectively our member's needs. This standardized data would also help to prioritize internal programs and better stratify those members with greater risk in order to achieve improved health outcomes.*

Thank you for your interest and support with this very important topic.

Nancy K Williams, RN BSN MS PHN CCM
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MCS Advantage

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<u>Overview:</u>

MCS conducts health risk assessments through several avenues: MCS makes efforts to conduct a health assessment of all MCS Advantage members. There are efforts and strategies executed to comply with the regulation that SNP members all have a health risk assessment performed. Appropriate intervention and support take place and an accurate health risk profile is maintained and updated for each member.

The initial and annual CHRA is conducted face to face by the member's PCP or Physician, using the MCS CHRA (electronic or hard copy form) that documents the health assessment including clinical and non-clinical findings. The HRAT (CHRA) includes a medical, psychosocial, cognitive, functional and mental health assessment that guides the care management approach and assigns the IDCT. This process allows the PCP or Physician to obtain an updated health profile for their patient and immediately develop an individualized care plan.

The (CHRA) Comprehensive Health Risk Assessment tool includes the following sections to be used to identify members with potential problems:

1. Personal Information: This section shall include general information to determine the Member and Provider general information and relation.

2. Vital Signs and Body Mass Index: This section shall contain the member's vital signs, such as: blood pressure, weight, height, among others and Body Mass index (BMI), and classification such as: overweight, underweight, obesity, severe/morbid obesity and normal.

3. Care Management General Assessment: This section includes living condition and environmental assessment, health literacy assessment, benefit limitations assessment, linguistics limitations assessment and cultural beliefs limitation assessment.

4. Review of Systems: this section contains information related to a system-by-system, review of the member's body functions.

5. Physical Examination: This section contains an objective description of the patient's chief complaint, illness or injury. Also included is a Skin Breakdown Evaluation related to the Chronic Pressure Skin Ulcer and the Chronic Non – Pressure Skin Ulcer.

6. Special Needs: This section contains information related to the utilization of devices, such as: artificial limb, Insulin pump, wheelchair, among others.

7. Medical Diagnoses: This section retrieves the description of the existing medical diagnostics, neoplasm previously reported, additional medical diagnostics and new medical diagnostics and description of the current treatment for each present condition.

8. Surgical Procedure History: includes the most recent surgical procedures performed on the patient in the current and last year.

9. Recent Hospitalization History: section displays the most recent hospitalizations of the patient in the current and last year

10. Family Medical History: section collects chronic conditions present in the patient family history.

11. Behavioral Assessment: This section collects information regarding any toxic habits of the member, such as: smoking, drug dependence, and/or alcohol dependence. The 2017 version includes the following information: physical activity and nutrition.

12. Pain Assessment: this section contains information related to the member's perception of their pain and its severity, if applicable.

13. Functional Status: This section contains the member's ability to manage activities of daily living (ADL) such as bathing, dressing, eating, toileting, transferring and the availability of a primary support person if the member is unable to perform those ADLs. The 2017 version includes assessment of the IADLs.

14. Fall Risk Assessment: This section evaluates members for potential risk to fall.

15. **Psychosocial Status: This section includes an evaluation of the member's Psychosocial Status, such as: member's subjective perception of his/her overall health status and quality of life, and depression and sleep evaluation.**

16. Preventive Care Review: This section contains information related to preventive screening tests applicable according to specific medical conditions, age and gender such as: mammography, colorectal cancer screening, LDL Screening, HbA1c testing, Eye Retinal Exam bone density, among others.

17. Education: This section contains information related to education provided to the member, such as: Advanced Care Planning, smoking cessation, alcohol or drug usage, among others.

18. Referral to MCS Classicare's Care Management Programs: This section contains alternatives for referrals to Care Management Program initiatives.

19. Attachment A-Evaluation for Diabetics: This section contains information related to the medical exam for diabetic members.

20. Attachment B-Medication Review: This section contains information of the medication history of long term and chronic medications. The 2017 version includes the prescriber name and specialty.

21. Attachment C- Cognitive Assessment- This section evaluates cognitive impairment.

22. Attachment D- My Health Goals: This section contains information related to the individualized care plan that includes goals, recommendations, and the next appointment for re-evaluation.

23. Attachment E- Alcohol Screening Test: This section contains the Michigan Alcohol Screening Test for assessing alcohol abuse.

24. Attachment F-Depression Screening: This section contains the self-reported mood questionnaire, Major Depression Inventory (MDI) developed by the World Health Organization (WHO), used for assessing depression.

25. Additional attachments for Home Visit Program evaluations:
    a. Detailed Review of System and Physical Examination: This section contains detail questions that provide additional information to support care coordination.

    b. Home Safety Risk Evaluation: This is an assessment to conduct an environmental scan of the member's home to identify potential risks.

Once the information has been uploaded from the CHRA, the data is used to stratify a health risk level of each member according to the algorithm created for the stratification by risk levels: low/mild, medium/moderate, and high/severe.

Health Risk Level Stratification:

- **Information/data collected from the CHRA is scored via an automated process and used to stratify the member's health risk. Stratification is divided into high, moderate, and low risk categories across five (5) dimensions: medical, functional, cognitive psychosocial status, and mental health needs.**

- The goal of automated stratification is to optimally categorize and assign members to the appropriate interdisciplinary care team. The low and moderate levels are assigned to the standard IDCT. The high-risk population is referred to the Care Management Programs and belongs to the IDCT Complex.

- Stratification level assignment is a fluid process, allowing a member to move between stratification levels in order to meet differing levels of need across the care continuum.

- The initial stratification is run within 90 days of member enrollment.

Based on the results of the CHRA automated stratification, members are assigned to a tier and the tiers to an Interdisciplinary Care Team (IDCT) that is responsible for developing the individualized care plan for the care coordination process of each member.

- Health risk level low/mild are assigned to the IDCT Standard (IDCTS).

- Health risk level medium/moderate are assigned to the IDCT Standard (IDCTS).

- Health risk level high/severe are assigned to the IDCT Complex (IDCTC).

The CHRA tool provides for direct referral to Care Management Programs in addition to the stratification process. It also provides for the identification of members with behavioral or mental health problems for referral to Behavioral Health Care Management, to be triaged for services and/or counseling.

<u>USE AND DISSEMINATION OF HRA INFORMATION BY THE INTERDISCIPLINARY CARE TEAM:</u>

MCS has established two types of ICTs: Standard and Complex.

Standard: The ICT Standard is responsible for implementing the individualized standard care plans for members who meet the CHRA criteria for low/mild and medium/moderate health risk stratification levels. The ICTS develops a standard care plan with recommendations and interventions that address general health maintenance, advance directives, and mental health plus individualized goals and interventions for preventive screening tests according to age and gender, and for prevalent diseases such as: Diabetes, Cardiovascular, respiratory, CKD, ESRD, Arthritis, Osteoporosis, infectious disease, behavioral health, Episodic Mood Disorder, Hypothyroidism, Alzheimer, and others.

Complex: The IDCT Complex is responsible for developing and implementing the individualized care plans for those members who meet the criteria for high risk/severe health risk stratification level according to their CHRA. The individualized care plans for high risk/severe risk members are fully customized care plans that are developed by the Care Managers as part of the Care Management Programs initiatives based on the data collected in their CHRAs and the care management health assessments.

Each member has its own specific ICT leaded by its care manager and composed of all his/her physical and mental health providers. They communicate and interact as needed to accomplish the member's goals via phone calls, conference calls and in occasion's face to face contact with the member. Due to the complexities of dual eligible beneficiaries' clinical and social issues may require the intervention of the MCS ICT Complex permanent core members that include different clinical and **psychosocial disciplines** represented by MCS and FHC staff plus the member and its PCP.

The MCS ICT Complex permanent core members meet on a regular basis for group discussions of the most challenging cases that have been referred by Care Managers, mental health coordinators/behavioral health counselors, PCPs, or by other members of the ICT. These cases benefit from the expertise and capabilities of the ICT Complex interactive discussion to look for alternatives to overcome barriers to meet the beneficiaries' identified needs. Case discussions

include a review of the member's current issues and the specific situation that may be causing these issues, as well as his or her:

- Medical Diagnoses
- Functional status for Activities Of Daily Living
- Disability
- Utilization Patterns
- Medical Treatments
- Measures Of Rehabilitation
- PCP's Plan Of Care
- Any physical, social, economic or emotional barrier to care
- Recent Significant care transition

The members of the ICT Complex develop a series of individualized recommendations for each case discussed to be coordinated by the Care Manager, while also ensuring that the member is in agreement, and that the revised care plan incorporates member preferences. Recommendations may include, but are not limited to:

- Referral to mental health provider
- Coordination for home visits by a physician
- Referral for social worker evaluation
- Coordination of services at home, or home care as needed
- Coordination of communication between PCP, specialist, mental health providers and social workers
- Canalization of caregiver needs through respite services
- Referrals to other MCS units for re-evaluation of operational processes that could be a barrier to clinical outcomes
- Referrals to other MCS units for re-orientation to providers regarding CPG, Model of Care, and quality issues
- Prioritization of identified problems

Care Management Program:

MCS Care Management Program provides a member-centric model that is designed to identify and incorporate the member's unique needs and goals into a comprehensive and cost effective, individualized plan to improve health status and quality of life. The program provides care coordination to all members and ongoing care management for the high risk population that includes decision support, member advocacy, identification and recommendation of alternative plans of care, identification and use of alternative funding and community resources. The Care Management Program incorporates key requirements from the Quality Improvement Program Requirements for Special Needs Plans (Model of Care), Medicare Improvement for Patients and Providers Act 2008 (MIPPA) and CMS guidance documents.

The program focus is a collaborative process for the medical management of beneficiaries including: The Health Risk Assessment to identify member's needs: medical, functional, cognitive, mental and psychosocial status. Development of an Individualized Care Plan with integration of physical and psychosocial needs. Communication with primary care physician and interdisciplinary care team, also conducting coordination of services, care transitions, preauthorization's and Self-care education to members. Evaluation of holistic care effectiveness.

The Care Management Program encompasses all MCS SNP enrollees who are eligible these for Medicare and Medicaid benefits and services.

All members benefit from the care management approach upon enrollment in a MCS. If there is a need for a more intense individualized care management they will be impacted by the Care Management Programs either as target members from an identified population, or as potential members from a referral source.

MCS uses the following data sources to analyze the health status and risks of members:

- Care Management Health Risk Assessment (HRA)

    o Through the HRA in a daily basics the care manager identify potential members for complex care management or health status change that may qualify to another program. The care manager collects data of each member's medical, functional, cognitive, mental and psychosocial status and risks.
    o In order to understand the needs of the SNP most vulnerable beneficiaries that participated in CM program, on an annual basis the MCS Medical Operations Efficiency and Care Management Unit, analyzes and conducts a population profile based on HRA data sources and be reported as part of MOC- SNP Population Description.

- Claims or Encounter data

    o A claims /encounter data report is generated at least monthly to identify members who may qualify for the CM Program based upon their utilization history. This includes both the frequency of encounter types and also diagnosis so that those members who are frail and /or have high risk conditions such as Diabetes with co-morbidities, Cardiovascular diseases, Heart Failure and slow progression CKD III and IV and ESRD are identified.
    o The Director of Care Management/designee reviews the report to identify target members who may benefit from the care management programs interventions.

- Hospital Discharge Data

    o The hospital admissions report is generated at least monthly to identify members who may qualify for the CM Program due to their Emergency Department utilization, admission and re-admission history.

- o The Director of Care Management/designee reviews the report to identify target members who may benefit from the Care Management Programs interventions.

- Pharmacy Data

  - o Pharmacy data is generated at least monthly to identify members who may qualify for the CM Program based upon their medication history which includes but is not limited to drug interactions, duplications of drugs, evaluation of medications habits, and polypharmacy.
  - o Pharmacy data is reviewed at least monthly by the VP of Pharmacy Pharm D and the UM Director to identify target members who may benefit from the care management programs interventions.

- Data collected through the Utilization Management (UM) process

  - o A Pre-Service Authorization Review, Hospital Admission, and Concurrent Review data is generated on going basics to identify members who may qualify for the CM Program based upon their utilization history.

- Data supplied by member or caregiver

  - o Self-reported data during Customer Service calls is documented by the MCS staff and referred on an ongoing basis to identify members who may qualify for the CM Program.
  - o The member will be referred if a social need is identified and /or any of the following diagnostics, diabetes with co-morbidities, CHF, Cancer, and Organ Transplant, Renal disease or ESRD is identified.
  - o The Care Management programs managers reviews the referrals to identify target members who may benefit from the care management programs interventions.

- Data supplied by practitioners

  - o Data supplied by practitioners is generated monthly to identify members with severe/high risk stratification level based on Comprehensive Health Risk Assessments (CHRA) submitted to the Plan. Members with Chronic Alcoholism are identified as a potential case for Behavioral Care Management Programs.
  - o Once member health risk level stratification information is received, the care manager begins the care management program interventions. In the initial telephonic contact the care manager validates through the care management health risk assessments the stratification level.

MCS Care Management receives referrals from a variety of sources and regularly analyzes its available data systems to identify the potential member with physical, mental and social necessities to participate in the program. Population identification SNP and Non SNP members occurs on a monthly basis and a list is referred to MCS's Care Management Programs for complex care management follow-up. Those members who subsequently meet the criteria for complex care management are identified as most vulnerable members.

Members who experience a critical event or diagnosis shall receive timely care management services. Multiple referral avenues shall be utilized to minimize the time between when a member's need is identified and when the member receives services. The Care Management approach help members navigate the care system and obtain necessary services in an optimal setting in a timely manner.

Member self-referrals and practitioner referrals allow MCS to consider members for enrollment to care management programs. In its literature to PCPs and specialists and through member outreach, MCS provides a means for member self-referral or practitioner referral by communicating the availability of programs with contact information (e.g., telephone numbers) to members and practitioners.

The Care Management concept refers to a set of evidence-based, integrated clinical care activities that are tailored to the individual patient and that ensure each patient has his or her own coordinated plan of care and services.

The MCS Care Management includes the following activities:

- Care Management Health Risk Assessment is a continuous process to identify member's needs: medical, functional, cognitive, mental and psychosocial status.

  o Through Comprehensive Health Risk Assessments (CHRA)
  o Through Care Management Programs health assessments
  o During Care transitions

- Encourage the Members during the Initial and Follow up Phone calls

  o To participate in the programs
  o To take an active role in their own treatment to ensure their outcomes be optimal
  o To sharing information, feelings and signs and accepting health team recommendations

- Data Analysis

  o From CHRA for health risk level identification
  o From utilization data, self-reported data and data supplied by practitioner to identify the most vulnerable members for Care Management Programs
  o From hospital review data for specific Education and Wellness interventions

- Referrals

  - To appropriate ICT according to health risk level stratification from CHRA data
  - To appropriate Care Management Program including behavioral from data analysis and other clinical programs referrals

- Development of a care plan with integration of physical and psychosocial needs.
  - Standard individualized for all members stratified low or moderate.
  - Individualized for members enrolled in care management programs with complex needs
  - Care plans for transitions

- Continuous Care Management as needed

  - Follow up and documentation the quality of care, services and products delivered to the member to determine if the goals of the care plan are being achieved, or if there is any barrier and if those goals remain appropriate and realistic. This part may also be called the monitoring, reassessing, and re-evaluation phase of care management.

- Communication with Primary Care Physician and Interdisciplinary Care Team

  - Care Managers support members retain providers continuity of care by ensuring communication between physicians, specialist and other members of the care team.

- Conducting coordination of services, care transitions, pre-authorizations

  - Identifies immediate, short term, and ongoing needs, as well as where and how these care needs can be met. The plan sets goals and time frames for achieving the goals that are appropriate to the individual, and are agreed to by the member's treatment team. The Care Manager is also responsible to ensure accurate clinical information and disease or procedure-specific during the planning, and to complete all the pre-service authorizations/transition of care for members, in compliance with the organization determination process expedite and standard request. During the pre-authorization process, coordination and care management, pertinent medical information available in the electronic record is transfer to providers involve in the treatment of the member.

- Education

  - Perform educational interventions taking into consideration member's health literacy to achieve a better understanding of the condition, promote engagement, self-empowerment and informed decision making regarding their

health care. Educational interventions includes the mailing of educational material to the member related to the condition, nutrition, risk factors, treatment adherence, safety measures, living planning activities and mental health among others.

- Measuring health outcomes

  o Effectiveness of the program specific clinical measure is evaluated against established performance goals as part of the Model of Care yearly evaluation.

The Complex Care Management Programs focuses its efforts on members with chronic, catastrophic, degenerative, and disabling conditions through the complex care management initiatives. It also works planned care transitions from home to a higher level of care. This program coordinates and provides clinical care and services related to medical conditions by monitoring the medical treatment plan provided by the primary care physician or specialist. This program directs efforts to improve health care quality for their members by implementing an individualized care plan and ensuring that medically necessary care is delivered at the appropriate level of care. Through the Palliative/Terminal Care Management, the Complex Care Management Program supports the most vulnerable, frail, disabled, incurable patients with progressive and in some instances life-limiting illnesses.

The Complex Care Management Program includes initiatives such as but not limited to:

a. Chronic Kidney Disease- for Members with CKD Stage III and IV. Goal: Avoid progression of disease and cardiovascular complications, avoid ER visits, avoid admissions and readmissions, ensure timely access placement for dialysis (AVF for hemodialysis) and ease transplant evaluation.

b. Diabetes- is supported by a multidisciplinary team that is responsible for providing targeted interventions for members who have been diagnosed with diabetes with co-morbidities. The target population is members with uncontrolled diabetes at high risk/high utilization because they have one or more diabetes related conditions. Members with diabetes with a home service request are also impacted to avoid further complications. Goal: Reduce risk or avoid progression of diabetes related conditions (nephropathy, retinopathy, neuropathy, cardiovascular disease), effective diabetes self-management and avoid skin ulcers and amputations. Performance/Goal outcome: Meets the National Means on: members with HbA1c in poor control (>9.0%), members with LDL levels >100 mg/dl and members with blood pressure >140/90 mm Hg. Coordinated preventive services (HbA1 and LDL Screening, Eye Exam, Nephropathy Monitoring).

c. ESRD – for members with CKD stage V with or without dialysis. Goal: Adequacy of hemodialysis and peritoneal dialysis, anemia management, and vascular access management (AVF)

d. End of Life/Palliative Care- for members with a terminal illness and a life expectancy of 18 months or less. Goal: Transition to hospice care, avoid ER visits, hospitalizations and readmissions before transition to hospice or if member refuses hospice.

e. Frail/Fragile- for members with unstable high risk chronic conditions; at risk for fragmented care; with behavioral or social issues that put them at risk of worsening their condition. Goal: Stabilization of conditions, maximize member's functionality, avoid ER visits and admissions/ readmissions, and facilitate communication between providers.

f. Oncology- for members with cancer diagnosis in active treatment. Goal: support medical treatment at the best level of care available.

g. Pre Transplant-for members on evaluation process and/or waiting list for organ and/or bone marrow transplant. Goal: ease organ and/or bone marrow transplant process.

h. Post-Transplant -for members who have undergone organ and/or bone marrow transplant. Only within first 6 months post-transplant. Goal: avoid post-transplant complications and preservation of transplanted organ.

The Care Management Program has 2 initiatives related to care settings transitions:

i. Transition of Care - is an acute care management for members with service request for home care, SNF, CORF, Rehabilitation Centers without criteria for complex care at the time of request. Goal: complete preauthorization process of expedited and standard service requests according to timeframes; ensure successful transition of care for members.

ii. Coordination Out of Area - is an acute care management for members with request for services and/or transition of care out of Puerto Rico. Goal: complete preauthorization process of expedited and/or standard service requests according to timeframes, ensure successful transition of care for members.

As part of the Care Management Program, the Community Outreach Program is responsible to address the non-clinical needs for the high-risk SNP members that may impact their health status. Also, The Community Outreach Program is in charge of the coordination with community organizations for assistance and access to the available community resources for members/caregivers. This program facilitates access to community services for the most vulnerable beneficiaries and/or their caregiver(s).

The Community Outreach Technicians (COT) receive both internal and interdepartmental referrals. COT aims to contact a member at different times, and will vary based on referral source, but occurs within the first 30 days.
Once the member is contacted and agrees to the home visit or phone call, the COT conducts a need assessment evaluation focused on identifying non-clinical needs. If there are clinical aspects

self-reported by the member, the COT refers to the complex care management program for evaluation and intervention. The COT identifies needed services and the community agencies that will be involved, in order to coordinate the services process. Provide orientation and/or service coordination with community organizations, public /private agencies to address non clinical needs that impact health care.

The COT provides information and/or coordinates services such as but not limited to:

1. Community Transportation alternatives – Members that cannot be transported by themselves, and who do not have family or social support for transportation to meet medical needs and/or basic needs to sustain life.

2. DME not covered by Medicare or Medicaid - Members in need of durable medical equipment not covered by the plan and/or a deductible barrier, and do not have the financial means to obtain them.

3. Home nutrition services - Bedridden members with no social or family support to assist them in the preparation of food. Members who cannot prepare food for themselves and who live alone and have no family or social support to assist them in the preparation of food.

4. Housekeeping Services - Members who live alone and cannot perform most activities of daily living and no have social or family support to assist them.

5. Caregiver Respite Services - Member is a full-time caregiver or the member has a full-time caregiver in need of "respite" for their own medical appointments.

6. Recreational alternatives – Members age 60 or older, independent in their daily activities, and expressing interest in community recreation or alternatives. COT provides information on health plan exercise and nutritional activities through the "Club de Amigos Classicos" strategies.

7. Transportation Department DTOP handicap tag - Members with physical or ambulatory limitations, with multiple recurring appointments who could benefit from preferential parking either as drivers or as passengers. COT provides information and application forms for removable DTOP or government agency identifying tags.

COT also receives referrals for a home visit to obtain more information on member necessities identified by the Care Manager.   They coordinate services to meet the goals of the individual care plan.

The COT provides information to the Care Manager, who establishes the interventions. The COT does the following:

1. Observation with a purpose: This occurs when the Care Manager needs more information to better identify the barrier that is affecting the appropriate management of the member's condition.

a. Social Barriers: identify if the member lives alone in rural areas, lives in a community with high crime, socioeconomic mediators (education and/or income), lack of access to health services, or illiteracy that can be an obstacle for care.

b. Support Barriers: identify support system and the interaction amongst the individuals, attitudinal barriers of member and caregivers.

c. Physical Barriers: identify cognitive status and visual, speech, hearing, mobility and language limitations and health literacy.

d. Architectural barriers: identify member home structure features that limits the access and mobility both indoor and outdoor, the condition of streets and sidewalks, and home safety.

e. Environment Barriers: identify home maintenance problems, pest control, pet care, poor lighting, noise level, availability of goods and services, availability of public transportation.

2. Validation of Non-emergency Ambulance services criteria: additional information to ensure the proper use of ambulance services and that the member meets the criteria required.

3. Medication Inventory: This occurs when the Care Manager needs to obtain information to perform medication reconciliation, when the member presents linguistic, culture or visual limitations that prevent him from proper medication use.

The Community Outreach Unit develops and keeps updated an inventory of available Community Resources. This is a useful tool to identify needed resources in the member's geographic area. The resources could be private, nonprofit organizations, or sponsored by the government, and might have eligibility criteria which members may have to fulfill in order to qualify for the service.

CARE MANAGEMENT INTERVENTIONS

The health risk assessments (HRA) is a continuous process in which the Care Manager obtains objective data about the physical and psychosocial needs of the member. It identifies service needs and barriers for service access.

Through the HRA the care manager identify if member meets criteria and agree to participate in the care management program. The care manager develop the member's individualized care plan with problems, goals and interventions. The care plan takes into consideration the program or initiative goals, the member needs identified by the health risk assessments and the member preferences.

The care manager documents interventions related to the care plan monitoring and follow up including health assessments questionnaires, depression screening questionnaire, phone calls, service coordination's, preauthorization's determinations, letters, referrals to other programs or resources such as Mental health care coordinators, ICT Complex Committee meetings and Community Outreach. Other services offered to the members by the care managers are referrals to Customer Service Department for benefit orientation and to Grievances and Appeals Department for canalization of complains.

The Care Management Programs initiatives, goals and interventions are developed using Clinical Practices Guidelines adopted by MCS, respond to the most prevalent diagnoses, characteristics and needs in the SNP and Non SNP population as evidenced by the MCS population analysis.

- The Care Management assessment includes but is not limited to the following:

  - Initial assessment of their health status, including pain management, skin condition, and condition-specific issues
  - Documentation of their clinical history, including review of systems, physical examination, special needs and medications
  - Initial assessment of **functional status in activities of daily living and risk factors**
  - **Initial assessment of their psychosocial and mental health status including cognitive**
  - **Initial assessment of their ethnicity, health literacy, and environmental limitations**
  - **Initial assessment of preventive care status, educational needs and fall risk evaluation**
  - **Evaluation of their cultural and linguistic needs, preferences or limitations**
  - **Evaluation of their caregiver resources**
  - **Evaluation of their available benefits and services and coordination needs**
  - Evaluation of their satisfaction

All services are provided taking in consideration the member cultural, linguistic needs, preferences or limitations.

For members enrolled in care management programs, the Care Manager also provide the member and/or caregivers with educational information regarding how to maintain health and remain in the least restrictive setting, to reduce their risk of hospitalizations and unplanned transitions. The beneficiary and/or caregiver(s) are educated about indicators that show that his/her condition has improved, is stable, or worsened in each follow up intervention, not only during care transitions, but during the care management process.

The care plan goals and interventions related to education are documented as "completed" once the phone call ends. The Care Manager performed educational interventions taking into consideration member's health literacy to achieve a better understanding of the condition, promote engagement, self-empowerment and informed decision making regarding their health care. Educational interventions also includes the mailing of educational material to the member related to the condition, nutrition, risk factors, treatment adherence, safety measures, living planning activities and mental health among others.

The Care Management Program Satisfaction Survey focuses on members that have voluntarily participated in Care Management Programs as a result of being referred by one of the referral sources as a potential case for care management and/or being identified as high-risk. The Care

Management Program Satisfaction Survey is performed on a daily basis to assure member feedback about the overall program, program staff, usefulness of the information disseminated by the organization and member's ability to adhere to recommendations to identify areas of opportunities for improvement.

The Care Management Program and Individual Care Managers Specialists, are monitored on an ongoing basis for effectiveness and compliance with the care management overall process and the regulatory requirements to identify areas of opportunity for improvement. The Care Management Program overall effectiveness is evaluated to determine if it meets the needs of members and providers. Quality of service, processes, program and individual health outcomes, participant satisfaction and individual care management staff performance are some of the key elements assessed to determine the effectiveness of the program.

Care Management Data Operation 2017

The referrals from different sources were weekly monitored and evaluated assuring better identification on population meets the criteria for the different programs. An average overall of 9,800 members per month during 2017 being managed in Care Management Programs. An average of 8956.17 Advantage members managed per month.

A total of 21,474 cases managed by the care manager at the end of 2017. The most prevalent cases type were as follow: Complex Cases: Frail, Chronic Renal Condition, ESRD, Oncology, End of Life and Pre and Post-Transplant members with 34.9%, the second programs managed was CCIP for Diabetes members accounts for 24.9% of the cases, followed by 28.5% of Acute Care Coordination and Transition of Care, 9.5% were eligible for the Readmission Prevention Program and 2.1% received a Community Outreach evaluation.

The 57% (14,643) were meet the complex care managed goals and/or the transition of care was complete successfully, representing that Care Management Program managed have been effective. The members that could not be managed in the Care Management Programs were 1,688 (6.6%) that refused to participated, 736 (2.8%) that died after be referred, 1,159 (4.5%) had expired coverage after be referred, 2,081 (8.1%) was identified no criteria for participate, 4,889 (19%) were not localized despite all effort to contact and 271 (1%) for other reasons.

A total of 2,648 referred member was assisted and/or coordinated available community services representing the 12.3% member's active in Care Management Program, The 97.2% non-clinical goals was completed.

Most Vulnerable Population

A total of 14,007 D-SNP members were identified as most vulnerable members and managed for the year 2017. Representing the 14.6% of Total Special Need Program (SNP) membership (95,958).

Analysis of data obtained through Care Management HRA tools help us to understand the demographic distribution of the SNP subpopulations of most vulnerable members. The high risk member enrolled in the care management program during the 2017, 58% were female, 42% male and the average age was of 74 years.

The most frequent self-reported conditions was: Hypertension (67.7%), followed by Diabetes Mellitus (46.9%), and Cardiovascular Disease (37.2%). The prevalence of other chronic conditions members self-reported was of 16.1% Heart Failure, 20.1% renal disease, 3.1% Infectious diseases, 14.2% Cancer, 8.3% Alzheimer, 25.4% Hypothyroidism, 24.2% Respiratory conditions, 6.5% COPD and 8.2% Rheumatoid Arthritis. An estimate of 48.8% members have at least two or more chronic conditions. The 96.8% of members with chronic condition answered attend to follow up visits as recommended.

Among Special Need beneficiaries managed in the Care Management Programs in 2017, the most prevalent program were as follow: Complex cases for 40.1% of the cases, the second programs managed was CCIP with 35.3% of the cases, followed by 15.9% of Acute Management – Coordination and Transition of Care, 6.2% were eligible for the Readmission Prevention Program and 2.5% received a Community Outreach evaluation.

CONTRACT H5577-017

During 2017 a total of **6,264** members for contract **H5577-017** were identified as a high risk members, referred to the MCS Care Management Program as well and initial Health Risk Assessment was performed.

In overall member's ethnicity: 97.4% answered that were Puerto Rican Hispanics, the 2.58% Hispanics from other country and 0.30% were no Hispanics. For the question of demographics characteristics, they answers that 44.30% live in urban area, 55.28% live in rural area and 0.29% live in distances communities. The aim is to identify care access barriers and provide the highest quality of health care within local remote and rural communities, minimizing the need for patients to routinely access clinical services out with their locality.

In general, the average weight is between 120-199 pounds and the average of height is 62.7 inches (5'2") among these members. For BMI measure, 26.3% were in the normal range, while 33.8% resulted being overweight, 29.3% being obese and 7.0% being morbid obesity; increasing a risk for comorbidity for chronic condition. The most frequent self-reported condition was: Hypertension (68.5%), followed by Diabetes (47.56%) and Cardiovascular Disease (37.1%). The prevalence of chronic conditions members self-reported was of 37.1% having cardiovascular conditions, 47.5% Diabetes, 15.6% Heart Failure, 68.5% Hypertension, 19.7% renal disease, 3.1% Infectious diseases, 13.9% Cancer, 7.0% Alzheimer, 30.3% Hypothyroidism, 25.1% Respiratory conditions and 6.8% Rheumatoid Arthritis. An estimate of 48.8% members have at least two or more chronic conditions. The 97.3% of members with chronic condition answered attend to follow up visits as recommended.

Regarding medication use, the 98.6% of members answered they used their medication as recommended. The 11.4% (712) used un-prescribed medication and the 74% (524 /712) of users reports that their physician knows about it.

For the questions regarding members ER and Hospital utilization: Three month before the assessment was completed, the 37.7% (1,983/5,262) of the overall members have visited the ER, in the amount of 66.2% (1,314) one time, 22% (437) two times and 8.4% (168) three times. Three month before the assessment was completed, the 33.8% (1,776/ 5,262) of the overall members were admitted in the amount of 66.5% (1,181) one time, 25.2% (453) two times and 6.7% (118) three times.

The 6.3% of members considered their health status as excellent, 19.9% as very good, 31.6% as good, 35.3% as average, and 6.5% as poor. Understanding illness perceptions and incorporating them into the care plan is critical to effective treatment. Gives care managers the opportunity to identify and correct any inaccurate beliefs patients may have.

The 18.0% members self-report that have a living wills or health care advance directives. All member received education regarding an Advance Directive at the time a member is admitted to the Complex Care Management Program.

The 41.3% members self-report have done screening mammography and 75.0% have done a colorectal cancer screening test in the last year. Consideration of the evidence leads us to conclude that the use of clinical preventive services is suboptimal. Interventions designed to enhance the appropriate use of clinical preventive services should focus on educating physicians how to prescribe these services, and target beneficiaries for whom present gaps in care, utilization and health status are low, and risks of disease are high.

Through the assessment the care manager identified characteristic, condition, or behavior that increases the likelihood of getting a disease or injury. The 21.7% was identified as sedentary, 23.2% (1,221/5262) have high cholesterol and the 90.3% (1,103/1,221) use statins medication to lowers the level of cholesterol in the blood. The 2.7% (143) of the overall member are smoker and 25.8% (37/143) of smoker members participated in a Smoking Cessation Program. The 0.6% of the overall member Ingested alcoholic beverages and 0.1% use illicit drugs. The care manager's impact this members with Effective health education, integrating health literacy and patient activation into the development of interventions to improve health care.

In overall, the 19.1% members self-report that live alone and 80.4% live with a family member, legal tutor or authorized representative. The member that don't live alone, the 94.6% live with family member, 0.45% with legal tutor, and 3% with authorized representative. The 15.4% of members reported having limitations in performing daily living activities. Most limitations related to instrumental activities such as cleaning, cooking, laundry, shopping and going to medical appointments.
Regarding caregivers, at least 94.07% of the members reported having a primary caregiver, and 90.8% reported their caregiver is available to help, representing 3.2% in both reports more than 2016. The role of caregiver is recognized as instrumental in the care management process, and

as reported they were more available to participate in the care during 2017. In overall 99.2% responded that they have no benefit limitations.

In overall, the 9.7% members are bedridden. The 17.4% (914) have a skin lesion and 74.8% (684/914) have recommended treatment for the lesion.

In overall for questions regarding cultural and linguistic barriers: the 0.7% present language barriers, MCS had a processes and standard policies to ease the access of interpreters or document in other languages for member and caregivers. The 1.7% answered that are illiterate and the highest levels of education achieved was high school with 37.2% overall. The 2.9% never go to school, 24.7% elemental school, 17.1% middle school, 15.9% college credits and 2.0% university degree. The 0.7% have speech difficulties. Visual and Hearing barriers were identified in members with 2.1% and 1.2% respectively.

The results suggest the uniformity of the population served in terms of cultural needs and preference, when less than 0.1% members reported having cultural needs, preferences or limitations and 2.8% reported spiritual beliefs needs. The 1.2% reported additional barrier related to cognitive function limitation being lack of understanding; less than 1% had some kind of limitation in transportation. The member that cannot be transported by themselves, and who do not have family or social support for transportation, care management coordinated with community transportation alternatives or if member have benefits for transportation coordinated with a provider. MCS care managers and community outreach technicians are well trained to overcome barriers related to those needs to achieve the best possible clinical outcomes.

In overall, for questions regarding mental health status and cognitive functions: the 25.3% (1,582) members have a history of emotional condition and 88.9% (1,407/1,582) of member that have history of emotional condition were currently in treatment. For 1.5% members answered that in the past two weeks felt sad most of the time and the PHQ-9 was performed by care manager. All members with a result of 10 points or more in the PHQ-9 was referred to Behavioral Health Services.

The Care Manager identified through the initial assessment and/or in the follow up management process of a complex cases a coordination of services members needed. As part of the care plan the care manager connected the member to the appropriate providers and complete transition of care process according to outcome measures to ensure a successful transition and continuity of care for members. The 12.1% (637/5,262) of the overall members had a necessity that required a coordination of health services. For the a total 637 members identify by HRA a transition of care or services was coordinated: 16.1% members an antibiotic infusion therapy, for the 42.2% a home care, for the 11.3% a DME, for the 1.2% a physician home visit and for the 6.5% a PCP home visit. The transitions of care and coordination involves, but is not limited to, supporting and educating the member and responsible parties, and helping them transition to or remain within—the least restrictive care setting.

Regarding the educations provided during the phone call and care plan satisfaction: the 99.1% members understand the education information provided during the assessment phone call. The 98.9% member agreed and were satisfied with the individual care plan stablished. The Care

Management overall process and structure including the Community Outreach Program provides for an effective care management plan for each member needs.

CONTRACT H5577-002

During 2017 a total of **1,321** members for contract **H5577-002** were identified as a high risk members, referred to the MCS Care Management Program as well and initial Health Risk Assessment was performed.

In overall member's ethnicity: 97.52% answered that were Puerto Rican Hispanics, the 1.93% Hispanics from other country and 0.09% were no Hispanics. For the question of demographics characteristics, they answers that live 44.49% in urban area, 55.33% rural area and 0.09% in distances communities. The aim is to identify care access barriers and provide the highest quality of health care within local remote and rural communities, minimizing the need for patients to routinely access clinical services out with their locality.

In general, the average weight is between 120-199 pounds and the average of height is 63.2 inches (5'3") among these members. For BMI measure, 36.3% were in the normal range, while 32.5% resulted being overweight, 20.6% being obese and 4.7% being morbid obesity; increasing a risk for comorbidity for chronic condition. The most frequent self-reported condition was: Hypertension (64.5%), followed by Diabetes (44.4%) and Cardiovascular Disease (37.7%). The prevalence of chronic conditions members self-reported was of 37.7% having cardiovascular conditions, 44.4% Diabetes, 18.4% Heart Failure, 64.5% Hypertension, 22.3% renal disease, 3.0% Infectious diseases, 16.3% Cancer, 15.2% Alzheimer, 30.6% Hypothyroidism, 20.4% Respiratory conditions and 4.8% Rheumatoid Arthritis. An estimate of 49.6% members have at least two or more chronic conditions. The 94.9% of members with chronic condition answered attend to follow up visits as recommended.

Regarding medication use, 97.9% of members answered they used their medication as recommended. The 8.5% (112) used un-prescribed medication and the 69.6% (78/112) of users reports that their physician knows about it.

For the questions regarding members ER and Hospital utilization: Three month before the assessment was completed 38.8% (422/1,088) members have visited the ER, in the amount of 64.2% (271) one time, 21.8% (92) two times and 11.1% (47) three times. Three month before the assessment was completed 38.3% (417/1,088) members were admitted, in the amount of 67.3 % (281) one time, 22% (92) two times and 9.1% (38) three times.

The 5.5% of members considered their health status as excellent, 19.5% as very good, 31.7% as good, 34.8% as average, and 7.9% as poor. Understanding illness perceptions and incorporating them into the care plan is critical to effective treatment. Gives care managers the opportunity to identify and correct any inaccurate beliefs patients may have.
The 18.2% members self-report that have a living wills or health care advance directives. All member received education regarding an Advance Directive at the time a member is admitted to the Complex Care Management Program.

The 68.2% members self-report have done screening mammography and 30.8% have done a colorectal cancer screening test in the last year. Consideration of the evidence leads us to conclude that the use of clinical preventive services is suboptimal. Interventions designed to enhance the appropriate use of clinical preventive services should focus on educating physicians how to prescribe these services, and target beneficiaries for whom present gaps in care, utilization and health status are low, and risks of disease are high.

Through the assessment the care manager identified characteristic, condition, or behavior that increases the likelihood of getting a disease or injury. The 28.5% was identified as sedentary, 18.9% (206/1088) have high cholesterol and the 90% (185/206) use statins medication to lowers the level of cholesterol in the blood, The 2.2% (24) of the overall member are smoker and 8.3% (2/24) of smoker members participated in a Smoking Cessation Program. The 0.7% of the overall member Ingested alcoholic beverages and none use illicit drugs. The care manager's impact this members with Effective health education, integrating health literacy and patient activation into the development of interventions to improve health care.

In overall, the 14.4% members self-report that live alone, 77.1% live with family member, legal tutor or authorized representative. The member that don't live alone, the 90.7% live with family member, 1.2% with legal tutor, and 7.1% with authorized representative. The 29.1% of members reported having limitations in performing daily living activities. Most limitations related to instrumental activities such as cleaning, cooking, laundry, shopping and going to medical appointments.

Regarding caregivers, at least 95.9% of the members reported having a primary caregiver, and 93.2% reported their caregiver is available to help, 3.2% more in both reports more than 2016. The role of caregiver is recognized as instrumental in the care management process, and as reported they were more available to participate in the care during 2017. In overall 99.0% responded that they have no benefit limitations.

In overall, the 24.5% members that are bedridden. The 28.5% (310) have a skin lesion and 79.3% (246) have recommended treatment for the lesion.

In overall for questions regarding cultural and linguistic barriers: the 0.9% present language barriers, MCS had a processes and standard policies to ease the access of interpreters or document in other languages for member and caregivers. The 1.7% answered that are illiterate and the highest levels of education achieved was elemental school with 34.4% overall. The 4.0% never go to school, 20.7% middle school, 28.9% high school, 10.0% college credits and 1.9% university degree. The 0.7% have speech difficulties. Visual and Hearing barriers were identified in these members with 3.0% and 1.8% respectively.

The results suggest the uniformity of the population served in terms of cultural needs and preference, when less than 0.1% members reported having cultural needs, preferences or limitations and 1.9% reported spiritual beliefs needs. The 2.0% reported additional barrier related to cognitive function limitation being lack of understanding; less than 0.8% had some kind of limitation in transportation. The member that cannot be transported by themselves, and who do

not have family or social support for transportation, care management coordinated with community transportation alternatives or if member have benefits for transportation coordinated with a provider. MCS care managers and community outreach technicians are well trained to overcome barriers related to those needs to achieve the best possible clinical outcomes.

In overall, for questions regarding mental health status and cognitive functions: the 19.5% (258) answered that had a history of emotional condition and the 88% (229/258) of member that have history of emotional condition were currently in treatment. For 1.4% members answered that in the past two weeks felt sad most of the time, the PHQ-9 was performed by care manager. All members with a result of 10 points or more in the PHQ-9 was referred to Behavioral Health Services.

The Care Manager identifies a need for a transition or coordination through HRA and/or in the follow up management process of a complex case. Connecting the member to the appropriate providers and complete transition of care process according to outcome measures to ensure a successful transition and continuity of care for members. The 15.3% member had a necessity that required a coordination of health services. For the 1.9% members an antibiotic infusion therapy was coordinated, for the 8.51% a home care, for the 0.9% a DME, for the 0.3% a physician home visit and for the 1.9% a PCP home visit. The transitions of care and coordination involves, but is not limited to, supporting and educating the member and responsible parties, and helping them transition to or remain within—the least restrictive care setting.

Regarding the educations provided during the phone call and care plan satisfaction: the 99.2% members understand the education information provided during the assessment phone call. The 98.7% member agreed and were satisfied with the individual care plan stablished. The Care Management overall process and structure including the Community Outreach Program provides for an effective care management plan for each member needs.

CONTRACT H5577-019

During 2017 a total of **11** members for contract **H5577-019** were identified as a high risk members, referred to the MCS Care Management Program as well and initial Health Risk Assessment was performed. Do to HRA revision on March 1st 2018, the total of members in the data of new questions were difference in compare to the question transitioned of last assessment of 2016.

In overall member's ethnicity: 100% answered that were Puerto Rican Hispanics. For the question of demographics characteristics they answers that they live 50% (4) in urban area and 50% (4) rural area. The aim is to identify care access barriers and provide the highest quality of health care within local remote and rural communities, minimizing the need for patients to routinely access clinical services out with their locality.

In general, the average weight is between 100-139 pounds and the average of height is 61 inches (5'1") among these members. For BMI measure, 36.4% were in the normal range, while 18.2% resulted being overweight, 0% being obese and 27.3% being morbid obesity; increasing a risk for

comorbidity for chronic condition. The most frequent self-reported condition was: Hypertension (54.5%), followed by Respiratory Conditions (45.5%) and Cardiovascular Disease (45.5%). The prevalence of chronic conditions members self-reported was of 45.5% having cardiovascular conditions, 36.4% Diabetes, 27.3% Heart Failure, 54.5% Hypertension, 9.1% renal disease, 50.0% Hypothyroidism, and 45.5% Respiratory conditions.

An estimate of 54.5% members have at least two or more chronic conditions. The 100% of members with chronic condition answered attend to follow up visits as recommended. Regarding medication use, 100% of members answered they used their medication as recommended.

For the questions regarding members ER and Hospital utilization: Three month before the assessment was completed, the 25% members had a visited one time the ER and 75% don't visited the ER. Three month before the assessment was completed 25% members were admitted one time and 75% were not admitted.

The 9.1% of members considered their health status as excellent, 45.5% as very good, 18.2% as good, 27.3% as average, and 0% as poor. Understanding illness perceptions and incorporating them into the care plan is critical to effective treatment. Gives care managers the opportunity to identify and correct any inaccurate beliefs patients may have. The 25% members self-report that have a living wills or health care advance directives. All member received education regarding an Advance Directive at the time a member is admitted to the Complex Care Management Program. The 25% members self-report have done screening mammography, this question was done only to women. The 75% have done a colorectal cancer screening test in the last year. Consideration of the evidence leads us to conclude that the use of clinical preventive services is suboptimal. Interventions designed to enhance the appropriate use of clinical preventive services should focus on educating physicians how to prescribe these services, and target beneficiaries for whom present gaps in care, utilization and health status are low, and risks of disease are high.

Through the assessment the care manager identified characteristic, condition, or behavior that increases the likelihood of getting a disease or injury. The 50% was identified as sedentary, 50% have high cholesterol and use statins medication to lowers the level of cholesterol in the blood. The care manager's impact this members with Effective health education, integrating health literacy and patient activation into the development of interventions to improve health care. No member smoke, Ingested alcoholic beverages or use illicit drugs.

In overall, the 27.3% members self-report that live alone, 63.6% live with family member, and 9.1% with legal tutor. The 57.1% of members reported having limitations in performing daily living activities. Most limitations related to instrumental activities such as cleaning, cooking, laundry, shopping and going to medical appointments.

Regarding caregivers, at least 90.9% of the members reported having a primary caregiver, and 90.9% reported their caregiver is available to help. The role of caregiver is recognized as instrumental in the care management process, and as reported they were more available to participate in the care during 2017. In overall 100.0% responded that they have no benefit limitations.

In overall, the 25% members are bedridden. The 25% (1) members have a skin lesion and 100.0% have recommended treatment for the lesion.

In overall for questions regarding cultural and linguistic barriers: the 9.1% present language barriers, MCS had a processes and standard policies to ease the access of interpreters or document in other languages for member and caregivers. None members answered that are illiterate and the highest levels of education achieved was elemental school with 50.0% overall, 25% high school, and 25% university degree. No speech difficulties were identified. Visual and Hearing barriers were identified in these members with 9.1% each.   The results suggest the uniformity of the population served in terms of cultural needs and preference, when the no members reported having cultural needs or limitations. The 18.2% reported spiritual beliefs needs. The 9.1% reported additional barrier related to cognitive function limitation being lack of understanding; no members had limitation in transportation. The member that cannot be transported by themselves, and who do not have family or social support for transportation, care management coordinated with community transportation alternatives or if member have benefits for transportation coordinated with a provider. MCS care managers and community outreach technicians are well trained to overcome barriers related to those needs to achieve the best possible clinical outcomes.

In overall, for questions regarding mental health status and cognitive functions: the 9.1% answered that had a history of emotional condition and is currently in treatment. No members answered that in the past two weeks felt sad most of the time and the PHQ-9 don't have to be performed by care manager.

The Care Manager identifies through HRA member's necessities for a transition or coordination and/or in the follow up management process of a complex case. Connecting the member to the appropriate providers and complete transition of care process according to outcome measures to ensure a successful transition and continuity of care for members. No members was identifies with necessities that required a coordination of health services.

Regarding the educations provided during the phone call and care plan satisfaction: the 100% members understand the education information provided during the assessment phone call. The 100% member agreed and were satisfied with the individual care plan stablished. The Care Management overall process and structure including the Community Outreach Program provides for an effective care management plan for each member needs.

MEDICAL HOME NETWORK

November 16, 2018

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

Thank you for the opportunity to respond to your Request for Information (RFI) regarding approaches for improving care for Medicare beneficiaries with social risk factors.

Medical Home Network (MHN) is a not-for-profit collaborative that has fundamentally changed how care is delivered. Our proven model of care unites provider communities and diverse healthcare entities around a common goal: to redesign healthcare delivery and transform the way care is managed at the practice level. The result is stronger patient relationships with their primary care team, and the realization of value in the safety net through technology-enabled population health management at the practice level.

It starts with providers and patients working together to improve health. Care teams drive engagement by developing relationships with patients that extend beyond the four walls of the primary care practice. We provide the tools and processes to help care teams engage patients and help them become an accountable member of the team. Research shows that patients who are involved in making their healthcare decisions tend to be healthier and have better outcomes. By connecting providers and delivering real-time information, we enable coordinated care management, improve transitions of care, and promote timely follow-up. But the most important change is that patients receive better care where and when they need it.

The MHN Accountable Care Organization (ACO) MHN ACO, LLC is provider-owned and provider-driven, consisting of 2400 providers in 12 organizations, serving about 118,000 patients in the Chicagoland area. We operate as equal partners, which means shared-decision making and true collaboration among our members. We are transforming health care delivery by offering coordinated, patient-centered care for Medicaid patients. We have an innovative technology platform that enables virtual delivery system integration and is the foundation of our patient-centered, team-based model. We are committed to improving care while reducing costs, and we are achieving results.

Our responses to the following questions are shaped by our lessons learned while operating our patient-centered, practice-level care management model on behalf of Medicaid beneficiaries in Illinois. We appreciate your consideration and welcome any opportunity to further collaborate.

4835-8680-7675, v. 1

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

Medical Home Network Accountable Care Organizations do not serve Medicare beneficiaries within the framework of the ACO, but many of our lessons learned with the Medicaid Managed Care population in IL are relevant across payor type. In particular, our model of collecting a Health Risk Assessment for every patient aligns with the Annual Wellness Visit model in Medicare.

Our research has shown that although many managed care networks do not systematically collect social and behavioral risk factors in a medical setting, social risk factors are associated with an increase in healthcare costs. Healthcare costs were $65 Per Member Per Month higher for beneficiaries who had trouble securing food, clothing, or housing (95% Confidence Interval [CI], $10 to $119; P=0.02). The presence of 1-3 addressable risk factors is associated with $132 higher Per Member Per Month spending, even when both groups reported infrequent hospitalizations (95% Confidence Interval [CI], $77 to $188; P<0.001). (Jones A, Lemak CH, Lulias C, Burkard T, Mc Dowell B, et al. (2017) Predictive Value of Screening for Addressable Social Risk Factors. J Community Med Public Health Care 4: 030.)

2a. Are social risk data being used to target service or provide outreach? If so, how? How are beneficiaries with social risk factors identified?

- MHN ACO member organizations conduct a health risk assessment (HRA) with each of their members within 60 days of enrollment. Our rate of HRA completion is currently 81%. As part of this HRA we collect the following social risk factors: Gender, Primary Language, whether a responsible adult is available at home to care for this member, whether the member lives in permanent or temporary (shelter, homeless, transitional) housing, whether the member feels safe at home, whether the member needs help obtaining the essentials (food, clothing, housing), whether the member has difficulty paying for medication.

- This data, along with clinical information, is used to stratify patients into four categories of risk: High, Medium, Low, and Low with Social Risk. We have found through research that our members categorized as Low with Social Risk have the same utilization rate as a member with Medium overall risk. We use these categories to guide the care manager in determining how often they should engage with the patient, ranging from daily for our highest risk members to quarterly for members with low risk. Care management caseload is managed based on members risk level.

2b. Are there especially promising strategies for improving care for patients with social risk?

Many of the medical homes in the ACO have programs that address social risks. They also have strong relationships with community-based organizations serving the needs of their specific populations. The MHN ACO has connected our medical homes to the majority of area hospitals through technology, capturing approximately 75% of patient activity in real-time, and is in the process of connecting with key community-based-organizations in the area. Integrating care management at the provider level means that a

MEDICAL HOME NETWORK

multidisciplinary care team is able to work with patients to holistically meet their needs and to refer patients to community partners. Sharing a common understanding of our members/patients and being able to communicate securely about these patients has led to improved workflows and outcomes for our patients.

2c. How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management and to provide additional services? What is the ROI in improved outcomes or reduced healthcare costs?

MHN has found that for our ACA Medicaid population, risk adjusted utilization was 15% lower for ER and 24% lower for inpatient admits compared to patients who were not part of the MHN Care management model.

2d. What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

MHN is currently partnering with NCQA to evaluate the effect that connecting medical homes and community-based organizations has on patient's social risk. Upon completion of this evaluation project, MHN and NCQA hope to contribute to best practices related to referring beneficiaries to social service organizations.

2e. What lessons have been learned about providing care for patients with social risk factors?

Building trusting relationships is the cornerstone to being able to successfully address social risk factors. MHN has embedded care managers in the medical homes and this has been demonstrated to be most effective at mitigating social risk. All of our care managers are employed by the medical home where they work, and whose patients they serve, and are part of a multidisciplinary, integrated care team.

2f. What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?

One challenge is the frequency with which some of our members move, change their telephone number, or present at a new location for care or services. By connecting all parts of the healthcare system, we're able to share information about the patient wherever they arrive and continue to connect them back to their medical home. There are also limitations to resources for stable housing and to psychiatric care.

There is also more opportunity to coordinate care across settings and to leverage technologies that encourage communication and collaboration and integration between medical, behavioral, and social service providers.

3a. Which social risk factors are most important to capture?

As part of our Health Risk Assessment for each patient we focus on a set of addressable social risk factors including whether the member lives in permanent or temporary (shelter, homeless, transitional) housing, whether the member feels safe at home, whether the member needs help obtaining the essentials (food, clothing, housing), whether the

member has difficulty paying for medication or is in need of transportation to obtain medical care.

In a recent publication we showed that for our population the most statistically significant factors identified in the HRA in predicting future cost and utilization were: needing help obtaining the essentials, self-reported health rating, and lack of transportation. (Jones A, Lemak CH, Lulias C, Burkard T, Mc Dowell B, et al. (2017) Predictive Value of Screening for Addressable Social Risk Factors. J Community Med Public Health Care 4: 030.)

3b. Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations? What are the burdens of this data collection on plans, providers and beneficiaries?

MHN ACO member organizations aim to complete an Health Risk Assessment (HRA) for each member within 60 days of enrollment, and 81% of members have an HRA completed.

Anyone on the care team can collect the HRA information, but most often it is an unlicensed Care Coordinator. The preferred workflow is to collect the information in person at the office, but some HRAs are also done telephonically. The HRA is collected once but then updated as appropriate by the Care Manager, as risk levels do shift over time. The HRA takes about 5 minutes to complete for an average patient.

3c. Would standardized data elements for EHRs help you collect social risk data? If so, how could these data elements be standardized?

MHN believes it would be useful to have standardized elements in the EHR that would be able to be interfaced into and out of our care management system, to further aid in the sharing of information across the healthcare ecosystem.

3d. What are barriers to collecting data about social risk? How can these barriers be overcome?

Prohibitions against sharing information from programs regulated under 42 C.F.R. Part 2 (the "Part 2 Regulations") create enormous real and perceived obstacles to sharing substance use disorder information. Although the Part 2 Regulations do not apply as broadly as is often believed, ambiguity in the regulations leads to widespread over-suppression of highly relevant data that could be leveraged to support continuity of care, reduction in duplication of services, and strengthen supportive services.

Additionally, every patient is different and has unique needs. Resolving those needs relies on the granularity of data that so often can be lost if unique cultural, social, and environmental factors that impact the populations served aren't taken into account when designing and delivering the social risk assessment. For example, assessing housing insecurity can be done using several different questions – a patient could screen positive on some but negative on others, and the resolution may be different depending on which

are true. Providing a framework for assessment but allowing for cultural competence and individual care team judgement for each member is key to attaining optimal outcomes.

3e. What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

We believe that programs that are truly subject to the Part 2 Regulations could and should be identified with tags or flags on the applicable NPI number. Tagging and segregating true Part 2 programs would free up the use of the vast amount of substance use disorder information that is currently inappropriately suppressed and can derail efforts to meaningfully engage and coordinate care for patients in unique moments of vulnerability.

Having patients become more easily involved in providing data is an opportunity for the future. Many of our patients have smart phone technology and we are interested in connecting with them more through modalities that they prefer and that help to engage them in their own care.

Thank you again for the opportunity to participate in the Public Meeting and submit this written statement. We welcome the opportunity to discuss these ideas in greater depth. To coordinate, please Cheryl Lulias, President and CEO, at 312- 274-0126 or clulias@mhnchicago.org.

Sincerely,

Cheryl Lulias

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President and CEO
Medical Home Network
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clulias@mhnchicago.org

4835-8680-7675, v. 1

From:	Bauer, Cliff <CBauer@miamijewishhealth.org>
Sent:	Thursday, November 15, 2018 1:23 PM
To:	ASPE SES IMPACT Study (OS/ASPE)
Cc:	Bauer, Cliff; Garg, Joyita; Chris van Reenen Ph. D. (chrisvr@npaonline.org); miap@npaonline.org; Lombardo, Margaret
Subject:	H1043 Florida PACE Centers, Inc. : Response to IMPACT Act Research Study - Request for Population Health Approach to Medicare Beneficiaries

Dear Assistant Secretary for Planning and Evaluation (ASPE), HHS:

As a determinant of health, medical care alone is insufficient for ensuring better health outcomes. Medical care is estimated to account for only 10-20 percent of the modifiable contributors to healthy outcomes for a population. The other 80 to 90 percent are sometimes broadly called the SDoH: health-related behaviors, socioeconomic factors, and environmental factors.

Deloitte Insights states that Social Determinants of Health (SDoH) encompass a wide range of factors and identifies the following as critical elements:

1. **Housing instability/homelessness:** Having difficulty paying rent or affording a stable place of one's own, living in overcrowded or run-down conditions.

2. **Utility needs:** Not being able to regularly pay utility bills (e.g., electricity, gas, water, phone), and or afford necessary maintenance or repairs.

3. **Food insecurity (hunger and nutrition):** Not having reliable access to enough affordable nutritious food.

4. **Interpersonal violence:** Being exposed to intentional use of physical force or power, threatened or actual, that results in or has a high likelihood of resulting in injury, death, psychological harm, etc.

5. **Transportation:** Not having affordable and reliable ways to get to medical appointments or purchase healthy foods.

6. **Family and social supports**: The absence of relationships that provide interaction, nurturing, and help in coping with daily life.

7. **Education:** Not having access to high school or other training that might help someone gain consistent employment.

8. **Employment and income:** Not having the ability to get or keep a job or gain steady employment.

Participants in the Program of All-Inclusive Care for the Elderly (PACE) face the first six identified social determinates of health while the last two (education and employment) are rarely if ever issues with frail older adults. Income is a determinant at every age.

Let us answer the questions posed by the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) regarding how PACE programs in general and Florida PACE Centers in particular address these issues.

How plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors: Every Participant in Florida PACE Centers received a complete medical and psycho-social assessment upon admission. The various members of the PACE interdisciplinary team conduct the assessments and, in consultation with other members of the team, develop a plan of care. The medical and nursing staff complete a comprehensive physical exam (with both vision and dental), additional diagnostic tests are preformed or ordered as needed. The Behavioral Health Specialist staff completes a psycho-social assessment that reviews social history, family dynamics, current living situations and social environment. The nutritionist reviews dietary preferences and needs and develops a plan to achieve and maintain healthy weight and meet the nutrition needs of Participant. The home care coordinator visits the Participant's home and assesses the natural environment the home is located in (the neighborhood), the physical condition of the space in which the Participant lives, and the need for any adaptive devices or repairs that would increase mobility and improve safety. The rehab staff assess physical function and mobility and reviews the use and appropriateness of current adaptive devices. If additional assessments needs are identified at this time, referrals are made, and assessments scheduled.

The unique feature of the PACE protocol is the way in which these assessments are reviewed by the interdisciplinary team (meeting as a group), discussed in terms of completeness and accuracy, and then wove into a single comprehensive care plan. The interdisciplinary team meets regularly to review the implementation of the care plan, conduct updated assessments and modify the care of plan as Participant needs change.

Two of the most important factor to capture are the actual physical environment that Participant is living in (regulations require that the Participant be able to live "safely" in the community) and the social (often family) support that is available. These represent questions that should be asked and answered during the assessment process.

Is the neighbor "safe" and the home in good repair? Is the furnishing appropriate and in good repair? Is the physical structure accessible (does meet certain criteria for universal design)? Can the participant use the bathroom and kitchen?

What social supports are available to the Participant? Does the family engage with the Participant, available and willing to help provide care and comfort? Does the Participant engage with friends and neighbors (and do they confirm this)? Does the Participant engage in community or religious organizations that are available and supportive?

Approaches plans, and providers have used to address the needs of beneficiaries with social risk factors: The service configuration of the Program of All-Inclusive Care for the Elderly (PACE) has several features which make it ideal to address the social determents of health. Two of the more important features are transportation and the adult day care center.

Florida PACE Centers has a fleet of 32 eight-twelve passenger buses to provide transportation to Participants. These buses provide transportation to and from the adult day center, to and from medical and medically related office visits not located at the PACE Center, to and from special social and recreational events (such as concerts) and when required, will provide transportation for food shopping. The transportation service has a

flexible design to ensure that transportation is not an issues leading to isolation and loneliness. In addition, the individual bus drivers are a continuous source of information on the physical and social environment in which the Participants live.

It is difficult to understand the importance of the adult day center in the PACE program and its benefits to Participants unless you have seen one in action. In addressing the social determinates of health, the adult day center program address two important elements. First, attendance at the adult day center address the element of social support by combating loneliness and isolation. Beyond its capacity to monitor participants physical conditions, it provide opportunities for social and recreational activities. Individuals can play cards and bingo, they can participate in discussion groups, they can watch TV and listen to music, and they do all of this in an environment that encourage interaction and new friendships. Though artificially created, it provides an opportunity for genuine social interaction and friendships.

The adult day center also pays an important role in nutrition. The day center provides a USDA certified breakfast, hot meal and nutritious snacks. It helps ensure that Participants receive appropriate nutrition.

In addition to these two services, the PACE program has an aggressive social work and health education program that engages both Participants and their families. These efforts are designed to have families become our partners in care. The PACE program also provides home modification (through general contractors) for Participants that require additional mobility assistance. Items provided include wheel-chair ramps, grab bars for toilets, bath tubs and showers and under particular circumstances, bathroom and kitchen remodeling. Finally, Florida PACE Centers works with several in-home meal providers to ensure that individuals not regularly attending day care receive nutritious meals on a regular basis.

Florida PACE Center is an active participant in Miami Dade and Broward County's system of elder care. FPC has an extensive provider network that includes hospitals, nursing homes, home care and home health agencies, hospices, assistive living facilities, home meal providers and durable medical requirement suppliers. A large network of specialty physicians is also available, including dental and vision services.

Florida PACE Centers also maintain relationships with the AAA in Miami Dade and Broward County and its organized aging networks to provide services outside of the scope of PACE. These include utility assistance and home repair. Florida PACE also works with the various housing authorities to assist in securing access to either low income housing or low-income housing vouchers. To be candid, Miami-Dade is having an affordable housing crisis and housing assistance is very limited, if available at all.

A modification in the PACE protocol to allow PACE to provide support for non-medicalized supportive housing and limited utility assistance within the PACE program would allow a cost effective (we believe) and appropriate service addition.

Evidence regarding the impact of these approaches on quality outcomes and the total cost of care: Several national evaluations have been conducted on both the cost and quality of care in PACE organizations and have been found to be positive.

We find that PACE programs in Florida have smaller percentages of Participants placement in nursing homes (FPC has $\leq$ 3% in LTC, compared to Miami-Dade County has 22% in LTC) than other LTC programs, which reflects the aggressive primary care provided by PACE. We find that providing both adapting devices and home modification reduces the number of falls, thus reducing hospitalizations; we find that providing nutritional meals (and dentures) increase overall health of participants lower medical costs; we find that transportation

services increase access to primary care and specialists allowing for early identification and prompt treatment, and the adult day center provides a defense against isolation and loneliness, provides nutritious meals and snacks, while providing an opportunity for the PACE Center aides to monitor both physical and mental health of Participants extending the reach of primary care. By addressing these social determinates of health, we improve the health of Participants, thus allowing more early intervention on the primary care side and reducing the need for extensive medical interventions by specialist and inpatient facilities.

Florida PACE Centers has an extensive quality assurance and quality improvement program designed to ensure that the quality of care provide to participants is of the highest quality. Florida PACE Centers regularly monitors contract providers to ensure both contract compliance and the quality of patient care. We participate in CMS, NPA and AHCA quality monitoring program.

The Florida PACE Centers' conducts semi-annual Participant satisfaction survey and our surveys all show 3.8/4.0 satisfaction scores with FPC. The Center also has a Participants council for each of its Center sites and monitors both satisfaction and quality of life. We believe that the range and scope of the high-quality medical services coupled with extensive long-term services supports provided by PACE improve Participants' health status and their quality of life.

Ways in which plans, and providers disentangle beneficiaries' social and medical risks and address each. We believe that the PACE protocol prevents the disentanglement of social and medical risks. We concur with that orientation and believe that disentanglement is not appropriate in providing long term services in supports. What we do believe is that the assessment process should be comprehensive: medical, psych-social, nutritional, and environmental (transportation and housing) and done by individuals who have the training and experience to perform quality assessments. The interdisciplinary team care plan provides the forum in which medical and social risks can be examined and prioritized. By having a complete understanding of both risks, better choices can be made to move forward with care. We also have a firm belief that once risks have been identified and understood, that appropriate licensed, trained staff address those issues. Our Clinical Team as 1 MD/DO and 1 ARNP for every 125 PACE Participants. With the interdisciplinary team and comprehensive care plan both medical needs and social determinants can be sorted and addressed in an appropriate and timely manner.

Sources

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Best Wishes,

Miami Jewish Health

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The Mission of Miami Jewish Health Systems is to provide compassionate healthcare through a full range of quality services, guided by research and education, honoring traditional Jewish values of dignity and respect.

November 15, 2018

BY ELECTRONIC SUBMISSION
ASPEImpactStudy@hhs.gov

Assistant Secretary for Planning and Evaluation
Department of Health and Human Services

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

Dear Sir or Madam:

Thank you for the opportunity to comment on the recently released Request for Information (RFI) on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

Michigan Medicine is known nationally and around the world for excellence in patient care, education, and research. Located in Southeast Michigan, it is composed of the University of Michigan Health System and the University of Michigan Medical School. As one of the largest health systems in our state and one of the nation's leading academic medical centers, Michigan Medicine fulfills its vision to create the future of health care through discovery and become a national leader in health care, biomedical innovation, health care reform, and education through the efforts of its clinicians and staff.

Through the University of Michigan Medical Group, Michigan Medicine employs over 2,700 physicians across 19 clinical specialties, including primary care. It provides both inpatient and outpatient care through its general acute care hospital with over 1,000 inpatient beds; more than 40 ambulatory locations with 140 clinics; specialty centers for cancer, depression and cardiovascular care; and home care services. Annually, the organization provides approximately 50,000 admissions, 100,000 emergency room visits, and 2.3 million ambulatory visits.

Michigan Medicine has historically led the nation in payment and delivery reform through its participation in Medicare's Physician Group Practice Demonstration Project (2005-2010), the Multi-Payer Advanced Primary Care Practice Project (2011-2016), and as a Pioneer Accountable Care Organization (ACO) (2012). Michigan Medicine currently participates in the Medicare Shared Savings Program ACO Track 1, the Michigan State Innovation Model Initiative, and CMS' Comprehensive Primary Care Plus medical home model.

Michigan Medicine is committed to identifying and addressing patients' social determinants of health (SDoH) as part of our overarching population health strategy. As a result of participation in several of the above value-based models, Michigan Medicine has expanded its efforts to identify and address SDoH

and appreciates the opportunity to comment on lessons learned and the importance of considering these factors as we attempt to fully understand the drivers associated with population complexity.

We are responding to some but not all the questions in the RFI. For ease of reference, we have prefaced each of our responses with the question in the RFI that it addresses.

Questions Related to Delivery of Services

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

Michigan Medicine participates in the Michigan State Innovation Model (SIM) Patient-Centered Medical Home Initiative, which requires participating Provider Organizations to screen all primary care-attributed patients for SDoH. Michigan Medicine began screening primary care patients in August 2017 and has screened almost 100,000 patients to date. If a patient screens positive for one or more needs on the initiative's screening tool, called the "Partners in Care Questionnaire," the primary care doctor is informed of the positive screen. The doctor discusses the need with the patient and asks if he or she would like a referral to resources to address the need. If the patient wants a referral, the primary care doctor sends a referral to Michigan Medicine's Guest Assistance Program (GAP), a central office comprised of Bachelors-level Social Workers trained in clinical-community linkages. The GAP office calls the patient and completes an additional assessment to understand the need further, then connects the patient to community resources to address the need.

Michigan Medicine is incorporating social needs data into primary care chronic disease management models, including the Diabetes Care Management Model. Compared to the general primary care population, diabetics utilize more services. A patient and family advisory council supported the development of a model that leverages a multidisciplinary care team to proactively manage diabetics. During weekly care team meetings, patients' disease and social history are discussed to identify a lead care manager and supports the patient may need to achieve HbA1c control. Care managers include a Pharmacist, Nurse Care Navigator, Registered Dietitian, and a Social Worker. Patients work with care managers to adjust medications, set goals, and connect with community resources. During this care management process, care managers are able to screen patients for social needs, re-screen patients, and/or follow-up on previously identified needs. Incorporating this data into the care team's decision-making has highlighted the impact of social needs on our patients' abilities to meet their health goals.

While routine screening is only done in the primary care setting, Michigan Medicine employs Social Workers throughout the organization to assist patients with behavioral health and social needs. Physicians throughout the health system can refer patients to Social Workers if social needs are identified. Additionally, if a patient is identified as particularly socially and medically complex (certain criteria must be met) by a physician, the GAP office, or an in-clinic/emergency department (ED) Social Worker, he or she can be referred to Michigan Medicine's Complex Care Management Program (CCMP). The CCMP is comprised of allied health professionals (the majority are Masters-level Social Workers) who provide intensive case management for complex patients. CCMP coordinates with community resources, including Community Mental Health and other social service agencies, to identify and address patients' barriers to managing complex medical conditions.

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Currently, Michigan Medicine is implementing an Epic functionality called the Longitudinal Plan of Care (LPOC). The LPOC is designed for clinicians throughout the system to understand a patient's care across the continuum. In additional to recent visits, problem lists, health goals and other clinical indicators, the LPOC displays a patient's social needs.

As part of the Michigan SIM, two counties in Southeast Michigan—Washtenaw, which is Michigan Medicine's home county, and Livingston, which is just to the north—were selected as a Community Health Innovation Region (CHIR). Michigan Medicine participates in the SIM CHIR ED Intervention. The goal of the intervention is to reduce unnecessary hospital ED use by connecting frequent users with social services. Patients become eligible for the intervention in two ways: through provider referral or predictive model. The predictive model incorporates dozens of variables—including previous ED use, diagnosis, health insurance, zip code, age, and gender—to predict individuals' future ED utilization in the next 6 months. The top 12 patients from the predictive model output are referred into the ED Intervention weekly. For participants in the intervention, care coordination involves a team-based approach among community-based organizations that is facilitated by an Information Technology (IT) platform called *MI Care Connect*, developed and hosted by PCE Systems. The Center for Health and Research Transformation (CHRT) serves as the administrative "hub" for the intervention. Each participant in the intervention is assigned to one of 11 community "hublets" (a health care provider or social service organization) based on a needs assessment and any pre-existing relationships between the participant and a hublet. The assigned hublet serves as the lead entity for care coordination, while working with other hublets on a shared care plan for the participant. Depending on the circumstances of a particular case, hublets work with participants to connect them to the services they need—such as establishing a relationship with a primary care provider, identifying food resources, applying for affordable housing, or accessing transportation assistance. Community Health Workers housed at the Washtenaw Health Plan serve as a shared resource for engaging participants and working to meet participant goals. Hublets meet together twice monthly, once a month to present and problem-solve cases, and once a month to make adjustments and improvements to the intervention work-flow and processes.

2. *Are there especially promising strategies for improving care for patients with social risk?*

Michigan Medicine's efforts to identify and target patients with SDoH are in their infancy. Evaluations for the Michigan SIM are currently analyzing the impacts of SDoH on health care utilization in the Medicaid population, as well as the impact of the SIM CHIR ED Intervention on health care utilization and outcomes. However, early evidence from the Intervention suggests that a shared IT platform and allowing clinical and community partners to coordinate services for a patient with social risk factors reduces duplication and waste among the providers and enhances patient satisfaction. Additionally, Community Health Workers have been particularly successful at contacting and engaging individuals who have social needs but are not medically complex. These individuals have proven the most difficult

to engage in the intervention because they do not have regular contact with the health care system beyond their use of the hospital ED.

3. *How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g. transportation)? What is the return on investment in improved outcomes or reduced healthcare costs)?*

The impact of targeting patients with social risk factors is currently being evaluated by Michigan Medicine and the State of Michigan. The costs of providing targeted services, including case management, to patients with SDoH include labor costs related to employing both Bachelors-level and Masters-level Social Workers (BSWs and MSWs) throughout Michigan Medicine, software license fees and training for shared IT platforms, and administrative management to implement and monitor SDoH initiatives. For example, to support primary care-embedded care management, Michigan Medicine spent approximately $6.5 million in Fiscal Year 2018 to support 75 Full Time Equivalents, including Pharmacists, Dietitians, Nurse Care Navigators, Panel Managers, and Social Workers. These care managers provide a broad variety of services—including medication reconciliation, psychotherapy, chronic disease management, clinical-community linkages, and gap closures—to 225,000 attributed primary care patients, approximately 8% of whom were identified with one or more social need through screening. In order for health care providers to realize a return on investment for reduced health care utilization that results from addressing SDoH, Michigan Medicine encourages the Department of Health and Human Services (HHS) to increase the proportion of Medicare payments linked to health care outcomes and quality. The current Fee-For-Service payment system does not encourage providers to reduce health care utilization and therefore reduces the incentive to address SDoH and improve outcomes.

4. *What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?*

Michigan Medicine's GAP is a central office that exists to connect patients to resources if their social needs are barriers to receiving needed health care. The GAP office has created an internal database of social services in Washtenaw County and surrounding areas and updates this database monthly.

When a patient is referred to the GAP office, social workers complete an in-depth assessment with the patient that often uncovers information beyond the reason for the original referral. The GAP office has found that this assessment is essential to fully understand the patient's needs in order to provide the right resources to successfully address those needs. The assessment also seeks to understand if the patient is independent enough for the GAP office to provide contact information for the resource and let the patient make direct contact with the resource. If not, the GAP office staff will call the resource and do a three-way telephone call while the patient is still on the line to ensure a connection is made.

As a result of needs identified in the community, Michigan Medicine recently added a question to the SDoH screening tool related to social isolation. GAP office BSWs did not feel equipped to address social isolation, so referrals for social isolation and intimate partner violence will instead be sent to the in-clinic MSWs who have additional training related to these needs.

Michigan Medicine has learned the importance of having care management resources embedded within the health care setting, compared to outsourcing this work to a third party. The ability for care managers and physicians to document findings and services in a patient's electronic medical record strengthens the ability to coordinate across care settings and prevents patients from being asked to repeat information each time they are connected to a new member of the care team.

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

Michigan Medicine has made several changes to the Partners in Care Questionnaire as a result of lessons learned throughout the first year of screening patients. For example, Michigan Medicine's employment question was originally worded, "In the last 4 weeks, have you been looking for work?" Several patients screened positive who had a job and were looking for another but did not need assistance. Related to health literacy, the original question was worded, "Do you ever have trouble understanding your doctor's written instructions?" Several patients in the older age groups (65+) responded positively because they interpreted this question as a vision question. In the original workflow, if a patient screened positive for one or more domains (needs), the Medical Assistant would put the responses into the electronic medical record and pend a referral to the GAP office. The physician was then expected to discuss the positive screening with the patient and ask if the patient wanted a referral for assistance with accessing resources. If the patient answered "yes," a referral was sent to the GAP office. If the patient answered "no," this was not discretely documented, except in the note at the physician's discretion. This process caused Michigan Medicine to not fully understand how many patients did not desire assistance and why.

To date, Michigan Medicine has relied on anecdotal evidence from the physician, when available. Capturing this data in a discrete field will allow Michigan Medicine to do additional analysis to understand the root causes of patients who screen positive but do not desire assistance. A gap in resources for a particular domain or patient population cannot be addressed unless the reasons patients are not getting or seeking adequate help are fully understood. For example, a high positive rate for food insecurity may lead local funding agencies to conclude that more funding is needed for food banks. However, evidence to date suggests that food resources are available in the community, but patients have a difficult time getting to the resources and that transportation is an underlying reason that they experience other needs. They may therefore respond that they do not want assistance with food insecurity, even though they cannot access the resources. One solution that has resulted from this

finding is to fund in-clinic resources so patients can access food, pharmacies, and other services while they are already at a medical appointment.

While Michigan Medicine provided scripting for Medical Assistants and physicians to discuss positive screenings with patients, some physicians have communicated that they did not feel equipped to discuss SDoH with their patients or they did not think it fit within the scope of a medical visit. As a result of these findings, Michigan Medicine would like to enhance training for residents and faculty around screening for and addressing social needs. Similarly, prior to the launch of the screening initiative, several physicians thought it was unnecessary to screen patients for SDoH because they were certain they knew if their patients had these needs. However, many were surprised that several patients screened positive.

Another lesson learned is that community social service providers were generally excited that the Provider Organizations were screening for SDoH and were not concerned about introducing new capacity issues. They were also very interested in using the data collected by the Provider Organizations to apply for additional funding, tailor existing services to meet identified needs, and partner to address gaps in services.

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

One major barrier to providing services for patients with social risk factors is the ability for community social service agencies to bill third party payers, including Medicare and Medicaid, for services. Additionally, Community Health Workers, which have been found to be particularly effective at engaging patients to address their social needs, often cannot bill for their services. Michigan Medicine strongly encourages HHS to consider allowing social service agencies to establish billing processes and for certain types of providers, including Community Health Workers, to be allowed to bill Medicare for services.

Another barrier is Michigan Medicine's capacity to connect to and follow up with all patients who screen positive. The GAP office has limited capacity, and Michigan Medicine has 225,000 primary care patients who are now being screened. Currently, there is a four-week lag time between when a patient screens positive and when the GAP office staff reach out to them. Michigan Medicine encourages HHS to provide additional financial support to address SDoH if universal screening is implemented in the future.

Additionally, coordinating care for patients with complex social needs is challenging without a shared IT platform. Without the ability to understand who else has a relationship with the patient and coordinate with those agencies, work is often duplicated, and time is wasted at agencies whose capacities are already limited. It is essential to provide flexible funding, like per-member-per-month payments, to support the development of infrastructure that can be accessed whether the patient is within the health system or out in the community.

Questions Related to Data

7. *Which social risk factors are most important to capture?*

Michigan Medicine captures the following domains, which were agreed upon by local health system and social service agency leadership. All of the domains below are required by the Michigan SIM, except health literacy and social isolation.

- Food
- Transportation
- Utilities
- Healthcare affordability
- Family care (child/elder care)
- Employment
- Social isolation
- Health literacy
- Personal safety (intimate partner violence)
- Housing

8. *Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?*

As a result of Michigan Medicine's participation in the SIM, all primary care practices screen patients for SDoH. All patients, regardless of health insurance, complete the screening at new patient visits and annually (or every three years, depending on the patient) during Health Maintenance Exams (HMEs). The current screening questions appear below:

1. In the last 12 months, did you worry you would run out of food before you got money to buy more?

     Yes   No

2. In the next 2 months, are you worried that you may not have stable housing?

     Yes   No

3. In the last 12 months, has the utility company shut off your service for not paying your bills?

     Yes   No

4. In the last 12 months, did you not see a doctor when you needed to or skip medications to save money?

Yes   No

5. In the last 12 months, did you have to go without health care because you did not have a way to get there?

Yes   No

6. Do you need help finding a local career center and/or job training?

Yes   No

7. In the last 4 weeks, did getting elder care or child care, make it difficult to work or study?

Yes   No

8. How often do you have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never   Rarely   Sometimes   Often   Always

9. How often do you feel isolated from others?

Never   Rarely   Sometimes   Often   Always

Michigan Medicine is currently planning to implement Epic's SDoH module to collect the data and populate the Longitudinal Plan of Care. Additionally, Michigan Medicine is researching Interactive Voice Response technology in order to follow up with patients who have been connected to resources by the GAP office. Once these quality improvement efforts are completed, Michigan Medicine would like to expand screening to other visit types, including visits at the primary care clinics other than HMEs, specialty visits, and ED visits. It took significant resources to create a validated, standard list of questions and to implement the questionnaire at all participating primary care clinics. Currently, the primary burden limiting the expansion of the screening is the GAP office's ability to reach all patients who screen positive within a reasonable time.

9. *Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?*

Yes, standardized data elements would help collect social risk data and would allow HHS to accurately use these data to compare social needs across providers. Prior to Epic's module, Michigan Medicine and other Provider Organizations in our region spent a significant amount of time researching and agreeing upon a standard list of questions in order to aggregate data in our region. Michigan Medicine encourages HHS to recommend a specific list of questions or domains for more accurate data aggregation and comparison. Additionally, Z codes are a special group of ICD-10 codes for the reporting of factors influencing health status and contact with health services. Michigan Medicine encourages HHS to consider incorporating Z codes into risk adjustment methodologies, including Hierarchical Condition Categories (HCC). The HCC risk adjustment methodology currently only reflects a patient's medical

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complexity, as there are limited data elements to indicate a patient's social risk. The ability to automatically bill a Z code when a patient screens positive for a social need can easily be built into an electronic health record. Z codes could be leveraged across the country as a standard way to document and bill for social needs.

Thank you again for the opportunity to provide a response to the Request for Information on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. Please let us know if you have any questions. I can be reached by telephone at 734-647-7483 and by email at leahhv@med.umich.edu.

Sincerely,

Leah Corneail
Population Health Office
Michigan Medicine

Good morning,

Greetings from MMM Healthcare. Below you will find our comments regarding the approaches to improve care for Medicare beneficiaries with social risk factors.

Taking in consideration the social risk factors of our membership, Quality Management (QM) provides preventive screening services to members with transportation issues at their home-vicinity thru the Preventour initiative. The Health Plan is closing the gaps in care for these members by assembling clinics at the PCP's medical offices at rural areas; this initiative impact these non-compliant members without the need to drive long distance to metro areas considering some of them don't drive or does not have transportation for area metro.

Also, last year we started providing screening services at the member's home considering some of them are homebound or with temporary mobility issues (fractures of big bones). Both the clinics and the home visits, are properly coordinate by a HP's Call Center representative and notify to the members; at the clinics there are well trained employees including nurses and Health Educators, and specialized vendors that are properly identify as HP's employees. The participation is 100% Voluntary; and most of the members are to participate ones the benefits are properly explained; once at the clinics or at their home, a consent is signed. All documents/results are keep well filed and treated according to HIPAA confidentially; results are share with the member's PCPs for reference and treatment as needed.

The following services has been provided at this initiative: Eye exam for Diabetics, Spirometry for COPD patients, DEXA for osteoporosis, pain screening and BMI. The services rendered by this initiative could be changed/added taking in consideration the membership needs as well as their social risk factors; and we can add laboratories, mammograms, Mental Health Interventions, Pharmacist evaluations, based on the membership needs. All related costs for the services provided is covered by the Health Plan. Also in any of the two scenarios, the HP's employees could be more proactive and made referrals to our Clinical and Social Services Programs or calls to PCPs/family members and in case of a true health emergency, call ambulance for transportation to hospital. This Initiative has been in place for the last 8 years and has help us outreached approximately 7,000 members per year and the closing of 10,000 gaps in care for the members served.

In addition, QM identified the social risk factors of the members served thru our Quality Outreach Call Center's representative that is responsible of doing outbound invitational calls for the preventive clinics at Preventour. If during these calls, the representative identified any members with some limitations under #4 or #5, the approach for the delivery of services is changed to coordinate a home-visit and/or addressed properly any other needed service as stated above.

Currently the only other method for the identification of the social risk factors of members touched by QM are the HOS initiative that provide every two years members data info with relevant social info. These databases are shared with the Clinical Program Units to address and implement strategies.

Thanks,

Carlos A. Puig

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MOLINA® HEALTHCARE

November 16, 2018

Ms. Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington DC, 20201

Submitted electronically via 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 Ms. Destro:

I am writing on behalf of Molina Healthcare, Inc. ("Molina") to share information about how our health plans identify and address social risk factors for our Medicare members through an enterprise-wide Community Connector program and through pilot programs like the recuperative care program for homeless members in Southern California. These programs ensure that the basic needs of vulnerable Medicare and dually eligible members are met, helping to improve quality of life and health outcomes.

Molina was founded over 38 years ago to provide quality health services to financially vulnerable families and individuals covered by government programs. Through our Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), Medicare Advantage Prescription Drug Plans (MA-PDs), Medicare-Medicaid Plans (MMPs), as well as MLTSS and Medicaid programs, Molina works to improve the quality of care and health outcomes for some of our nation's most vulnerable citizens. We have been serving dually eligible individuals for over a decade and currently serve approximately 100,000 Medicare-Medicaid members. We also have the largest membership of any MMP with 57,000 members in six of the nine demonstrations.

Community Connectors
To identify and care for our most vulnerable Medicare and dually eligible members, Molina utilizes an integrated and interdisciplinary care team led by a Molina Care Coordinator and comprised of the member, their family as applicable, all providers involved in the member's care and often times, a Community Connector. Community Connectors are Community Health Workers trained by Molina and are the eyes and ears in the community for the Care Coordinators. They provide members with education, advocacy, and social support, and work closely with community based services like shelters, churches, adult day programs, and food banks.

Community Connectors are an important part of the integrated and interdisciplinary care team. They live in the communities they serve and work hard to develop trusting relationships with

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members. Hiring individuals from the communities they serve helps Molina members feel comfortable sharing information with the Community Connector and inviting them into their home for in-person visits. These stories illustrate how Community Connectors work with the Care Coordinators and clinical care teams to identify and address social risk factors for dually eligible members.

1. A 47-year-old dual eligible member suffering from blindness in one eye, depression, high blood pressure, kidney disease and a history of brain cancer lived in a roach infested apartment with her fiancée. The apartment building was in very poor condition and scarcely occupied. There were no elevators in the building and the member struggled with the stairs every time she entered or exited the building. The member struggled with the idea of accepting help to find a safer living situation. The member's Care Coordinator explained that Molina could provide assistance and with the member's permission, the Care Coordinator introduced the member to a Molina Community Connector. The Community Connector worked with the member to understand her needs and preferences. She provided the member and her fiancée with listings of available low-income apartments in the area and helped them consider various options. The member and her fiancé moved into a new building directly across the street from the hospital where the member's medical providers are located. The new apartment building is bug-free and handicap accessible. The member and her fiancée now participate in social gatherings organized by the building staff and enjoy taking walks in their new, safe neighborhood.

2. A 68-year-old dual eligible member with a history of hypertension, COPD, opioid overdose, seizures, and depression expressed concerns to her Care Coordinator about feeling unsafe in her home and her desire to live in a community with other seniors. The Care Coordinator referred the member to a Community Connector who helped her apply for several assisted living and subsidized housing opportunities and as a result was placed on a wait list for low-income senior apartments. After a period of time on the wait list, the Community Connector was notified that one of the facilities the member applied for had a home available. The Community Connector advocated on the member's behalf and was successful in getting the member's application approved. She now lives in a senior apartment and is no longer fearful at home. The member has indicated that she is happy in her new apartment and her emergency department use has decreased. The Community Connector continues to work with the member to make her apartment a safe and comfortable place to live.

3. A 67-year-old dual eligible member had been sleeping in an apartment with no running water. The member did not speak English and was not engaged in his health care despite suffering from arthritis. The member's Care Coordinator referred the member to a Community Connector for housing support and assistance finding a primary care physician. The Community Connector met with the member and his English speaking sister and assisted them in finding a primary care physician who speaks Cantonese. The Community Connector also helped them identify a number of specialists and made sure a translator would be present during the appointments. During an in-person visit with the member, the Community Connector reviewed housing options in the area and helped the member submit several applications. The member secured housing in a nearby senior subsidized apartment, has an established medical home, and is engaged in his health care.

Recuperative Care Pilot Program

People need a safe, stable and supportive place to recover from illness and injury. Recuperative care programs provide a place for homeless members that are ready to be discharged from the hospital, who have a need for follow-up care but have no place to go. Recuperative care programs provide clinical oversight of a members medical discharge plans and a link to social services while ensuring the member's basic needs of housing, food and transportation to medical appointments are met. Recuperative care programs link members with mental health services, job training resources and can be a bridge to permanent housing through social services staff that facilitate and provide linkages to community resources.

Molina Healthcare of California partnered with the Illumination Foundation to provide recuperative care services to a limited number of homeless dual eligible members in Los Angeles and San Bernardino counties. When a homeless Molina member is hospitalized, a Care Coordinator (and other staff as appropriate) meets with the member in the hospital to explain the recuperative care program, address the member's questions and concerns, and assess their willingness to participate. If appropriate and upon approval, when the member is ready to leave the hospital they will enter the recuperative care program with a discharge plan and care team in place.

The goal of the program is to reduce unnecessary hospital lengths and stays and prevent inappropriate readmissions. In California, homeless adults and children stay in hospitals 4 days longer than the average hospital stay with each day costing close to $3,000. The Illumination Foundation has a unique program designed specifically to care for homeless patients who do not have a place to recuperate after emergency room or hospital discharge. The program ensures that patients will have a place to stay off of the streets to properly recover and prevent a return to the emergency room. As a result, the program shows outcomes with 50% fewer readmissions within 90 days of being discharged to recuperative care than patients who are discharged to their own care[1].

Thank you for the opportunity to provide comments. Molina is committed to working with our state and federal partners to develop and implement programs that improve health and quality of care for our members in the most cost efficient ways. Through our experience serving at-risk members for close to four decades, we have seen that addressing the root causes of social issues can drastically improve members' experiences with the health care system, and ultimately alter their lives for the better.

Sincerely,

Carolyn Ingram
Senior Vice President, Policy and Government Affairs
Molina Healthcare, Inc.

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[1] Illumination Foundation: https://ifrecuperativecare.com/

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

Table of Contents

Introduction

Mountain-Pacific Quality Health (Mountain-Pacific) is excited to contribute to this request for information on social determinants of health (SDoH) and share how we have assisted hospitals, health systems and communities. Mountain-Pacific is the Medicare quality innovation network-quality improvement organization (QIN-QIO) serving Montana, Wyoming, Alaska, Hawaii and Guam, American Samoa and the Commonwealth of the Northern Mariana Islands, some of the most rural, frontier and remote areas of America.

Rural and frontier health care has unique challenges to delivering care to high-risk patients, including distance to care, provider shortages (especially around mental health and substance use providers), a lack of a Health Information Exchange, working with disparate populations like Native Americans and Veterans, transportation, affordable housing, and fewer options for specialty services. Over the last four years, Mountain-Pacific has used strategies to address complex care patients with social determinants of health and their medical co-morbidities and the underlying system-level gaps in care.

Working with health care systems and community stakeholders in three communities in Montana, we developed a medical/social model that is adaptable and scalable to different community needs. This project was funded through a Centers for Medicare & Medicaid Services (CMS) Special Innovations Project award and a Robert Wood Johnson Foundation grant.

Three Montana communities of Billings, Kalispell and Helena partnered with Mountain-Pacific to create community outreach care teams who visit patients in their home setting to address clinical needs and issues related to social determinants of health. There are two key aspects of the model: 1) creating the optimal climate for system change, including education across community stakeholders, and 2) creating an effective registered nurse (RN) and community health worker (CHW) ReSource Team to appropriately address patient needs and measure results. The initial pilot of 36 patients yielded nearly $1.8 million in hospital savings by reducing hospital readmissions and avoiding unnecessary emergency department (ED) visits.

The communities wanted:
1. A program that included visits in the home setting, because clinic visits do not provide the whole picture. For example, a patient with breathing issues may fail to mention her thirty (yes, thirty) cats during a clinic visit. Eyes in the home setting better informs the clinic team, resulting in a more complete picture of a patient's barriers the health.
2. A combined medical /social model.
3. Use of a nontraditional workforce and to train and deploy community health workers (CHWs).
4. To use HIPAA-compliant tablet technology as clinic extenders to help nurses operate at the top of their licensure by focusing on clinical needs
5. Create trusted patient relationship with the teams.
6. A patient centered model where the patient identifies goals meaningful to their health goals.

The communities developed a rural/frontier complex care model consisting of an RN, CHW and tablet for video conferencing and education. The model targets patients with two or more inpatient admissions and/or emergency department visits in six months who are not at end-of-life. It focuses on home visits and intensive case management to tackle the social determinants of health.

We explain how Mountain-Pacific is serving Medicare beneficiaries and working to improve their health outcomes, *especially those with social risk factors*, by answering the following questions:

Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?
Mountain-Pacific assisted each of the three pilot sites in developing community specific approaches to address SDoH. In general, the communities use the following methods to identify SDoH needs:

1. **Reviewing utilization data to identify eligible patients** - Some of the smaller facilities review daily ED and inpatient (IP) admissions for patient patterns. Then, the health system reviews the electronic health record (EHR) for significant factors related to SDoH. In large part, these clues are often in the provider notes and revealed through admission trends.
2. **Using risk-stratification tools to identify high-risk patients** - Then administering a SDoH assessment to better understand their needs.
3. **Testing and developing a variety of SDoH assessment tools** - Initially, there was interest in the LACE tool, which identifies patients who are at-risk for readmission or death within thirty days of discharge based on Length of stay, Acuity of admission, Co-morbidities and emergency room visits, but applying it to the outpatient setting did not meet the needs of the teams. One health system developed its own tool after reviewing tools like, LACE, PREPARE, and generalized forms.
4. **Provider intuition** - Often, a primary care team working with a patient senses an underlying factor, which the patient has not articulated. For example, a congestive heart failure (CHF) patient having trouble managing fluid levels states she is following provider recommendations. However, the CHW sees Costco rotisserie chicken containers on the counter during a home visit. A Costco rotisserie chicken has three days' worth of sodium. The visit creates an opportunity for the ReSource Team to address health literacy and nutrition issues.

Are there especially promising strategies for improving care for patients with social risk?
The ReSource Team model has achieved significant success at the community, provider and patient levels. As the QIN-QIO, Mountain-Pacific played a key role in developing and implementing this model in the three communities.

Community Level
When a coalition has an interest in improving the health of a community, the group can consider what will motivate and drive the various stakeholders and facilitate a process that meets the

needs of competing organizations. Mountain-Pacific convenes stakeholders and shares data to identify the number of shared patients who have multiple IP and/or ED visits in a six-month period. This data is relevant to health systems and nursing homes facing penalties and Star rating concerns. In addition, as multiple agencies get involved, these high-frequency patients are large consumers of resources such as staff time, charity and services. Dialogue and analysis of QIN-QIO data can inform and develop a business case and a shared community vision of how to work with complex care patients.

The data collected on complex care patients often represents gaps in care and community deficits such as lack of affordable housing or insufficient transportation: issues beyond health care. Community coalitions work to address these issues. One example of system change involved confusion in making referrals to mental health services. Clinic teams' confusion on mental health referrals, appropriate contacts, paper work and provider-level referrals led to uncoordinated and insufficient care. Coalitions addressed the problems with education sessions and created a behavioral health referral project shared broadly across the community, which resulted in a more connected network of services that could care for patients collaboratively. Another informed example involved the lack of affordable housing. This impacts the ability to discharge patients in a timely and safe manner. The coalition members learned the issues and options through another educational series and applied for a housing grant to work collaboratively on a solution.

Assessing community assets, programs and gaps in care maximizes existing resources allowing the model to adapt to community without duplicating services or overlooking unmet needs. The conversations solicited during assessment also convene the network of care into a common dialogue.

Provider Level

The general make-up of the ReSource Team is an RN and CHW(s). The care model wraps services around patients in their home setting. The team builds a trusted, personal relationship with each patient and identifies additional physical, situational, emotional and social barriers to the success of their health care.[i] Another tenant of the model is the improved communication and care coordination with primary care and specialty care providers. The ReSource Team works to build better communication with the patient through Motivational Interviewing techniques and builds a care plan to communicate more effectively with the team and the providers. The model allows the patient to dictate their goals for improved health rather than imposing goals on the patient.
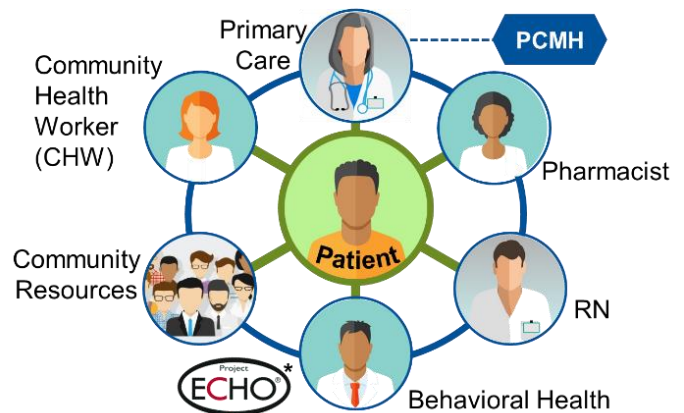
Additionally, best practices support "care going to the patient" rather than "the patient going to the care." Therefore, tablet video capabilities are an effective relationship-builder and healthcare-extender connecting patients to providers.[ii] For example, a patient may live an hour away from the health care provider, and to make the best use of the RN clinical expertise, the CHW travels to the client with the tablet and conducts a video chat back to the nurse. This saves the nurse an hour of drive time to the patient, an hour visit and an hour drive back to the clinic. Instead, the nurse now schedules a 20-minute clinical visit with the patient from her desk, and the CHW addresses the other non-clinical needs for the patient. As we learned and adapted the work, the tablets brought in other services such as pharmacy, nutrition and specialty services (like cardiac care navigators) into the home. This made a more direct and timely point of care for the patient without compromising the patient with traveling to services.

The primary care teams reported greater satisfaction, better communication and time efficiencies. These complex care patients take a lot of time and effort to manage their health conditions and other issues. By assigning the patients to a specific ReSource Team, primary care capacity increased to care for additional lower risk patients. The ReSource Teams created comprehensive care plans and hand-off procedures to keep providers informed and build a better picture of the full scope of patient needs and challenges, including SDoH. Provider teams reported an appreciation for the additional information and helped form strategies to address patients' medical and social challenges.

Providers and care managers identified the following benefits during thirteen random provider/care manager interviews:

- Less stressful
- More productive
- Less time consuming
- Having 'eyes in the home' is beneficial
- Able to connect patients with needed community resources/referrals
- Patient's needed more one-on-one time to accomplish goals
- Provider/patient relationship improved
- Improved communication with patient
- Felt the program was important
- Would like to use CHWs more often
- Felt part of a team
- Improved patient care
- Decreased utilization
- Patient's needs were met
- Patient's felt "cared for"
- Patient has better understanding of diseases/management
- Increased rate of hospital follow-ups
- Improved recovery, more successful transitions of care
- Proactive approach

- Patients have another professional to reach out to, moving away from "only the provider" allowing for care to occur when its needed
- Improved patient engagement

An additional opportunity to educate provider and ReSource Teams comes from virtual, monthly de-identified case conferences. These can occur at a statewide level and/or community level. The QIN-QIO acts as a convener. Case presentations are modeled after Project ECHO collaborative learning sessions, and attendees participate by video or telephone. The purpose is to share best practices and help ReSource Teams working in geographically isolated locations to trouble shoot cases. Over time, the individuals attending the conferences create relationships and actively support each other through this emotionally challenging and complex patient work.

The case conferences have experts and the various participating sites on the call. Communities share cases through a common, formatted/structured document on the screen. The experts are APRNs/PhDs from an educational institution (University of Pennsylvania School of Nursing and /or Montana State University College of Nursing), clinical pharmacists and behavioral health professionals (clinical psychologist and or LCSW). The participating sites are the RNs and the CHWs. One site presents and seeks help with the patient case. The experts weigh in on clinical and medical elements and may present historical successes, tools or resources to help the team work with the patient. Sites can also share successes or new situations that inform the experts and the other sites. The additional participants can offer solutions or support to the presenting site. This transfers knowledge from site to site. According to the sites, they receive valuable information on each monthly call. Participation has remained high throughout the project.

Patient Level

The intervention's focus is to build a relationship between the patient and the ReSource Team. The work starts with establishing rapport with the patient and building a relationship with the patient when they have acute needs and are more receptive to offers of assistance. The ReSource Team member asks open-ended questions to understand the patient's needs and priorities, then customizes the services to the patient's needs.[iii] It is not the beginning of a program's intake checklist, but rather a conversation for getting to know the patient and troubleshooting. Then the ReSource Team begins home visits and finding the support the patient needs to stabilize his/her concurrent medical and social needs. The patient is evaluated for progress and transition to the primary care setting at 30, 60 and 90 days.

**Care Management Intervention Timeline
Beginning at Time Patient is Discharged Home**

Bedside discussion with patient	Home Visit #1 (RN, CHW)	Home Visit #2 (CHW)	PCP Visit (RN)	Specialty Visits	Home Visit #3 (CHW)	Specialty Visits	Home Visit #4 (CHW)
Patient Discharge home	Enrollment Intake Form CPQC Med Rec./Ed, Pill Box PCP agenda Clinical Coordination Social Coordination	Chronic Disease Evaluation & symptom tracker Follow Up on Social Referrals	Coordination & Review of Discharge Summary, Problem List, Med Rec., Symptom Tracker		Assess Trends from Symptom Tracker Med Rec./Ed, Pill Box Reconciliation Follow Up on Social Referrals		Assess Trends from Symptom Tracker, Reinforce Med Teaching & Chronic Disease Targets Assess social goal progress

Start   Day 2   Day 8   Day 15   Day 22   30 Days

Decision Point
→ Graduation & Hand Off to PCP
→ 60 day intervention to complete care plan
→ Extended Engagement

Home Visit #5 (CHW, HC)	Home Visit #6 (CHW, HC)	Home Visit #7 (CHW, HC)	Home Visit #8 (CHW, HC)	Home Visit #9 (CHW, HC)
Chronic Disease Self-Management Skills Health Care Navigation Skills Development Completion of Care Plan	Chronic Disease Self-Management Skills Health Care Navigation Skills Development Completion of Care Plan	Chronic Disease Self-Management Skills Health Care Navigation Skills Development Completion of Care Plan	Chronic Disease Self-Management Skills Health Care Navigation Skills Development Completion of Care Plan	Contact by iPad Care Plan Maintenance

31 Days   38 Days   42 Days   50 Days   60 Days   90 Days

Decision Point
→ Graduation & Hand Off to PCP
→ Extended Engagement
→ < 6 Month Intervention to Complete Care Plan

Color Indicators:
Blue – Clinical Dominate
Green – Social Dominate
Red/Orange – Physician Dominate

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Prior to the start date, the ReSource nurse reviews the ED note, health and physical (H & P), the diagnosis and active problem list, the medication profile and what led to the hospitalization. The ReSourse nurse and CHW start the intervention with a home visit. Most visits occur in the home, but some occur in cars, fast food restaurants and gardens. The first appointment lasts from one to three hours, depending on the patient's engagement level, the number of home distractions and the patient's ability to stay focused. Distance to patient homes can be up to 30 miles one way. Most home visits involve listening to family and/or social dynamics, and it is time-challenging to build the relationship and find key moments to interrupt or redirect without seeming task-oriented or agenda-based. By listening, patient challenges and barriers to care become evident. The ReSource nurse listens for medical and social cues, and the CHW listens for social challenges and opportunities. Both being present prevents miscommunication and gaps going forward. The patient health survey and financial intake (if relevant) happen during the first home visit. Both tools help inform the care plan. After the first visit, the ReSourse nurse and CHW huddle, and the ReSource nurse develops an individualized plan of care that

becomes a working document. The CHW maintains communication with the patient in a manner that is most likely to be successful. For example, some patients prefer text, while others like face-to-face or phone calls.

The frequency and amount of home and telephone visits vary depending on medical and social complexity, patient engagement, patient activation and the availability of community resources. The CHW facilitates nurse-to-patient video conferencing. The CHW is in the patient's home more frequently and sometimes more than once a week. This serves as a time-saving, efficient practice, unless an event demands subsequent ReSource nurse face-to-face visits. The ReSource team has flexibility to manipulate their schedule to accommodate acute patient needs as they arise to better avoid an unnecessary readmission.

How are costs for targeting and providing those services evaluated?
Cost data for targeting and evaluating the ReSource Team model are in the following table. Kalispell implemented the ReSource Team model fully. The results show the better outcome.

Return on Investment (ROI) – Summary of the Three Communities				
NOTE: Each of the three communities tracked clients and costs differently.				
	Billings	**Helena**	**Kalispell**	**Total**
Project Start Date	Dec 2016	Sept 2015	Sept 2015	
Patient Enrollment Start Date	Feb 2017	May 2017	Oct 2016	
Target No. of Patients	50	65	65	180
Year-to-Date No. of Patients	31	**130***	65	**226**
Cost Savings	**$2,532[1] Feb – Dec 2017 (9 patients)**	**$447,024[2] May – Sept 2017 (130 patients)**	**$1,808,029[3] Oct 2016 – Feb 2018 (36 patients)**	**$2,257,585**
Care Team Costs	$188,944 (through Dec 2017)	$56,894 (through Nov 2017)	$197,698 (through Feb 2018)	$424,483
ROI	**-1.0 to 1**	**Not available[4]**	**8.1 to 1**	

*This community used intensive hospital discharge teaching, targeted post-discharge telephone follow-ups, and extended in-person teaching during clinic visits. These steps were in lieu of home visits.

[1]Used Medicare Paid Claims. This reflects 9 Medicare clients who were 6-months post enrollment by Dec 2017.

[2]Used Medicare estimate of $10,286 per readmission and AHRQ estimate of $1,390 per ED visit. The Comprehensive Primary Care Plus (CPC+) payment model was also implemented during this time frame.

[3]Used hospital's self-reported, all payer, billed claims.

[4]The full care team's costs are unavailable, so no ROI can be calculated at this time.

From the most mature community program, we were able to calculate the following changes in charges:

Graph 6. Cost Profile for Kalispell All-Payer Patients with 6 Months Post-Enrollment Data (36)
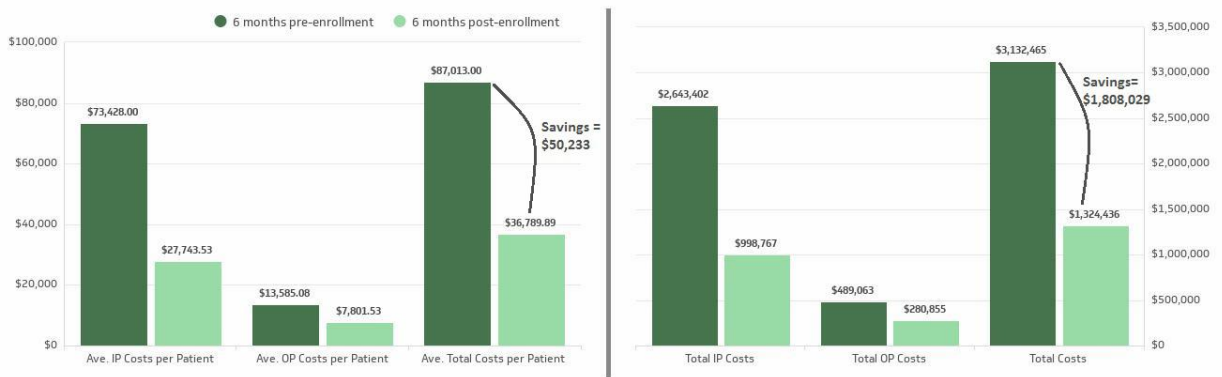
*IP = Inpatient; OP = Outpatient.

*IP and OP costs from actual billed visits within internal Kalispell Regional Healthcare System data.

What is the return on investment in improved outcomes or reduced health care costs?

The following graphic displays the cost savings for the Kalispell community.

Total Cost Savings
(36 patients 6 months post enrollment)

Savings of
$2,545/patient

$113,571

Total savings:
$1,808,029
ROI: 8 to 1
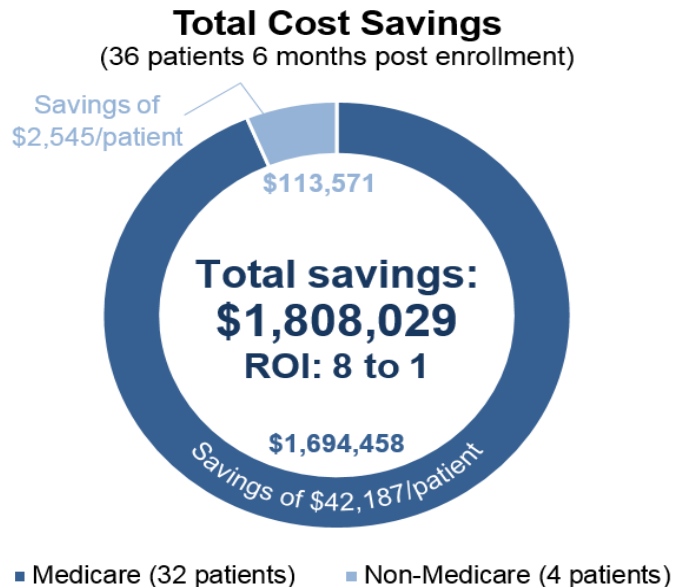
$1,694,458
Savings of $42,187/patient

■ Medicare (32 patients)   ■ Non-Medicare (4 patients)

What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

A data-driven community coalition and effective and efficient use of care teams, including CHWs is a demonstrated best practice.

A potential best practice is the purposeful hiring of a veteran as a CHW. In Montana, one in ten residents is a veteran. It is likely a patient, spouse, family member or care giver has served our country. Veteran CHWs understand the language and culture of service. They are also familiar with the structure and processes of the Veteran Administration (VA) system and can help patients better navigate the VA and local health systems. Kyle is a CHW and an honorably discharged veteran. His Army Special Forces training taught him to successfully interact in a team setting, quickly assess and troubleshoot a situation and be culturally sensitive. Plus, he has been trained in interviewing skills to understand patient motivations.

The key, suggests Kyle, is to look beyond behavior and listen to what patients have to say. Many chronically ill patients "are irritated with hospitals and systems at large," says Kyle. "They're frustrated. They don't think people are listening to them. But when a person they trust is willing to explain complicated medical jargon or help fill out their paperwork, real change can happen."

From a business perspective, this is a solution where everyone benefits. In Kyle's case, his military experience did not readily transfer to the civilian world, so he enjoys the opportunity to

give back to his fellow service members and help develop a new workforce. The program gets a high-functioning CHW who is working at a living wage, because he is benefiting from both his VA retirement and his CHW salary.

A potential best practice includes mapping community resources as an important part of the referral process. In part, having a local CHW expert is quite effective, since these resources change and update often. One team developed a data base of community resources allowing the team, community and the patient to be more efficient. Here is an example of how it worked for a Native American community: http://blackfeet.mpqhf.com/.

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

Lesson Learned	Significance of the Work (the "Why")
The importance of creating a collaborative environment prior to the implementation of the ReSource Teams	Brings together community stakeholders to address high-risk patients.
The team of a RN and CHW is an efficient and viable way to treat complex care patients in a rural setting	ReSource Teams have adapted from nationally recognized complex care models to smaller scale teams pairing an RN and CHW. This design accounts for the limited workforce, such as APRN and RN shortages.
Home visits are important	They help create trust between the patient and team, allow for "eyes in the home," offer opportunities for safety assessment, nutrition evaluation and identification of other social/economic barriers, including health literacy.
Pharmacy and medication management	These are polypharmacy patients who regularly have multiple providers writing prescriptions for complex medical conditions. The ReSource Nurse facilitated medication reconciliation by having a pharmacist evaluating medications for interactions, duplication and side effects impacting the patient. Additionally, the pharmacist can assess and recommend alternative medications that are more affordable for the patients.

Lesson Learned	Significance of the Work (the "Why")
Behavioral health issues are prevalent	Most patients have diagnosed or undiagnosed mental health and addiction disorders. The most common diagnoses identified are depression and anxiety. In Montana, there is a shortage of psychiatrists, mental health professionals and Licensed Addiction Counselors, often leaving mental health co-morbidities unaddressed. Connecting the patient to behavioral health services is extremely important.
Narcotic pain management is prevalent	A high percentage of patients are prescribed opioids and benzodiazepines. They often need pain management services to address dependency issues while working through other medical complexities. There are not enough pain specialists available to meet the population's need.
Social Determinants of Health (SDoH)	SDoH factors are a key characteristic of many complex care patients. It is important to assist with connecting patients to community resources they may not be aware of, are unable to contact, or they have too low of literacy to complete the application forms for support programs.
Housing and affordable housing is a major factor for many of these patients	Most patients are not home owners and may have alternative living arrangements such as living in a shed or working for a bed and shelter. This is not an ideal environment for chronically ill patients and may contribute to their medical issues.
Health literacy	Health literacy is one of the leading SDoHs contributing to patients' situations. Oftentimes, patients needed education on medications and on how to communicate with providers about their diagnoses, so they can comprehend and participate in their care plan.
Provider Intuition	Providers have an intuitive sense about their patients and when there are additional factors beyond the clinical impacting their care. There is a human factor that cannot be identified through in data analysis or risk stratification.
Transportation	A high percentage of patients have issues regarding transportation. Solution example: A CHW posted on Facebook the need for two tires to make a patient's access to care drivable. The community donated four tires.

Lesson Learned	Significance of the Work (the "Why")
ICD-10 Z codes are a great way to collect SDoH information	A standardized way to collect information related to SDoH is currently not available. There are few ways to share information across several technology platforms. The use of ICD-10 Z-codes 55-74 is a viable means to collect and quantify SDoH information. Montana Medicaid will soon begin implementing Z-codes for billing based on the work and discussions of this project.
Patient labeled for "non-compliance"	The patient is usually labeled "non-compliant" for not following the physician care plan. A 15-minute clinic visit does not allow time to address issues beyond clinical concerns. The home visits allow a more comprehensive understanding of the patient, broader view of the situation and contributing factors to medical complexity. This whole-patient view can debunk the label of "non-compliance."
Tablet technology	HIPAA-compliant tablets and other handheld technologies offer a simple way to connect various disciplines with the patient (e.g., RN, care coordinators, pharmacy, nutrition and behavioral health). They are also effective ways to educate patients with videos, diagrams, websites and, when necessary, completing community resource applications.
Case conferences are critical to collaborative learning	This is a safe learning environment for ReSource Teams to share and review best practices. It is also important for teams in rural environments to connect, because they are isolated in their practices. The case conferences help the teams advance the work.
CHW workforce development	This program successfully shows how CHWs are an important part of connecting patients and providers. The CHWs are essential for wrapping nonmedical community resources around patients, bridging gaps and overcoming barriers to care. Patients frequently let their guard down when they are not around medical providers and nurses. Therefore, the CHWs are better able to garner trust and get to the root of problems while efficiently connecting with patients.
Veteran CHWs	Honorably discharged veteran CHWs can connect with veteran patients, caregivers and family members. During their military service, the veterans learned to work in a team environment, quickly assess their surroundings and make decisions, be culturally sensitive and become versed in the military and VA vernacular and culture. The veteran CHWs receive respect and trust from the patients that other members of the team do not.
Data	QIN-QIOs can provide important data to open discussions, build business cases and analyze communitywide patient data.

Lesson Learned	Significance of the Work (the "Why")
Patients and providers appreciate the ReSource Teams	Through interactions with the ReSource Teams, patients express the feeling of being listened to and respected. Complex patients who have been disenfranchised by the health care system are empowered with innovative solutions and educated to verbalize their needs. Providers gain insight into the patient's life outside of the office that directly affects their ability to care for the patient and patient outcomes. The project provides an innovative approach to eliciting better connections to primary care and managing patient medical and social conditions.

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

Lack of resources in the community is the biggest barrier. For example, there is a profound shortage of psychiatrists and licensed addiction counselors in Montana. A large portion of this complex care patient population is struggling with pain management and opioid dependency. Unfortunately, health system barriers prevent the patient from getting to more optimal health. Because many community services are funded by grants or donations, resources may change or be eliminated.

In addition, incentives are not aligned to provide services from a community perspective. Financial incentive, even alternative payment models (APMs), aims financial incentives towards health systems and providers without funding going to community services. When housing is an issue, how can this be funded through a health system reimbursement methodology? What is needed is community level incentives and reimbursement where all the players have equal responsibility for patient outcomes and successes. Accountable Care Communities (ACCs) did not work for rural communities because they did not have the beneficiary base to meet the minimum requirements of that APM.

Providing a Rural ACC option would be a potential solution for our less populated states.

Providing a means to combine federal funding across organizations like HUD, Federal Reserve, Medicare, Medicaid, Department of Labor, etc. would allow for creative solutions addressing medical and social concerns while creating greater governmental efficiencies and innovative pilots. Trying this in a rural setting on a smaller scale could show proof of concept which could later be scaled and spread to urban settings. In short, the solution needs to get beyond the medical providers and stretch across multiple agencies and settings.

Current provider reimbursement is a barrier to shifting provider organizations from crisis and episodic care management to prevention and addressing the impact of social determinants health have on a patient's ability to comply.

Felony convictions from long ago are a barrier. Many patients have drug-related felony convictions, which precludes them from supportive housing, jobs with background checks, college admittance and financial aid, professional licensure in many states and generally the

ability to move forward and out of their circumstances. Without a well-paying job, it is also difficult to obtain health insurance.

The solution is multi-fold: Community organizing with a feedback loop, an intervention team, patient/provider engagement and an education model working together to improve care for these high needs, high-cost patients.

For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?

These conditions greatly affect the patients and providing services to them. Bringing the medical/ social services to go to the patient, in their home setting, mitigates some of effect of these conditions. ReSource Teams order to overcome patient issues like disability functional status or frailty.

Which social risk factors are most important to capture?

Average Age	Males	Females	Don't Own Their Home	Own a Car	Active Drivers
61	30	35	38 (58%)	50 (77%)	38 (58%)

Kalispell ReSource Team Patients ICD-10 Codes to Identify SDoH [n=65]	# of Patients with SDoH	% of Patients with SDoH
Problems related to education and literacy, unspecified	51	78.5%
Problems related to housing and economic circumstances	40	61.5%
Lack of adequate food and safe drinking water	21	32.3%
Insufficient social insurance and welfare support	7	10.8%
Problem related to housing and economic circumstances, unspecified	23	35.4%
Problems related to social environment	39	60.0%
Problems of adjustment to life-cycle transitions	24	36.9%
Problems related to living alone	17	26.2%
Other problems related to primary support group, including family circumstances	37	56.9%
Other stressful life events affecting family and household	23	35.4%
Problem related to primary support group, unspecified	27	41.5%
Problem related to unspecified psychosocial circumstances	51	78.5%

What are the burdens of this data collection on plans, providers, and beneficiaries? · Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

ICD-10 zcodes allow SDoH to be captured and recorded in EHRs because they are a common language across different platforms.

These codes quantify SDoHs and measure the prevalence of various social determinants of health in the community. The high-level codes that the Billings team uses are in the following list:

Persons with potential health hazards related to socioeconomic and psychosocial circumstances:

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

Source http://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65

There has been significant regional and national interest in this program:
The project was featured in a 2017 PBS NewsHour story. In this story, one patient reported her Medicare costs went from $100,000 in a six-month period to less than $6,000 in a seven-month period after she found affordable housing. The Super-Utilizer Pilot Project is also a 2017 American Hospital Association (AHA) Case Study.

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, 28,371 views as of July 20, 2018.

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- Montana State Innovation Model Design, Governor's Council Meeting. March 8, 2016. https://dphhs.mt.gov/Portals/85/Documents/SIM/160308GovernorsCouncilSlides.pdf

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November 16, 2018

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

Thank you for the opportunity to respond to your Request for Information (RFI) regarding provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. NCQA believes that addressing social risk factors is critical to improving health care outcomes. Currently, NCQA addresses and collects information on social risk factors through ongoing research and several of our recognition and accreditation programs. These programs evaluate how providers and health plans serving Medicare beneficiaries work to improve health outcomes for beneficiaries, especially those with social risk factors. For a full list of our accreditation and recognition programs that address social risk factors, please see Table 1.

Current Barriers to Collecting & Addressing Social Risk Factors: NCQA believes that the lack of standardized frameworks and collection of social risk factors is a foundational barrier to tailoring services to patients with social risk factors. This lack of standardization limits what information is collected and analyzed but also serves as a barrier to alternative payment arrangements that could encourage or reward providers for identifying and addressing social risk factors.

Our research has shown wide variation in social risk assessment approaches. We used the National Academy of Medicine (NAM) framework (NASEM 2016) social risk categories to characterize assessment content and compare items. We identified 15 programs assessing patient level social risk. Commonly assessed risk factors included housing, food insecurity, employment, education, financial support, social support, transportation, domestic violence and utilities. Four framework-recommended risk factors were not collected by any programs. This type of variation limits our ability to understand the impact of social risks and the effectiveness of interventions to address these risks.

NCQA is currently engaged in research to evaluate the effect of connecting medical homes and community-based organizations on patient's social risk. Findings from this work, which is funded by the Robert Wood Johnson Foundation, are expected late 2019. We believe that these findings will contribute to promising strategies for improving care for patients with social risk, best practices to referring beneficiaries to social service organizations that can address social risk factors, and lessons learned about providing care for patients with social risk factors.

Opportunities: NCQA believes that the lack of standardized reporting on social risk factors is a foundational barrier to tailoring services to patients with social risk factors. Because of this, NCQA believes that creating standardized, consensus-based value sets of grouped codes will allow providers to document and be reimbursed for addressing social risk factors in a consistent manner across the health care sector.

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NCQA believes that to create robust value sets that will allow for the representation of social risk factors in health care data, the following activities are necessary:

1. Consensus Development of Use Cases. A workgroup should be convened to create a set of use cases. Each use case will describe how the social risk factor will be assessed and addressed, across the continuum of care, making data transfer and comparison possible. Feedback will be obtained from all stakeholders, including employers, consumers, plans, states, and the federal government.
2. Consensus Development of Value Sets. A workgroup should then further refine value sets initially developed by a consultant. The workgroups will solicit public and expert comments to ensure resulting standards meet diverse user needs.
3. Request for New Codes. Concepts without an existing code would then be identified and new codes should be requested from the relevant governing authority.

With a set of standardized codes, NCQA believes there are opportunities to leverage our existing accreditation and recognition programs to collect and analyze social risk data. Having standardized social risk data being collected at the health plan, provider and organizational level could allow for identification of trends in social risk among specific Medicare beneficiary populations. This information, along with promising practices and lessons learned from our ongoing research, could be used to develop targeted interventions to address the social risk factors most prevalent in a given population with the goal of improving health outcomes and decreasing overall healthcare costs.

Thank you again for the opportunity to comment on your request for information. If you have questions, please contact Paul Cotton, Director of Federal Affairs, at (202) 955-5162 or cotton@ncqa.org.

Sincerely,

Michael S. Barr, MD, MBA, MACP, FRCP
Executive Vice President
Quality Measurement & Research Group

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Table 1: NCQA Recognition and Accreditation Programs Addressing Social Risk Factors

Program	Description
Long Term Services and Supports (LTSS)	Through our LTSS program, NCQA assesses organizations ability to coordinate medical, behavioral and social services and help keep people in their preferred setting—often, their home and community. The program evaluates organizations in areas such as managing care transitions, performing person-centered assessments, and planning and managing critical incidents. Our LTSS standards identify and collect social risk factors such as the availability of paid and unpaid caregiver resources and community resources. Additionally, we ask organization to demonstrate that they collect the following information about their patient population: • Identification of characteristics and needs of the population, • An initial assessment of SDoH, • An initial assessment health beliefs and behaviors, • An evaluation of the patient's cultural and linguistic needs, preferences and limitations, • An evaluation of caregiver resources and involvement, and • An evaluation of community resources.
Health Plan Accreditation	Over the last 25 years we've used a rigorous and comprehensive framework to assess health plans through our Health Plan Accreditation Program. As of November 2018, over 1,000 health plans were accredited through this program. NCQA assesses plans practices around collecting social risk factor data through four of our Health Plan Accreditation products: Long Term Services and Supports (LTSS) Standards, Quality Management and Improvement Standards, Network Management Standards and Population Health Management Standards. For example, one of our Population Health Management asks health plans to demonstrate that when entities assess the characteristics of their population social determinants of health are included.
Case Management Accreditation	Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet comprehensive medical, behavioral and social needs of patients and their families while promoting quality, cost-effective outcomes. NCQA accredits Case Management organizations, evaluating how organizations identify social risk factors and/or their collection. For example, one standard requires that organizations conduct an initial assessment health beliefs and behaviors and evaluate the patient's cultural and linguistic needs, preferences and limitations.
Patient Centered Medical Home (PCMH)	NCQA's Patient-Centered Medical Home (PCMH) Recognition program is the most widely adopted PCMH evaluation program in the country. Approximately 13,000 practices (with 67,000 clinicians) are recognized by NCQA. More than 100 payers support NCQA Recognition through financial incentives or coaching. The patient-centered medical home is a model of care that puts patients at the forefront of care. PCMHs build better relationships between patients and their clinical care

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Recognition Program	teams. Research shows that PCMHs improve quality and the patient experience and increase staff satisfaction—while reducing health care costs. Our PCMH Recognition Program has 12 standards that incorporate social risk factors. One standard asks PCMHs to demonstrate that family/social/cultural characteristics, social functioning, and social determinants of health (SDoH) are included in their health assessment. Additionally, our PCMH program assesses how organizations target patients for care management services. PCMHs used the following criteria for targeting care management: • Behavioral health conditions, • High cost/high utilization, • Poorly controlled or complex conditions, • Social determinants of health, and • Referrals by outside organizations, practice staff, patient/family/caregiver.
Managed Behavioral Healthcare Organization (MBHO) Accreditation Program	NCQA believes that managing behavioral health plays a key role in the current emphasis for health care providers to deliver care that incorporates medical, behavioral and social risk factors. This has led to the development of our MBHO Accreditation program which focuses on areas including care coordination to reduce fragmented care and complex case management, a challenge for initiatives where complex cases are common. Our MBHO Accreditation Program identifies and collects social risk factors through the incorporation of LTSS Standards and Quality Management and Improvement Standards. For example, one of the Quality Management and Improvement Standards asks entities to demonstrate that their program structures incorporate methods for identifying and reducing specific health care disparities, provide information, training and tools to staff and practitioners and support culturally competent communication.
Multicultural Health Care Distinction	Our Multicultural Health Care Distinction identifies organizations that excel in providing culturally and linguistically sensitive services, and work to reduce health care disparities. For example, organizations seeking this distinction must demonstrate use of competent translators, mechanisms for providing translations in a timely manner, and that mechanisms for evaluating the quality of translations are in place.

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National Hospice and Palliative Care
Organization

November 16, 2018

MEMORANDUM

To: ASPE Impact Research Study at ASPEImpactStudy@hhs.gov

FROM: Judi Lund Person, MPH, CHC
         Vice President, Regulatory and Compliance
         NHPCO

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

The National Hospice and Palliative Care Organization (NHPCO) is writing to comment on the Request
for Information from plans and providers on approaches to improve care for Medicare beneficiaries with
social risk factors. NHPCO is the largest membership organization representing the entire spectrum of
hospice and palliative care programs and professionals in the United States. We represent over 4,000
hospice locations and more than 57,000 hospice professionals in the United States, caring for the vast
majority of the nation's hospice patients. NHPCO is committed to improving end-of-life care and
expanding access to hospice and palliative care with the goal of creating an environment in which
individuals and families facing serious illness, death, and grief will experience the best that humankind
can offer.

We appreciate the work of the National Academies of Sciences, Engineering, and Medicine (NASEM) to
identify the six practices that achieve high levels of performance for beneficiaries with social risk factors.
The six factors of commitment to health equity, data and measurement, comprehensive needs
assessment, collaborative partnership, care continuity, and engaging patients in their care are all
tenants of the hospice care model. Hospice is considered to be the model for quality, compassionate
care at the end of life. Hospice care involves a team-oriented approach of expert medical care, pain
management, and emotional and spiritual support expressly tailored to the patient's wishes.

Emotional and spiritual support also is extended to the family and loved ones. Generally, this care is
provided in the patient's home or in a home-like setting operated by a hospice program. Medicare,
private health insurance, and Medicaid in almost every state cover hospice care for patients who
meet certain criteria. Today, many hospice care programs have added palliative care as a service line
to reflect the range of care and services they provide, as hospice care and palliative care share the
same core values and philosophies. Defined by the Centers for Medicare and Medicaid Services and
the National Quality Forum in 2008, "*palliative care* means patient and family-centered care that
optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout
the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual

needs and to facilitate patient autonomy, access to information, and choice."[1]

Palliative care extends the principles of hospice care to a broader population that could benefit from receiving this type of care earlier in their illness or disease process. To better serve individuals who have advanced illness or are terminally ill and their families, many hospice programs encourage access to care earlier in the illness or disease process. Health care professionals who specialize in hospice and palliative care work closely with staff, community volunteers, and community resources to address all symptoms of illness, with the aim of promoting comfort and dignity. Therefore, hospices are uniquely poised in communities across the country to transform a health care industry from a medical model to a compassionate holistic care that has accounted for social risk factors since the inception of the benefit.

NHPCO is pleased to answer the questions in the RFI below.

How do plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors?

> Hospices identify beneficiaries with social risk factors and continue to assess them through the comprehensive assessment process and the development of the individualized plan of care. As required by regulation, hospices update the plan of care at least every 15 days through interdisciplinary team meetings or more frequently as needed.

> **Recommendation:** Consider applying the requirement of Title 42 Part 418.54 to all providers, which requires hospices to conduct a comprehensive assessment and regular updates to the individualized plan of care by an interdisciplinary team that takes into account psychosocial, emotional, and spiritual care.

Approaches beyond the NASEM principles and health plan taxonomy that work to improve care for Medicare beneficiaries with social risk factors

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

   Hospices continue to identify ways to reach communities where there are beneficiaries with social risk factors through community meetings, connections with the faith community and a variety of other outreach efforts. The valuable relationships developed with community organizations where services are offered is a key component of the identification process. The development of these relationships over years are critical to the success hospices have had to adapt to the needs of the beneficiary and family. The volunteer network also allows hospices to support those beneficiaries with serious illness and with identified social risk factors to learn about the "wrap around" services and supports available as palliative care and hospice are needed.

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[1] Code of Federal Regulations, § 418.3

2. **Are there especially promising strategies for improving care for patients with social risk?**

    NHPCO believes that successful strategies are those that start with the comprehensive assessment and development of an individualized plan of care. This assessment and plan will ensure that providers and plans can access what is needed for the individual beneficiary and their family to address any and all social risk factors with attention to cultural and linguistic appropriateness[2,3]. The ability to identify specific beneficiary and family needs, provide meals, caregiver respite, or transportation to appointments are all temporary measures to alleviate beneficiary and caregiver strain. Hospices that have developed ties in the community demonstrate their ability to respond to beneficiary needs in the community every day. Although ASPE is focused on service delivery, we also encourage an examination of the broad institutional structures that impact access to health care.[4]

3. **How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?**

    For hospice providers, targeting and providing these services are a part of the holistic approach to care that hospice offers to patients and their families. Case management is a given, as is a comprehensive assessment and individualized plan of care. The cost for targeting social risk factors is a part of that process. The provision of services, such as transportation, meals, and caregiver support, would often be provided by hospice volunteers at little or no cost to the hospice. The reduction in healthcare costs may include no hospital admissions or emergency department visits as the patient and their family is supported in home settings.

4. *What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?*

    Success in referring beneficiaries to social service organizations will involve building and maintaining community relationships so that needs can be identified and services can be provided seamlessly. For patients with serious illness, the care needs can be complex and multi-faceted, so collaboration with other social service agencies is a must and built on trust and experience.

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

    Addressing the most basic needs for beneficiaries and their families is essential before any improvement in health can be assumed. If a beneficiary is food insecure, has transportation issues that will impact the ability to get to doctor appointments or if the caregiver is stressed, the ability to focus on health issues is significantly diminished. A comprehensive assessment, which

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[2] O'Brien, A, et.al. Considering Aboriginal palliative care models: the challenges for mainstream services. Rural and Remote Health 2013; 13: 2339

[3] Culturally and Linguistically Appropriate Services

[4] Reimer-Kirkham S, et. al. Death is a Social Justice Issue: Perspectives on Equity-Informed Palliative Care. Advances in Nursing Services. Vol. 39. No. 4 pp 293-307

includes questions that would indicate risk areas, will be essential for developing the plan and securing the resources to meet these needs.

6. **What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome? For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?**

    The complex needs of the beneficiary with serious illness and their family are specific to each beneficiary, and the social and medical needs and risks are impossible to disentangle. Beneficiaries in need of food, housing, transportation and other social needs are on their own to manage outside the medical system. Although clinicians recognize there is a need to provide social support and stability in order to achieve improved health outcomes, there is no mechanism currently to address non-medical needs. Clinicians often only have time to address the diagnosis, symptoms, and treatment of a serious illness with few resources to address the social risk factors upon discharge from their care. Other members of a beneficiary's care team are needed to provide the necessary wrap-around support for beneficiaries and ensure quality of life for this patient population.

    Hospice is a holistic approach to care that could be replicated from the end-of-life setting to the primary care setting and would be effective in addressing social risk factors. As a part of the comprehensive assessment and care planning process, these factors are addressed in dialogue with the patient and family. For beneficiaries whose stay in hospice is less that the median length of stay of 18 days, it is much more difficult to address with the limited time the beneficiary receives the hospice benefit. Community-based palliative care has started to address some of these needs for beneficiaries with serious illness and could continue to address these risks, although we have found that it may still be too late to have a real impact on quality and total cost of care.

Data

1. **Which social risk factors are most important to capture?**

    There are 3 important social risk factors that hospices have found to be the most informative when developing the individualized plan of care. The socioeconomic position, social relationships and the community context. The socioeconomic position is often collected by other providers and payers, but the information is not consistently shared between providers and plans. The information is critical to understanding the beneficiary and family's level of health literacy and financial strain. The socioeconomic information may also inform the provider of whether the beneficiary and family are able to secure consistent housing, food, medication, and transportation that could impact the priorities in the care plan.

    Another informative social risk factor is the social relationships because they provide an indication of services that may need to be provided by the hospice to address caregiving and custodial needs. Social relationships are important to ensure there is a meaningful support network in the community such as friends, family, faith community, and extended caregivers. Beyond providing the hands-on help in the home, the social relationships (if present) also reduce beneficiary anxiety and fears when interacting with the clinical team.

Finally, the community context is vital to understanding the social risk factors that impact quality and total cost of care. The cultural diversity – beyond race and ethnicity, language, and nativity – cannot be captured by standardized methods of data collection such as surveys. A successful strategy in some communities is to identify and train "lay health care workers" who are trusted leaders in the community. In order to understand the community context and its complexities, qualitative data collection is necessary to capture the local community's belief regarding the elderly, disabled, serious illness, end of life care, and the community's general relationship with local medical institutions and clinicians. Collecting data regarding the community context must use qualitative information gathering modalities (e.g. beneficiary interviews, extended time in local establishments, wind shield observations, and community leader interviews) to obtain meaningful findings. However, we recognize the qualitative data collection methods are costly and time consuming. We recommend holding stakeholder meetings to develop qualitative data collection guides/protocols and identify interoperable IT investment to share the qualitative data across plans and providers.

2. **Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?**

   As noted above, hospices identify beneficiaries with social risk factors and continue to assess them through the comprehensive assessment process and the development of the individualized plan of care. As required by regulation, hospices update the plan of care at least every 15 days through interdisciplinary team meetings or more frequently as needed. The hospice nurse collects the information for the initial and comprehensive assessment. The interdisciplinary team continue to provide insights and feedback to the individualized plan of care and is not restricted to Medicare beneficiaries. The hospice care delivery model applies to all hospice patients in order to reduce confusion and burden on the care team.

3. **Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?**

   Hospices need financial support to implement standardized elements if they are not already collected in their EHR systems. The EHR solutions in the field are not customized for the hospice population; however, hospices have worked with vendors to use the existing platform and diligently negotiate with vendors to collect data elements to comply with Medicare regulations. Although this approach meets the need, hospices are often left out of the business requirement discussions and testing to ensure the EHR system can adapt to collecting social risk factors that are meaningful for the end-of-life population. If standardized data elements are considered for EHR, we urge ASPE to ensure the full spectrum of providers, from primary care providers to hospices, are included in the development of the social risk data elements.

4. **What are barriers to collecting data about social risk? How can these barriers be overcome?**

   A primary barrier for being able to collect the data about social risk factors falls squarely in the area of electronic medical records. Many current electronic medical record systems do not collect data about social risk. Adding new elements to the EMR system is challenged by the

financial capital requirements and is exacerbated by limited interoperability across data systems, particularly when considering a variety of community providers. With the rapid pace of new data collection requirements and software vendor hours needed to customize data systems, the financial burden to ensure the compliance with regulatory requirements, financial requirements, and IT security is high. This is often a factor for providers who may be committed to addressing social risk factors but IT infrastructure and interoperability issues make it impossible.

5. **What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**

   The rapid growth in research and development of advanced technology offers promising opportunities to collect social risk data and specialize treatment options for patients. Information technology security, software development, artificial intelligence, machine learning, telemedicine, mobile health applications, and blockchain technology all offer promising opportunities for personalized care plans that consider health behavior, treatment plans, and multiple social risk factors[5,6,7,8]. However, the abundance of data will not solely address quality and total cost of care nor does it always accurately predict a person's right to choose healthcare options[9,10].

   We urge ASPE and all stakeholders to not lose focus on the human aspect of providing health care. Health care is more than analyzing data and administering treatment. High quality care with high rates of beneficiary satisfaction are the result of care teams that focus on the person, honoring their wishes, and taking the time to build a relationship. If we fall victim to fancy bells and whistles or assume that the data collected gives us the ability to "tell/predict" what the beneficiary should or shouldn't have for services, we may lose sight of protecting that beneficiary choice for their own goals of care. After 40 years of experience, hospice have proven that the foundation to high quality and high satisfaction is person-centered care honoring care goals defined by the beneficiary and family.[11]

We strongly urge Medicare to include social risk factors for beneficiaries in the commitment to person-centered care, especially for beneficiaries with serious illness or at the end of life. Much can be learned from the whole-person approach practiced in hospice, which includes discussions with the beneficiary about goals and values, as well as advance care planning, comprehensive assessment and care planning. NHPCO stands ready to discuss any of our comments on this RFI at any time.

Thank you for the opportunity to comment.

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[5] Will Blockchain Transform Healthcare?
[6] Ten Promising AI applications in Healthcare
[7] AMIA Calls for Federal Alignment of Health Data Privacy Policies
[8] Machine Learning Healthcare Applications - 2018 and Beyond
[9] Why so many people chose the wrong health plan.
[10] 3 reasons Why Comparative Analytic, Predictive Analytics, and NLP Won't Solve Healthcare's Problems
[11] Measuring Patient-Centeredness of Care for Seriously Ill Individuals: Challenges and Opportunities for Accountability Initiatives

November 16, 2018

The Honorable Brenda Destro
Acting Assistant Secretary and Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Submitted electronically via email: ASPEImpactStudy@hhs.gov

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

OCHIN appreciates the opportunity to submit the following comments in response to the RFI IMPACT ACT Research Study. We applaud HHS's efforts as social risk factors, also called social determinants of health, are becoming more relevant in the movement towards value-based care. OCHIN has engaged in our own research on social determinants of health and we are pleased to have the opportunity to share our learnings in this space.

OCHIN is a 501(c)(3) not for profit community-based health information technology (HIT) collaborative based in Portland, Oregon. OCHIN receives support from the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) and is an HRSA-designated Health Center-Controlled Network (HCCN). OCHIN's mission is to pioneer the use of health information technology (HIT) in caring for the medically underserved. As such, OCHIN serves community health centers (CHCs), including Federally Qualified Health Centers (FQHCs), rural and school-based health centers, safety-net providers and public health and correction facilities across the nation. OCHIN's comments come through the lens of members we serve.

OCHIN encourages ASPE to consider:

- Research that specifically supports the connection between social risk factors, also known as, social determinants of health (SDH) collection, training, and education for providers and staff;

- Incorporating and standardizing SDH collection into electronic health records and workflows;

- Use of closed loop referrals for community resources;

- The importance of extending claims data to providers at the point of care for full understanding of cost of care for those treating the most complex patients; and

- Expanding community resources available to help those with risk factors.

OCHIN Comments on the IMPACT ACT Research Study

In one of OCHIN's most recent studies, we piloted several health centers' collection and integration of SDH data into the EHR. [1] Individuals with social risk factors were identified through different methods. OCHIN looked at use of geocoded community level social SDH data from publicly available resources.[2] This could be the median household income in a geographic area, or the unemployment rate of the same area. Using census or similar data can also create a loose outline of possible risk factors of a patient. This is the more common method of collecting social risk data.

OCHIN, as a national leader in SDH collection through the EHR, builds upon geocoded community level data by collecting additional patient data at the time of service using the OCHIN Epic PRAPARE tool. [3] Through our work, we have determined where the bulk of effort is necessary to support safety-net programs for collection of SDH data. First, clinics must utilize standardized EHRs to be able to accommodate the SDH data. Second, clinics require funding and support for training and education to ensure data is properly collected. Third, clinics require associated community resources to improve patient outcomes. Finally, clinics require access to claims data to pair with their clinic data to understand their true cost of care.

I.   Standardized EHRs and SDH Definitions

Currently, EHRs are permitted a certain level of variability between regions and states. This creates clear complications when data is collected on a mass scale. It also effectively limits interoperability between providers on different EHR systems. Competing or unmatched discrete fields between EHRs result in information transferring into notes fields rather than corresponding organized fields. This requires additional provider or administrative time to reorganize relevant data into fields in the second EHR to prevent providers from missing key health information of patients. This presents a real additional burden and potential for human error when EHRs transfer data between systems.

An addition into the workflow like SDH collection has the potential of drastically increasing provider burden. Collection requires training, time, cultural understanding, and relevant referrals. Without a well-established system that can overcome likely and foreseeable complications, collection will only increase provider burnout, cause patients additional stress, and fail to improve health outcomes for the most vulnerable patients.

With all the discussion around capturing SDH or risk factors, the efforts are complicated when no definitions are determined for what social determinants or risk factors are, how they are categorized, or measurements for them.[4] When trying to establish if a patient is in a walkable neighborhood, what measurement is being applied? How is "healthy food" defined? To be able to research the data that is

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[1] Gold R, Bunce A, Cowburn S, et al. Adoption of Social Determinants of Health EHR Tools by Community Health Centers. *Ann Fam Med.* 2018;16(5):399-407.
[2] Bazemore A, Cottrell E, Gold R, et al. "Community vital signs": incorporating geocoded social determinants into electronic records to promote patient and population health. *J Am Med Inform Assoc.* 2016;23(3):407-412.
[3] Gold R, Cottrell E, Bunce A, et al. Developing electronic health record (EHR) strategies related to health center patients' social determinants of health. *J Am Board Fam Med.* 2017;30(4):428-447.
[4] DeVoe J, Bazemore A, Cottrell E, et al. Perspectives in Primary Care: A Conceptual Framework and Path for Integrating Social Determinants of Health Into Primary Care Practice. *Ann Fam Med.* 2016;14(2):104-108.

collected around these factors, having national standards is necessary for simple analysis and then subsequent application.

II.   Training and Education

In OCHIN's study, the incorporation of these new processes into the workflow posed a burden for providers.[5] Despite the training, any large addition to workflows can result in difficulties, causing widespread stress. Providers and staff not only must learn how to navigate the unfamiliar discrete data fields, but they must learn how to appropriately ask the right questions, convey the true purpose of this data collection without frustrating patients, and then connect patients to valuable resources.

Communication training is a large portion of SDH data collection. The lack of trust between the patient and staff or provider, and a suspicion of what the information is to be used for is a substantial barrier. This is not an entirely unfounded concern, as it is unclear how payers will utilize this information in their cost and reimbursement calculations. Additionally, when a parent brings in a child for a cough, and the provider begins asking about the household income, the parent may not understand the purpose, and become agitated by the providers seemingly unconnected interest. Navigating this situation takes compassion and finesse.

This lack of trust exists on all levels, as patients rarely accurately inform providers about the extent of their destructive habits, for example. Not many people disclose the true answers to many of these questions. For those suffering consequences of social risks, shame often tempers the response. Similarly, when there are cultural differences between staff and patients, it can almost equate a language barrier, making accurate collection more complicated. In some cases, there is an actual language barrier.[6]

Extensive training can overcome these barriers. It can help staff and providers ask the right questions, give the proper explanation of how the information is going to be used, and even anticipate cultural differences to learn how to successfully communicate. Given the uniqueness of each clinic, these trainings will need to look different for each, to accommodate differences in population, workflows, and available community resources. These trainings should be ongoing to handle unforeseen communication and data collection issues.

Training and education requires extensive funding. Losing funding and reimbursement continues as one of the largest concerns of community health centers. Risk-based payments structures result in facilities serving more complex patients receiving less funding, as successful outcomes are difficult to obtain. Clinics should not be punished for the complexity of their patients, but instead for their ability to serve all patients, regardless of income or health complexity. The safety net requires a robust network of well-funded clinics to secure this population's health and welfare. SDH data has the capability of

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[5] Laforge K, Gold R, Cottrell E, et al. How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care: An Overview. *J Ambulatory Care Manage.* 2018;41(1):2-14.
[6] Li V, McBurnie M, Simon M, et al. Impact of Social Determinants if Health on Patients with Complex Diabetes Who are Served by National Safety-Net Health Centers. *J Am Board Fam Med.* 2016.29(3):356-370.

conveying the complexity of these patients, which can be integrated into value payment calculations, ensuring safety net clinics are not financially neglected.

III.   Community Resources

It is critical to have robust community resources available for each social determinant/risk identified. Staff and providers have expressed the importance of being able to transfer the patient over to a community service. The referral process allows staff and providers to feel that there is a purpose to asking the questions beyond simply inputting the information into the EHR for later analysis. Having the ability to organize a referral, staff and providers can speak to the value of this data collection with confidence, resulting in more successful communication with the patient, leading to more accurate data collection.

Referrals come in the form of targeted services and outreach. The providers have (or need to have) community resources to refer patients to depending on their specific needs and the care they seek. Referrals in the form of concrete appointments or warm hand offs (to a community resource on site) result in higher rates of follow ups. Closed-loop referrals for these community resources then provide better data to assist clinics in determining the success of their efforts, or how to improve them. This essentially means having the community resource electronically confirm that the patient was seen and the service rendered.

Staff indicated having these resources available is essential to their confidence in identifying and addressing social determinants. However, staff noted it is important to inquire as to whether the patients desire assistance. Many of those who indicated a social determinant declined assistance. For example, during OCHIN's study, only 15% from one clinic and 21% from another requested help. We believe this reflects the need for intense communication training and valuable community resources.

IV.   Clinic and Claims Data

For pilot clinics, it is difficult to determine costs of services when there is no access to claims data. The value of clinic and claims data for providers is not only beneficial for those integrating SDH workflows, but for all of those supporting those within the safety net. Pending changes in reimbursement systems require clinics to be able to analyze their own costs of care to determine how best to increase the value of their services and risk stratify the high-risk population they serve.

This data collection has potential to improve value of care by accounting for some of the difficulties associated with these risk factors. Having awareness of these social risk factors allows providers to change their treatment plans to accommodate issues like housing insecurity, food scarcity, or exposure to violence. With the movement towards providing solutions for patients' social needs, the

support system only works as well as the data collection itself. It is clear more research is required in this area of health management.[7,8]

　　　　We appreciate your consideration of our comments. Please contact Jennifer Stoll at stollj@ochin.org should you have any questions.

Sincerely,

Jennifer Stoll

VP, Government Affairs and Public Relations

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[7] Gottlieb L, Cottrell E, Park B, et al. Advancing Social Prescribing with Implementation Science. *J Am Board Fam Med*. 2018; 31(3): 315-321.

[8] Cottrell E, Gold R, Likumahuwa S, et al. Using Health Information Technology to Bring Social Determinants of Health into Primary Care: A Conceptual Framework to Guide Research. *J Health Care Poor Underserved*. 2018;29(3):949-963

Ochsner™
Health System

November 16, 2018

Submitted Electronically via: ASPEImpactStudy@HHS.gov

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
Immediate Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: **Request for Information: Impact Act Research Study: Provider and Health Plan
        Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors**

Dear Ms. Destro:

On behalf of Ochsner Health System (Ochsner), I am pleased to offer comments in response to
the Request for Information concerning provider and health plan approaches to improve care for
Medicare beneficiaries with social risk factors. We commend leaders of the Department of
Health and Human Services (HHS) for considering emerging information and programs that will
facilitate the important contribution of social services and support to the health of Medicare
beneficiaries.

Overview of Ochsner Health System

Ochsner, one of the nation's leading health systems, is headquartered in New Orleans and
provides a comprehensive range of services through its network of more than 30 owned,
managed, or affiliated hospitals, and 110 total sites of care, including its health centers and
urgent care clinics, which are located throughout Louisiana and Mississippi. Ochsner offers a
wide array of specialized and nationally ranked services with its 3,600 affiliated physicians,
including 1,300 employed OHS physicians practicing in more than 90 specialties and
subspecialties, and 20,000 employees. Each year Ochsner and its hospital and physician partners
serve over 1 million individual patients who come from every state in the nation and more than
60 countries across the world. Finally, Ochsner is one of the nation's largest independent
academic medical centers with nearly 300 full-time residents and fellows participating in 28
ACGME accredited programs and four additional specialty programs; a global medical school in

partnership with The University of Queensland School of Medicine based in Brisbane, Australia; and, programs of biomedical research.

Ochsner's Commitment to Value-Based Payment and Delivery System Reform

OHS maintains a strong commitment to helping lead the nation's shift toward successful implementation of value-based payment models. From a Medicare payment and delivery system reform perspective, Ochsner has developed and is highly committed to the type of integrated health care system many policymakers envision. OHS offers a comprehensive range of services, coordinated systems of patient care, a sophisticated electronic health record, and the geographic reach, scale and clinical capability necessary to manage and improve the health of a large and diverse patient population. We strongly support the movement to adoption of two-sided financial risk models, which incentivize high-quality care and reductions in total cost of care for patients.

We are proud that for six years Ochsner has engaged in the Medicare Shared Savings Program (MSSP) through its Accountable Care Organization (ACO) and successfully has transitioned to the Track 1+ ACO program with approximately 25,000 attributed beneficiaries. In four of the six years it has been in the MSSP program, Ochsner has reduced spending below its benchmark, and system performance results during 2017 will generate a savings of $11,536,235. In addition, Ochsner serves another 35,000 Medicare Advantage enrollees using a full risk capitated payment mechanism, providing the efficient delivery of high quality care to enrollees.

Identifying Beneficiaries with Social Risk Factors

Ochsner is preparing to incorporate social risk factors into its Epic electronic health record in 2019 that will facilitate the use of questionnaires and other tools to determine the need to help beneficiaries address social needs related to:

1. Depression
2. Emotional Distress
3. Food Insecurity
4. Transportation Insecurity
5. Mobility Issues
6. Alcohol Use
7. Tobacco Use
8. Social Connections and Isolation
9. Family Conflict and Instability
10. Financial Strains

We may also develop and utilize additional risk factors and customize our electronic health record to better reflect the needs of patients and beneficiaries.

All of these measures can be tracked over time and presented in multiple formats. They will also be integrated into our data analytics and artificial intelligence programs that can be used for predictive modeling to facilitate proactive assistance and services for beneficiaries with specific needs for social support. We believe this information will increasingly shape the direction of our population health initiatives in the coming year.

Development of Approaches to Address the Needs of Beneficiaries with Social Risk Factors

Ochsner is planning to use the social risk factor information created in 2019 to develop programs and initiatives to support beneficiaries. In addition, we have begun working in collaboration with commercial insurers to address some of these issues where, for example, one major insurer recently created and shared with us a map of the New Orleans and Baton Rouge areas depicting transportation deserts or gaps that we can use to provide targeted transportation services to assist beneficiaries in traveling to physician appointments and receiving other important health care services.
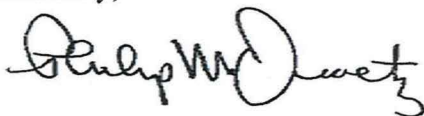
We also support recent policy changes within the Medicare Advantage program that provide health plans with more flexibility to offer beneficiaries transportation, meals, home modifications, and other home health services. We believe this is an important step in the right direction and should be expanded through the use of waivers for other value-based payment programs and accountable care organizations.

Finally, we note that the need for this type of social support for Medicare beneficiaries is extensive and will be challenging to provide on a large scale with existing resources. In response, Ochsner is planning to partner with payers, community agencies and programs, and philanthropic organizations to expand and strengthen these initiatives in a way that will make a meaningful impact on the health of a large number of Medicare beneficiaries.

Conclusion

Once again, on behalf of Ochsner Health System, please accept our thanks for your thoughtful consideration of these comments. Ochsner has a strong commitment to value-based payment models and care for Medicare beneficiaries that encompasses their medical and social needs. We strongly support this important endeavor and would welcome an opportunity to serve as a resource for you and your colleagues in addressing these policy issues and providing better care and quality of life for Medicare beneficiaries.

Sincerely,

Philip M. Oravetz, MD, MPH, MBA
Chief Population Health Officer
Ochsner Health System

From:	Diane Thorson <DThorson@co.ottertail.mn.us>
Sent:	Friday, November 16, 2018 9:36 AM
To:	ASPE SES IMPACT Study (OS/ASPE)
Cc:	Karen S. Martin; Karen S. Martin
Subject:	Social impacts

I would like to comment on your request for information regarding social determinants of health that could be captured in an electronic health record. Public Health and Home Health agencies have been utilizing the Omaha System taxonomy. This taxonomy is based upon 42 problems commonly found for persons living in the community. It is structured into four domains. Environmental, Psychological, Physiological, and Health Behaviors.

The Environmental and Health Behavior Domains capture the type of information that is needed to plan for care needed in the community based upon income, residential, sanitation, nutrition, physical activity, health care supervision, and medication management. Each of these domains allow for capturing specific signs and symptoms that persons report or are observed.

More information can be found at
www.omahasystem.org or www.omahasystemmn.org

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

Program of All-Inclusive Care for the Elderly (PACE)

Contributors:
PACE Association of Michigan
PACE Southeast Michigan
Care Resources
Genesys – PACE of Genesee County
Great Lakes PACE
Huron Valley PACE
Life Circles
PACE Central Michigan
PACE North
PACE of Southwest Michigan
Thome PACE
Senior Care Partners PACE
Senior CommUnity Care of Michigan

Identifying Beneficiaries with Social Risk Factors

Program of All-Inclusive Care for the Elderly (PACE) organizations are unique health plans and care providers, committed to keeping older adults with challenging healthcare conditions in their home, by caring for their medical, physical, and social needs. In order to be eligible for PACE, individuals must be 55 years old or older, live in a PACE service area, meet a nursing facility level of care, and be able to live safely in the community with support from PACE. Approximately 90 percent of PACE participants are dually eligible for Medicare and Medicaid, representing a population with lower socioeconomic status, inequitable access to good health care, and overall greater disease burden than the average Medicare beneficiary.

PACE organizations design and utilize best-practice assessment and intervention methods to address the interrelationship between the complex health conditions and associated social risk factors affecting the overall well-being of participants. Possibly the most important aspect of the PACE approach to identifying and addressing social risk factors is the design and function of the interdisciplinary team (IDT). The IDT includes experts from eleven disciplines who work together to treat not just a symptom, but the entire person. Disciplines include a Day Health Center Manager, Primary Care, Nursing, Physical Therapy, Occupational Therapy, Social Work, Recreational Therapy, Dietary Services, Transportation, Personal Care Services, and Home Care Services.

The assessment process for PACE participants begins prior to enrollment. PACE participants are assessed during the intake process by a nurse and/or social work intake coordinator using a semi-structured interview and various screening measures not only to determine eligibility for PACE, but also to gather robust information to assist in beginning to build a person-centered plan of care. Once eligibility requirements are determined, the participant candidate is transported to the center to be evaluated by the primary care team and other disciplines, depending on the most pertinent presenting issues. This assessment allows the IDT to continue gathering information to add to the plan of care, which is immediately implemented upon enrollment. Once enrolled, new participants are assessed by all disciplines within the first month (initial), then on an ongoing basis every six months (semi- and annual), and also as needed any time there is a change in the participant's status. Each discipline, based on their area of expertise, uses structured and semi-structured best-practice assessment methods to obtain, synthesize, and interpret information that contributes to the building and ongoing review and updating of the individualized, person-centered plans of care.

Pre-enrollment intake assessments are intended to give an overarching summary of a participant's history and current presentation including not only medical issues, but a thorough biopsychosocial review of one's socioeconomic position; race, ethnicity, and community context; gender; social relationships; residential and community context; legal issues (including advanced care planning and health care proxy). Once enrolled, all participants are assigned a social worker. Upon enrollment, at every six month assessment, and as needed, social workers are reviewing these social risk factors and recommending interventions based on identified changes in status and needs. Additionally, social workers assess for and intervene and/or recommend interventions to address caregiver burden. As PACE is not a 24-hour facility, caregivers are looked at as instrumental 'partners' in caring for participants and keeping them independent in their own homes. All other members of the IDT are sensitive to and cognizant of the interrelationship between medical conditions and social risk factors, which includes utilizing assessment tools containing items that address social determinants of health and a multi-disciplined approach to care planning and problem solving (the IDT meets every day).

Individual PACE organizations are always seeking to expand upon the minimum requirements of the traditional PACE model in order to enhance the care delivered to participants. PACE Southeast Michigan (PACE SEMI), Huron Valley PACE, Senior Care Partners PACE, Genesys – PACE of Genesee County, and the other PACE organizations in the state of Michigan have developed and implemented several innovative initiatives and approaches to both identify and address the social risk factors of their participants.

With regard to improving the identification of social risk factors and the impact they have on the overall well-being of participants, PACE SEMI developed and implemented an acuity measure, which seeks to identify participants who are at greater risk for utilization of avoidable ED visits, 30-day hospital readmissions, and nursing home placements. The tool identifies and synthesizes scores based on multiple variables including, 'Disease', 'Behavioral', 'Social', 'Utilization Risk' (history), and 'Care Management Risk' (history). Implemented in early 2018, the tool has already demonstrated promise in identifying and care planning for risk factors that affect overall utilization, including social risk factors. In conjunction with the use of the acuity measure, PACE SEMI has implemented Utilization Management workgroups at each of its centers. The purpose of the groups is to review utilization data and trends in order to enhance the plans of care for participants and subsequently improve the organization's utilization numbers overall. Similarly, Huron Valley PACE has developed and implemented a comprehensive Utilization Management Plan. The utilization management focuses on maintaining high-quality, medically necessary and cost-efficient treatment for all participants. The Utilization Management Plan ensures that participants receive medically necessary and appropriate care at the appropriate time and in the appropriate setting. Huron Valley PACE and Senior Care Partners PACE have both implemented a 5 Star Risk Care Model. This model focuses on participants that are recently discharged from hospitals or skilled nursing homes. Huron Valley PACE's IDT members identify participants for 5 Star list based on their professional oversight and comprehensive assessments. More intensive monitoring and support is provided to those identified participants. Interventions are developed and implemented to minimize or eliminate the risk. When the goal(s) is met, the participant is removed from the 5 Star list.

Approaches to Address the Needs of Beneficiaries with Social Risk Factors

PACE organizations regularly provide 'all-inclusive' care that is designed to address the needs of participants with social risk factors. Services are truly comprehensive and fully integrated and address from top to bottom, all the needs a frail, nursing home eligible older adult requires to live independently in the community. Primary care and nursing providers focus on complex medical needs while social workers actively address all social risk factors that are interwoven and further add to the complexities of participants. Additionally, mobility, strength, and adaptive functioning, which are essential for independent living, are a few of the various focuses of physical and occupational therapy. Dietary services play an important function in addressing not only the nutritional health of participants, but also social factors, as PACE dietary services assist with food insecurity issues through its frozen meals program. Home care, personal care, and transportation ensure that participants have what they need to live safely in a well-kept environment, appropriately manage activities of daily living, and travel safely to and from all appointments, respectively. Recreational therapy works to increase participant socialization and engages participants in meaningful activities inside and outside of the day health center to enhance their overall quality of life. The IDT as a whole, often through information obtained from the social work assessment, addresses caregiver-related issues including burden and burnout. Caregivers are viewed as important partners and services are designed to help them maintain their ability to function in the role (e.g., respite services; caregiver support groups).

PACE SEMI has developed and implemented various strategies to expand upon the traditional PACE model and to better address the social risk factors of its participants. A few of these include: (1) The expansion of 24-hour care coverage; (2) The addition of ancillary services; (3) The integration of Clinical Pharmacy Services with Primary Care; (4) The integration of Behavioral Health Services with Primary Care; (5) The development of a new care model – Participant Care Team (PCT); (6) The addition of Spiritual Care Services; (7) The implementation of End of Life Care; (8) Enhancing assistance with Medicaid redeterminations; (9) The development of a Philanthropic Community Giving Assistance program; and (10) the expansion of community-based partnerships. Taken together, all contribute to furthering the philosophy of providing 'all-inclusive care'.

1. **24-hour Care**: PACE SEMI has developed a process through which its primary care and medical coverage could be expanded and provided more thoroughly through the implementation of a 24-hour/365 day on-call answering and paramedic service. Huron Valley PACE, Senior Care Partners PACE, and other PACE organizations have also begun to utilize contracted community paramedic services.

2. **Ancillary Services**: In addition to traditional primary care, PACE SEMI understands, values, and provides for the needs of older adults, which include services such as dental, vision, audiology, and podiatry.

3. **Clinical Pharmacy Services**: Works closely with primary care to provide additional expertise around the appropriate prescribing, management, and oversight of medication utilization.

4. **Behavioral Health Services**: Works closely with primary care and the rest of the IDT to address the cognitive, behavioral, and emotional well-being of participants. Also addresses issues stemming from the growing number of participants presenting with serious mental illness and substance use disorder diagnoses.

5. **Participant Care Team (PCT)**: A participant-focused, proactive care-management model with a focus on Quality, Collaboration and Streamlined Communication, Assessment and Care Planning, Service Delivery, Prevention, and Optimal Health and Social Outcomes. Each participant is assigned to a core team of 'experts' including a Registered Nurse Case Manager, a Social Worker, a Nurse Practitioner, and a Licensed Practical Nurse.

6. **Spiritual Care Services**: Non-denominational services to address the spiritual, emotional, and relational well-being of participants. Other PACE organizations, including Genesys – PACE of Genesee County, have identified the need and demonstrated the benefits of including spiritual care services through the use of Chaplains and other types of spiritual care providers.

7. **End of Life Care**: Services to ensure quality of care, quality of life, and continuity of care for PACE SEMI participants, as well as, support to family and significant others, during end-of-life phases. The program is made available to participants with limited life expectancy, whose disease is not responsive to curative treatment, those who decline cure related treatment options, as well as, those who though currently stable, have advanced disease and would benefit from the program.

8. **Medicaid Redeterminations**: PACE SEMI recently added full time eligibility specialists to assist in unburdening participants through educating, guiding, and helping to obtain and process required documents during the annual Medicaid redetermination process.

9. **Philanthropic Community Giving Assistance Program**: Aims to raise and donate funds from community donors to keep participants with financial hardships safe and independent in the community by providing for basic and emergency needs when other avenues of assistance have been exhausted.

10. **Community-Based Partnerships**: PACE SEMI continually seeks ways to expand services by contracting with other community-based organizations. Since ensuring the safety of the living environment is critical for the well-being of older adults, PACE SEMI contracts with living facilities with different levels of care and other property management and home health care organizations that provide 24-hour per day staffing and medication management protocols.

Huron Valley PACE has also developed new initiatives and strategies outside of the traditional PACE model to address social risk factors including: (1) Communication "Aphasia" Group; (2) Men's Group; (3) Healthy Aging Group, (4) Wellness Group (focuses on healthy eating); (5) Food Pantry (partnership with local food pantry); (6) Holiday Meal Program (staff financed and supported); (7) Volunteer Program; (8) Intergenerational Program; (9) Positive Approach™ to Care (PAC) (education provided internally and to the community that offers practical and structured approaches for caring for individuals with dementia); and (10) Dance with Me (exercise group for individuals with dementia).

Senior Care Partners PACE expands upon the traditional model of care through (1) the creation of 'Intervention Toolboxes' targeted to meet specific care needs; (2) partnerships with local mental health agencies; (3) including both the participant and their family at care planning sessions as well as ongoing family meetings throughout the care process; (4) a thorough transition of care protocol to allow for seamless transitions throughout the healthcare continuum when needed; and (5) a robust triage process in which homecare and day center staff identify acute needs (clinic and homecare nurses are available for response to immediate needs).

Impact of Approaches on Quality

PACE organizations are required to regularly measure, monitor, and report various quality metrics, some of which include:
- Number of days in the community
- 30-day hospital readmissions
- Emergency department visits
- Falls
- Nursing home placements
- Per member per month cost

Various studies have demonstrated that despite the complex needs of its participants, the PACE care model contributes to the following positive outcomes (Beauchamp, et al., 2008; Eng, et al., 2015; Fretwell, et al., 2015; King et al., 2012; Segelman, et al., 2014):
- Participants stay in the community longer
- Improved access to and continuity of care

- Decreased rates of emergency department visits and hospitalizations
- Better medication adherence
- Significantly decreased isolation/loneliness
- Improved sense of community
- Improved mobility
- Happier, more satisfied participants
- Caregiver support and relief
- Full end-of-life care
- Per member per month cost savings over nursing home placements – this is why Medicare and Medicaid continue to fund the PACE model!

Strategies to Disentangle and Address Social and Medical Risks

As previously stated, members of the IDT have their own unique role in assessing and addressing the needs of participants, while at the same time, all remain sensitive to and cognizant of the interrelationship between social and medical risks. Depending on the discipline, the assessment being completed may dictate a focus that is more on medical risks (e.g., primary care; nursing) or more on social risks (e.g., social work; spiritual care). However, when the disciplines come together as an IDT to care plan for participants, assessment data and recommendations are based on a whole-person approach, as opposed to treating a symptom or single risk factor.

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Response to Request for Information Regarding Social Risk Factors for Health

I am responding from a PACE program (Program of All Inclusive Care for the Elderly) in Rhode Island. The model of PACE, in its name even, is directed to provide all-inclusive care. Our mission is to preserve and sustain the independence of older adults who have significant health needs and wish to remain in the community.

PACE programs are uniquely organized to address social and economic risk factors in the population we serve and have a high percentage of persons with these risk factors. Greater than 90% of our participants are dually eligible and therefore compromised by poverty, including a high percentage of ethnically diverse persons and immigrants, living in lower socio-economic neighborhoods, ~~have~~ high utilization of public assistance programs and often face housing struggles. A majority have low health literacy, a history of poverty, poor nutrition, inconsistent health care, higher than average trauma history, significant behavioral health and substance abuse history and ~~have~~ multiple medical co-morbidities.

As we are a capitated insurer, it is imperative that we address these social/economic issues to reduce risk and improve our participant's health. Here is how we assess and manage these issues.

How does PACE of RI identify beneficiaries with social risk factors:

1. From the first call and through the intake process we are collect~~ing~~ information about income, housing, education, social support systems, occupational history, language, ~~and~~ transportation issues in addition to medical history.   Also collected is information about gender, race, ethnicity, and nativity. This information is collected via in person home visits ~~to the person's home~~ where further observations about the living situation and other risk factors are made and documented.
2. Upon enrollment in the PACE program a social work assessment, including a full social history, ~~by an MSW~~ is conducted by an MSW ~~, again in the participant's home and a full social history is completed.~~ This again reviews the social history, family relationships, current social support systems, financial concerns, housing, language, legal history, trauma history, psychological risk factors, as well as screening for depression and cognitive health. ~~cognition.~~

3. Upon enrollment there is also an assessment by nutrition and the community RN in a home visit which encompasses a nutrition history and current nutritional issues, which may uncover food insecurity issues.

4. Each participant is assigned a SW/RN case management team that remains stable throughout their tenure in the PACE program. This ability to form a relationship with the participant and for the participant to be able to identify persons whom they can trust and share concerns with forms the core of our ability to identify the SES and intervene rapidly when risk factors arise.

5. The unique ability of the PACE program to individualize care for each participant and the depth of the relationship leads the participant to naturally bring their concerns to the 'team' when social and economic problems or crises occur. Unlike in the traditional medical system, there is not duality in the system that would split medical care from assistance with SES issues.

Approaches used to address the needs of beneficiaries with social risk factors:

1. PACE is based on the Interdisciplinary Team approach to provision of care. Therefore, each participant not only has a PCP but also 10 other members of the team who serve to assess, monitor and respond to social risk factors. Team members include CNAs at the day center or in the home, transportation personnel, rehab staff, day center staff, RNs in both the day center and home, social worker and activities staff, all of whom are in frequent communication with and are observing the participant in a 'high touch' pattern. Team meetings occur several times per week when those at most risk are reviewed and plans to intervene can be made.

2. Some of the service provided that address these issues routinely include:
   a. Transportation: to and from medical appts as well as to and from the day center and at times to attend appts to maintain, renew or start public assistance programs
   b. Interpreter services: professionally trained interpreters are provided for all assessments, medical appts, and when needed for other services
   c. Technology: Use of medication machines and personal emergency response systems (e.g. Lifeline)

d. Medication delivered to the home, including OTC medications that are felt necessary by the medical team
e. No co-pays for any service, including medications
f. Coordination of all care
g. Life enrichment activities provided in our day center
h. Rep payee services
i. Social work case managers assist with a large variety of issues including:
    i. Housing
        1. Assist with completing housing applications
        2. Coordination with housing residential service coordinators to address special needs to maintain access (e.g. home care services)/ prevent eviction
        3. Rep payee services to maintain access to housing
        4. Assist with accessing or maintaining SNAP, social security benefits
        5. Assist with pest removal (e.g. HC to deal with bed bugs)
        6. Coordinate with legal services
        7. Assist obtaining bedding and furniture
        8. Write letters for accommodating medical needs (e.g. two-bedroom apts.)

    ii. Food Insecurity
        1. Assist with accessing or maintaining SNAP, social security benefits
        2. Provide MOW
        3. Going to food pantries

    iii. Transport
        1. Assist with accessing RIDE program
        2. Assist with completing bus pass applications
    iv. Utility Needs
        1. Help complete LIHEAP applications
        2. Assist with utility protections letters

3. Connect to free cell phones and reduced-cost landline service

     v. <u>Interpersonal safety</u>
1. Report abuse, fraud, self-neglect
2. Department of Elderly Affairs
3. Alliance for Long-term Care (LTC Ombudsperson program)

    vi. <u>Misc.</u>
1. Working with community victim advocates
2. Answering questions about social security benefits and certifications for medical insurance
3. Take ppts. to local offices to obtain social security cards, birth certificates and State ID
4. Assist with connecting to immigration services
5. Assist with financial issues (debt or managing banking problems)
6. Refer family members to social services
7. Refer clients to services for the blind

3. Community based collaborations we utilize are many and include:
a. State Department of Health
b. State Department of Health and Human Services
c. State Ombudsperson for Long Term Care
d. The Alzheimer's Association
e. Local police and fire departments
f. RI Emergency Management Agency
g. RI Special Needs Registry
h. RI Bar Association and RI Legal Services
i. Housing departments and resident service coordinators in senior housing
j. Department of Elderly Affairs
k. YMCA
l. Local Food Bank and pantries
m. URI Outreach Programs

n. Senior Victim Advocates
o. Assisted Living Facilities
p. RI Geriatric Education Consortium
q. Hospital Ethics Committees
r. SE Asian Community Center

What evidence do you have of these approaches on quality outcomes and the total cost of care?

1. Even though PACE cares for the highest risk dual eligible population in the Medicare pool our hospitalization and re-hospitalization rates match or are lower than the rates for the total Medicare population.
2. Rate of falls and sentinel events are low
3. Rate of pressure ulcers is low and success with difficult wound management is high
4. ER utilization is reduced after enrollment in PACE
5. Though we care for participants who qualify for nursing home care, our long-term care utilization is low.
6. Caregiver stress levels are reduced after the participant enrolls in PACE

How does our plan disentangle beneficiaries' social and medical risks and address each?

1. This is accomplished using the Interdisciplinary Team (IDT) Care Plan meetings where the participant's goals and problems are integrated into a plan of care after assessment by the 11 disciplines.
2. Each discipline is responsible for a thorough assessment at least every six months that informs the team about risks and problems.
3. This is also accomplished through routine team meetings where the IDT can problem solve issues of any type that arise between care plans.
4. This means, for example, that the PCP is not responsible to solve housing or finance issues, and the social worker is free from resolving medical concerns. Yet they remain aware of the total person and can tailor the discipline specific interventions in context of the total social, economic, cognitive, medical picture.

Unique, also, to the PACE program is the ability to be flexible about how the benefit is utilized. We can utilize our resources to assist in many of these socio-economic issues because we have latitude to perform tasks that might be excluded from the standard Medicare benefit. Quite a few times we ask ourselves, 'Could they (the participant) get this service in a regular health plan'? And though the answer is 'no' we often need to provide that service to make the participant successful in their current situation.

In conclusion, the PACE model allows for a holistic approach to health care that is structured to address both medical and socio-economic concerns in development of a plan of care. It is clear from our experience in RI that without this integration, health care would be compromised. The participant seems to benefit in an added way when their fears and anxieties about social and economic concerns are addressed and this allows for a sense of safety and security. When the more basic needs for life such as food, housing, heat, and safety are addressed the participant and family can focus on measures to ensure health. The relationships fostered by this model of care make this partnership possible. The integration afforded by the IDT approach allow each discipline to utilize their skills, training and strengths to address the varied needs of the participant at risk.

From:	Akanbi, Olamide <Olamide.Akanbi@ProMedica.org>
Sent:	Friday, November 16, 2018 4:12 PM
To:	ASPE SES IMPACT Study (OS/ASPE)
Subject:	RE: ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Please find Paramount's responses to the ROI.

- How plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors
  - Our plan uses a claims based predictive modeling analytics database to assist with member stratification and identification.
    This database has a variety of tools to assess risk including; a clinical condition tool, a current health status classification tool, and an opportunity score tool which contains algorithms classifying members into a risk-stratified hierarchy based on individual scores from the following weighted components; Compliance, Cost, Lifestyle, Risk and Utilization. The Lifestyle component evaluates member specific socio-demographic health status, including housing/homelessness/zip code.
  - The assessments utilized within our plan's care management department, as well as the self-reported Health Risk Assessment, address a wide variety of social risk factors including but not limited to race/ethnicity, housing, food insecurity, safety, and personal health habits.

- Approaches plans and providers have used to address the needs of beneficiaries with social risk factors

  - Plan care managers share member centric care plans with primary care providers; requesting input and often collaborating with imbedded office care navigators to enhance member outreach and engagement.
  - Our plan uses a structured transition of care program for identifying and managing at risk members; using collaboration and coordinating care between various settings to assure barriers are identified and needs are addressed to reduce the likelihood of a readmission.
  - Directly connecting members with community resources; using 3-way calling, in person meetings, and/or frequent follow up to assure the member understands next steps and has the ability to make necessary connections.

- Evidence regarding the impact of these approaches on quality outcomes and the total cost of care
  - No update at this time

- Ways in which plans and providers disentangle beneficiaries' social and medical risks and address each
  - Performing accurate and thorough assessment of member in order to identify social risks
  - Prioritization of identified barriers/needs/risks with member input
  - Gap analysis related to needed/ordered services vs services completed; for example, following a hospitalization, were ordered medications, DME and home health services actually put into place for the member? If not, what prevented the completion? Cost, miscommunication, transportation, etc. Identification of this root cause may identify social risks that prevent the member from understanding or being able to address the medical care needed. This method can potentially lead to identifying causes for re-admissions, ED visits, lack of provider follow-up, and medication non-compliance.

- Often times, it is impractical to separate the social and medical risks; noting that someone who is concerned about their next meal or how they will afford to heat their home may not be capable of considering day to day management of a chronic condition, such as monitoring blood sugars or following a specific dietary restriction.

Thank you,

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Our Mission is to improve your health and well-being.

HHS RFI:
IMPACT ACT, 2018

Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

Vidya Ayyr, MPH, Director of Social Impact

Social Risk Factors Report
Parkland Health & Hospital System I Community Health Institute

In 2017, Parkland established the Community Health Institute (CHI) with the primary focus on keeping individuals healthy in the community.

Recognizing the importance of the social determinants of health, the CHI supports research and innovation in primary, secondary and tertiary prevention. The CHI has established an intra-organizational Social Determinants of Health Impact Governance Committee that drives system-wide strategic initiatives to address the social determinants through coordination, adoption of best practices, and innovation.

In addition, the CHI has created an inter-organizational Social Impact Action Team that brings a multi-disciplinary group from local hospitals and community based organizations together to identify common public health issues and impact the social needs of our community.

Our commitment to care, compassion and community.

Acknowledgements

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GERIATRICS

PROGRAM NAME:	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	Geriatrics encompasses 3 primary service areas in the Parkland ambulatory system and operates as an interdisciplinary practice model: 1. There are 6 Geriatrics clinics located in strategic areas across the county to allow access to seniors near their home; each module has social work support and access to RD, PharmD, and BH services 2. When seniors can no longer "get to the clinic" and are "homebound by Medicare definition", we offer Senior HouseCalls- primary medical visit in the patient home; this service includes social work point of entry to screen all aspects of social, environmental, support needs; NP or MD medical visits, LVN for EKG, lab/urine draws, immunization, wound care; chaplain for end of life and bereavement support. Many patients do not meet the skilled criteria for home health care and this service provides their medical visit regardless of skilled need. 3. Seniors in the "most high risk zip codes areas of Dallas as determined by access related demographic data" are served by Parkland Outreach Services program which provides in-home case management support, van transportation to health and social services visits, health education and health outreach/screening.		Services areas utilize standardized operational metrics that range from cost/visit to program cost. Benchmarking is completed regularly with similar service providers. There are costs related to interdisciplinary geriatric practice that are not incurred in many private settings but are well researched and supported in Geriatric practices and in safety net institutions. In 2015, Senior HouseCalls completed a 5 year retrospective IRB review of the program that included outcomes and cost analysis and showed decrease in ED use for clients. ROI has not been recently reviewed in our area but most systems utilize high cost user data to support special services.

	This program is able to provide strategic efforts to underserved communities; examples: in 2017, we increased screenings for Asian seniors through efforts at Buddhist temples; in 2018, a Quality project involved recontacting Latino seniors due to underuse of our van service. 4. As part of these interdisciplinary programs, we offer in home and dementia caregiver education, Senior Companion program referrals in additional to referrals to all community agencies, case management services for persons with neurocognitive impairment, those over age 85 who live alone, and the unbefriended and additional services that range from Advanced care planning classes to Medicare open enrollment information. 5. The overall Department also provides additional outreach and education in the community ranging from providing fall risk screening or flu drives in senior centers to professional education.		
Are social risk data being used to target services or provide outreach? If so, how?	Social risk factors have driven special services in our safety net health system for many years. In our community health primary care clinics, there are multiple demographic and social indicator questions (detailed in another section) that help drive some of the interdisciplinary referrals, but especially social work involvement with patients. Population health reports/registries have allowed staff to more easily locate and focus on individuals with target concerns that range from frequent ED use, recent		

	hospitalization, and certain high risk conditions like CHF. Geriatrics provides additional phone and outreach contacts with many of these individuals and overbooks face to face visits based on need. Health and social mapping has assisted us in targeting outreach efforts ranging from zip codes target areas for mammograms, colorectal cancer screening, access/transportation issues, flu drives,etc The most common department outreach/screening is Fall Prevention activities focusing on individual and environmental screening and education.		
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	Referrals are especially important for our seniors who may have no internet or smart phone access in a world of on line access. Advocating with agencies allowing us to make a direct referral on behalf of the patient as well as allowing us to check in the on the referral status has been significant with this group. Not all agencies can accommodate the volume, variety of languages in our population and we have worked collaboratively to support the translation need. Medicare and Medicaid benefits and eligibility can be difficult to understand and helping individuals understand these processes is important. Senior HouseCalls maintains a log of all patients that helps us remind individuals/families about eligibility renewal dates for QMB, MQMB and Parkland financial screenings; 80% of our Hosuecalls patients have cognitive impairment and remembering and completing deadlines is challenging for them but these financial programs are essential for their service supports in the community.		
What lessons have been learned about providing care for patients with social risk	Flexibilty in scheduling and seeing patients is essential; many caregivers can't miss work and need to bring the senior for care the 1st visit of the day or the last; transport services often bring patients late for		

factors?	appointments and we don't turn away late patients regardless of presentation time.		
	It is difficult to target who will benefit and who will not benefit to focus limited resources. Staff have personal and ethical principles that focus our attempts on serving everyone regardless of situation and there are individuals who we do not impact. We also believe that intentional screening makes a difference in allowing earlier intervention before obvious issues present. Redundant questions by various disciplines also can yield a benefit as some patients will disclose information to their provider and not the social worker to the nurse but not the doctor, etc		
	Barriers include: Language, literacy, technology, home environment, family/social support can complicate many patient situations.		
	Parkland has a robust language translation network but is difficult to complete hour long cognitive assessments in languages like Urdu and Mandarin via a phone line; we are using a low literacy cognitive screen newly validated that assists with low literacy patients. Cost eligibility and reminders are often sent leveraging technology but many of our patients don't have smart phones and have limited minute phones only; we assist as we can with calling agencies while they are at our locations and allowing them direct access to speak to service providers.		
	Home environments with pest infestations have grown over the last 3 years with rise in bed bugs; we partnered with the City of Dallas and provided a Conference on Bed Buds in 2108 for seniors and professionals but there is no inexpensive solution. We inquire about guns in our homes but still enter homes if guns are not visible or unless there is a report of family violence. We attempt to mobilize family support		

	through family conferences but in some cases, the senior is actually the most stable family member, supporting multiple generations financially and physically.		
Which social risk factors are most important to capture?	Geriatrics most frequently uses these factors: 　　　Neurocognitive impairment 　　　Living alone and/or with family history of abuse 　　　Residence/environment 　　　Transportation 　　　Income, but most importantly health insurance-coverage, lack of coverage, drug plans 　　　Social isolation and social support (formal and informal)		
How is data collected about social risk? (by whom, when, what methods, etc…)	In the community health primary care clinics, there are demographic and social indicator questions completed by business (race, ethnicity, address, gender identification, funding, language) and nursing staff (learning assessment and style, suicide and depression risk, domestic violence) at each patient visit that help drive referrals to the interdisciplinary team as well as provide medical providers information for their encounters/patient history. Medical provider, nurse or social worker in Geriatrics also completes standardized, validated assessment tools for cognition, falls, depression, ADLs, IADLs that further help staff involve the team in care and focus our high risk case management supports. Social workers complete detailed assessments of family and living environment, income/health insurance, and informal and formal support networks. Population health reports/registries have allowed staff to more easily locate and focus on individuals with target concerns that range from frequent ED use, recent hospitalization, certain high risk conditions like CHF. Geriatrics provides additional		

	contacts with many of these individuals and overbooks face to face visits based on need. Health and social mapping has assisted us in targeting outreach efforts ranging from zip codes target areas for mammograms, colorectal cancer screening, access/transportation issues, etc		
What do you see as promising future opportunities for improving data collection?	Interdisciplinary and multidisciplinary approach to care for older adults has long been documented in the literature for enhancing outcomes ranging from quality of life to reduced morbidity/placement to decreased cost. Parkland Geriatrics utilizes the multi-discipline models in several ways: we offer "one stop shop" by providing patients access to social work, RD, PharmD the same day as the doctor appointment, thus increasing their compliance with holistic care while decreasing the cost of transportation for multiple appointments. We also offer multi-discipline programs including Dementia education classes/support for caregivers and Advanced care planning options (English and Spanish). Geriatrics utilizes social and health screens targeted at identifying risk, allowing intervention before disability. Example: screen for fall risk and provide the assistive device before the fall; screen for sensory loss and provide vision and hearing so the individual can continue in social activities; use the medication reconciliation process to determine who can't afford to fill medications and who can't remember to take medication as prescribed. This focus on maximizing function and uncovering syndromes is a hallmark of Geriatrics. Screening for cognition, depression, urinary incontinence, medications, falls, hearing, vision, weight is standard and at least yearly in our practices.		

SOCIAL WORK (COC)

PROGRAM NAME: Social Work COC	Program Overview	Patient Data /Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	For all admitted patients, a psychosocial assessment is completed within 24 hours of admission, which assesses each patient's social determinants of health. In addition, if patients are identified by the interdisciplinary team as needing assistance with psychosocial needs, referrals are made to the case management team for assistance. In the primary care and outpatient settings, patients with identified psychosocial needs are referred to the social worker for assistance. Specific programs are listed below.		
How do you work to identify beneficiaries with social risk factors?	Patients with high ER utilization, homelessness, readmitted in 30 days, and/or those with high risk readmission diagnoses are identified via a track-board in the ESD and interventions are provided accordingly. Social workers also intervene with these patients in the primary care and outpatient settings. In addition to psychosocial assessments, all admitted patients are discussed in daily interdisciplinary huddles to assess for medical and social risk factors that would prevent a successful transition to the next level of care.		
How do you address the needs (medical / social) of beneficiaries?	Once risk factors are identified via the ESD track-board, psychosocial assessment, and/or provider referral, patients are referred to social service agencies, lower levels of care, and any other resource as pertinent. Similarly, in the primary care and outpatient settings, patients are referred to social service agencies and other		

	resources as pertinent.		
Are social risk data being used to target services or provide outreach? If so, how?	Multiple programs target services for those identified via social risk data: Transitional Care Unit (TCU): Through risk analysis created by a partner agency, PCCI, patients with high risk for readmissions are enrolled in the TCU program where patients are closely followed to ensure medication compliance, follow-up appointments are scheduled, and psychosocial barriers are addressed. Acute Response Clinics (ARC): These clinics allow patients who were recently discharged from the hospital or seen in the ER receive prompt follow-up appointments. High ESD Utilizer Program: Patients with more than five ESD encounters in thirty days are tracked on a daily basis. Those with greater than ten ESD encounters receive intensive case management via an interdisciplinary committee to address risk factors driving the patient to the hospital for non-emergent care.	Reduced ESD encounters; increased compliance with outpatient appointments; increased medication compliance Decreased readmissions Decreased ESD encounters; stable housing/shelter; compliance with medical and mental health care follow-up	
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	Warm Handoffs A warm handoff must be coordinated by the social worker/case manager between the patient and service organization, to ensure the referral is received by the social service organization and to ensure the patient's compliance with following up on provided referral. Parkland Post-Acute Network Due to social risk factors requiring partnering with social service agencies, Parkland hosts a monthly Parkland Post-Acute Network, with providers across the continuum of care to network and collaborate on resolving system and patient issues. In addition, daily collaboration with community partners is		

	vital for the successful transition of patients into the ambulatory setting.		
What lessons have been learned about providing care for patients with social risk factors?	Patients require warm handoffs across the continuum of care for success and avoid negative cyclical behavior patterns. Increased and continued communication is needed with partner agencies whether a homeless shelter, skilled nursing facility, etc. to ensure patient needs are truly understood as the patient transitions from one setting to another. Patients have complex psychosocial needs with varying levels of support. It is important to engage the patients and leverage all available supports – formal and informal.		
Which social risk factors are most important to capture?	Housing stability, transportation access, medication access, familial/community support, mental health diagnoses and access to care, medical diagnoses and access to care, and food insecurity.		
How is data collected about social risk? (by whom, when, what methods, etc…)	Data reports and tracking are generated from information captured in the Epic electronic medical record. Monthly tracking of patient demographics occurs and includes assessing zip code, patients with established/non-established PCPs, number of homeless patients, number of ESD visits, hospital admissions, and compliance with follow-up appointments.		

VCARE

PROGRAM NAME: VCare	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	Parkland Health and Hospital System, a public safety net entity, serves a large vulnerable population of uninsured patients. Many of these patients with complex health and social needs frequently use the Emergency Department (ED) as a portal of care. The Value Based Care (vCare ©) Program was developed to re-design primary care delivery upstream to improve the wellbeing of the overall patient population while avoiding excessive downstream utilization, including unnecessary ED visits. In launching this program, Parkland had a unique opportunity for integrating care within its Population Health Program since it consists of both an 800 bed tertiary care hospital and a large network of Community Oriented Primary Care (COPC) Clinics.	The initial vCare © patient cohort, enrolled in January 2017, has demonstrated early success with high impact outcomes. This patient cohort (n = 15) had an aggregate baseline of 1.68 ED visits per patient per month ratio (June – December 2016). By May 2017, significant improvement in this cohort was demonstrated with 0.67 ED visits per patient per month ratio - a reduction of 1.01. To date, more than 96 patients are enrolled in vCare ©. From an individual perspective, one vCare © patient, who had nearly 100 ED Visits within one calendar year, consistently has had "0" ED visits per month, is gainfully employed, renting his own apartment and regularly keeping his primary care visits. Now that vCare © has demonstrated "proof of concept",	Please see Case exemplar in Attached CMS Powerpoint – Slide # 9 and 10 and in Attached Second CMS Powerpoint Slide#9.

		Parkland is re-engineering its entire Population Health Program by designing multidisciplinary team-oriented personalized care across all of its COPC sites.	
How do you work to identify beneficiaries with social risk factors?	Social Worker Conducts an Intake Social Determinants of Health Risk Assessment.		
How do you address the needs (medical / social) of beneficiaries?	The Multidisciplinary vCare Team consists of a primary care provider and registered nurse who address the health care needs of the vCare patient while the social worker addresses the health care related social needs of the patient. Patient progress/status is reviewed jointly by the multidisciplinary team on a weekly basis.		
Are social risk data being used to target services or provide outreach? If so, how?	Yes, As Stated Above.		
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?			The expanded vCare program includes use of standardized health-care related social needs risk assessment tools for the purpose of identifying and stratifying levels of risk, titrating individualized applications of evidence based practice

			guidelines based on risk stratification, and monitoring remediation of risk within and across patients.
What lessons have been learned about providing care for patients with social risk factors?	Parkland Health and Hospital System, a public safety net entity, serves a large vulnerable population of uninsured patients. Many of these patients with complex health and social needs frequently use Emergency Departments (ED's) as portals of care. In addressing Parkland's mission for improving health and wellbeing within the community, Parkland leaders across several departments embarked on initiatives providing "Better, Smarter, Healthier" care for High ED Utilizer patients resulting in reduction in unnecessary ED visits and admissions at the acute care point of service. These groups included Complex Care within the ED, Value-Based Care (vCare©) in the primary care clinics and Faith Health Initiative in the community. Using a Care Optimization and Standardization Initiative (COSI) performance improvement methodology, programmatic accomplishments and individualized patient-centered care improvements were initially achieved. As these multidisciplinary teams proceeded to advance, they recognized opportunities to strengthen *intra-organizational collaboration* for intensifying each program's uniquely distinct approaches while *collectively leveraging* resources to further *impact* health and wellbeing in the community. This inspired inauguration of the *High ED Utilizer Affinity Group* including the original High ED Utilizer groups along with Parkland's Behavioral Health		

	Department and Community Health Institute. The Affinity group meets monthly engaging in dynamic bi-directional collaboration. As the Affinity group's progress accelerated, leaders further recognized opportunities for advancing *inter-organizational collaboration* with other healthcare systems and community based organizations (CBO's) to *collectively leverage inter-organizational* resources within an integrated network of health and social services for the highly vulnerable across Dallas County. This *Collaborative Coalition* encompasses dynamic navigation involving health service delivery across multiple healthcare organizations as well as CBO coordination addressing homelessness, food insecurity, and post-incarceration community re-entry. The *Coalition* is launching innovative multi-faceted initiatives expected to significantly *impact community health* upstream advancing population health where it begins rather than waiting for downstream detection of disease and chronic illness.		
Which social risk factors are most important to capture?	Early pilot participation in the CMS Accountable Health Communities (AHC) Grant using the CMS developed Health Care Related Social Needs Screening Tool has demonstrated the top three social risk factors for the Parkland Patient Population to include: food insecurity, transportation needs, and housing.		
How is data collected about social risk? (by whom, when, what methods, etc…)	**QUANTITATIVE** Using pre-test/post-test methods, <u>Healthcare Driven Measures</u> are subjected to analysis across organizations participating in this *Coalition* including: Access to Care, Same Day Clinic Visits, ED Visits,		

Observation Stays, Hospital Admissions, Hospital Readmissions, Patient/Family Experience, Total Cost of Care.

In addition to considering the Healthcare Driven Measures identified above, a normalized ratio based on consideration of "Opportunity" ED Visits was developed in Parkland's vCare© Program and has been favorably reviewed by CMS in June 2017. This ED Visits Per Patient Per Month Ratio will be utilized as a program evaluation outcome measure across Parkland High ED Utilizer Affinity Group participants and will be shared with all participating *Coalition* healthcare systems for consideration.

Multi-organizational data regarding volumes and characteristics of ED visits will be analyzed across all participating *Coalition* healthcare organizations using a Regional Master Patient Index (REMPI) Limited Data Set available from the Dallas Fort Worth Hospital Council (DFWHC) Data Registry.

Given that the ultimate purpose of this Coalition is to improve the health and wellbeing of the Dallas County community, the Regional Health Partnership 9 Community Needs Assessment (CNA) (2018) is being utilized for baseline assessment of the community's overall health with longitudinal tracking on an annual basis to determine improvements in measures within CNA Strategic Priority domains: Capacity/ Access, Chronic Disease, Care Coordination/Preventive Care (including ED Utilization), Behavioral Health (including Mental Health and Substance Use Disorder) and Infant/Maternal Health.

QUALITATIVE

In addition to quantitative data, consideration of individual case studies/exemplars will provide rich

contextual information as well as most importantly furnish insight into the "voice of the patient". These case exemplars will be studied at the individual level as well as subjected to further qualitative analyses using Grounded Theory Method of Content Analysis to identify common categories and themes to further inform development of patient-centered interventions.

OUTCOMES

Quantitative Analysis of Healthcare Driven Measures is being conducted using pre-test/post-test methods to demonstrate collective impact of Parkland's High ED Utilizer Affinity Group including Complex Care, vCare© and Faith Health Initiative. Parkland is proposing multi-organizational analysis of this data among participating *Coalition* members.

The initial vCare © patient cohort, enrolled in January 2017, demonstrated proven success with high impact outcomes. This patient cohort (n = 15) had an aggregate baseline of 1.68 ED Visits Per Patient Per Month Ratio (June – December 2016).   By May 2017, significant improvement in this cohort was demonstrated with 0.67 ED Visits Per Patient Per Month Ratio – a statistically significant reduction of 1.01. To date, more than 96 patients have enrolled in vCare ©. Data for the second vCare© patient cohort (April – August 2017) is undergoing analysis. Preliminary results indicate an even lower baseline pre-intervention ED Visits Per Patient Per Month Ratio with significant reduction in the post-intervention ratio.

Preliminary results of REMPI DFWHC Registry data indicate that a discrete sub-population of patients (n

	= 80) are the Highest ED Utilizers (>30 ED Visits During 12 Months) receiving ED services across two to three of DFWHC healthcare organizations. This recent information provides even greater impetus for advancement of the *Coalition*. Although preliminary results are quite compelling, further data sharing data across healthcare organizations awaits finalization of a Memorandum of Understanding. Comprehensive analysis of Regional Health Partnership 9 Community Needs Assessment (CNA) (2018) is being conducted. Early results are profound indicating that excessive alcohol consumption occurred in 17 percent of the total adult population in Dallas County in 2018. Detailed CNA analysis is being provided as the *Coalition's* baseline measurement. Qualitative Analysis of individual and group level patient case study data is being conducted for both baseline and post-intervention analysis.		
What do you see as promising future opportunities for improving data collection?	Integrated Comprehensive Health and Social Care Electronic Record such as that which is being developed by EPIC.		

ACUTE RESPONSE CLINIC (ARC)

PROGRAM NAME:	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	The acute response clinics (ARC) provide timely acute care access for patients who are being discharged from the Emergency Department (ED), Urgent Care-ED and Inpatient units; who will otherwise be at risk for readmission, or cycling back through the ED.	FY2017 – 3,345 Medicare patients were seen by the ARCs	
How do you work to identify beneficiaries with social risk factors?	The ARC nurses are responsible for completing the screening for suicidal risk, violence, and psychosocial components at each visit.		
How do you address the needs (medical / social) of beneficiaries?	The ARC physicians provide the medical care needs and when risk factors are identified the patients are referred to the social workers for assistance.		
Are social risk data being used to target services or provide outreach? If so, how?	Through risk analysis created by a partner agency, PCCI, patients with high risk for readmissions are enrolled in the Transitional Care Unit (TCU) program where patients are closely followed to ensure medication compliance, follow-up appointments are scheduled, and psychosocial barriers are addressed.		
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	The social workers complete an assessment and based on the identified needs they make the appropriate referrals to social service organizations.		
What lessons have been learned about providing care for patients with social risk factors?	Patients have complex needs with different levels of support and this affects their ability to keep appointments and continue with follow up care.		
Which social risk factors are most important to capture?	Transportation access, medication access, housing needs, food insecurity and financial resources.		
How is data collected about social risk? (by	The data is being captured in our Electronic		

whom, when, what methods, etc....)	Medical Record (EMR) by our clinical and social work teams.		
What do you see as promising future opportunities for improving data collection?	The development of an electronic process in the EMR that also captures the social risk factors.		

BEHAVIORAL HEALTH & PSYCHIATRY

PROGRAM NAME:	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	We provide a Psychiatry ER, Extended Psychiatry Observation, Psych Specialty Outpatient Clinic, Integrated Psychiatry, Consult Liaison Psychiatry Services, Psychiatry Inpatient Unit, and a RIGHT Care team. and identify those social risk factors upon assessment.		
How do you work to identify beneficiaries with social risk factors?	We have an expansive number of social workers in behavioral health departments assessing patients for these social risks all across Parkland.		
How do you address the needs (medical / social) of beneficiaries?	We connect them with resources to aid with food, prescriptions, transportation, counseling, social support resources. It is a standard of care to provide care coordination.		
Are social risk data being used to target services or provide outreach? If so, how?	PCCI information		
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	In addition to our social workers, PCCI developed a technology to assist patients in connecting to resources local to their communities. Another best practice is the RIGHT Care Team. We address patients mental and social needs in the community. LOOP BACK		

	ANALYTICS		
What lessons have been learned about providing care for patients with social risk factors?	Patients with mental health issues need housing, stable support, access to medication, food and transportation.		
Which social risk factors are most important to capture?	Housing, support, financial stability, transportation		
How is data collected about social risk? (by whom, when, what methods, etc…)	Pulled from the EHR		
What do you see as promising future opportunities for improving data collection?			

FAITH-HEALTH

PROGRAM NAME:	Program Overview	Patient Data / Outcome	Costs / ROI
How is your program serving Medicare beneficiaries, especially those with social risk factors?	Parkland's Faith Health Program is the convener and member of the DFW Faith Health Collaborative, a collaboration between the four: Baylor, Methodist and Children's. Although,	As of 2018, we began companioning patient with trained volunteers as Faith Health Community Caregivers, which are volunteers from local faith communities. It is our goal to evaluate these metrics in this fiscal year.	We will analyze the ROI in this fiscal year and determine the impact and effectiveness of our Faith Health Program.
How do you work to identify beneficiaries with social risk factors?	Currently, we have started talks with Pieces Iris to work with the Accountable Healthy Communities Grant. This program provides our partnered faith communities to document and track social risk factors, and work with the patient to eliminate or mitigate the social risk. We also utilize a Faith Health Caregiver Monthly Report, maintain monthly continuing education where we discuss patient barriers and are available to our partners 365 days of the year.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
How do you address the needs (medical / social) of beneficiaries?	The needs are addressed by way of the DFW Faith Health Collaborative. We are four major hospitals and over 80 faith based community communities with far reaching resources. When a patient has a	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.

	need we reach into the resources of the hospital and faith communities.		
Are social risk data being used to target services or provide outreach? If so, how?	Yes. Our Faith Health Community Caregivers encounter social risk daily, and provide navigation and accompanying to those services if/when needed.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?	We have found the best practices to refer patients to social services organization is through companionship. The patient population we service are highly isolated and lonely, while managing	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
What lessons have been learned about providing care for patients with social risk factors?	We have learned Dallas County has a lacks solutions around homelessness, income equality and affordable housing.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
Which social risk factors are most important to capture?	Faith Health realizes the most important social risk factors to capture are: 1) Isolation/Loneliness 2) Housing arrangements 3) Income 4) Literacy Level 5) Food Access	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
How is data collected about social risk? (by whom, when, what methods, etc…)	Data is collected about social risk with our Faith Health Caregiver Monthly Report.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.
What do you see as promising future opportunities for improving data collection?	In the near future, we will utilize the Iris platform and EPIC.	It is our goal to evaluate these metrics in this fiscal year.	It is our goal to evaluate these metrics in this fiscal year.

REQUEST FOR INFORMATION:

IMPACT ACT Research Study: Provider and health plan approaches to improve care for

Medicare beneficiaries with social risk factors

Section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 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. The first component of the required work, a 2016 Report to Congress,2 focused on socioeconomic information currently available in Medicare data.

This request for information is part of the second component, which expands the analyses by using non Medicare datasets to quantify SES, and will be completed no later than October 2019 as required by the authorizing legislation. Following up on ASPE's first Report to Congress, **HHS is interested in how plans and providers serving Medicare beneficiaries:**

- **Identify beneficiaries with social risk factors**
- **Approaches plans and providers have used to address the needs of beneficiaries with social risk factors**
- **Evidence regarding the impact of these approaches on quality outcomes and the total cost of care**
- **Disentangle beneficiaries' social and medical risks and address each**

There is growing recognition that social risk factors – such as income, education, race and ethnicity, employment, housing, food, community resources, and social support – play a major role in health. Despite ongoing efforts, significant gaps remain in health and in life expectancy based on income, race, ethnicity, and community environment.

At the same time, the health care system is increasingly moving towards higher levels of provider accountability for the quality, outcomes, and costs of care. Value-based or alternative payment models, which tie payment to the quality and efficiency of health care delivered, are in place in nearly all Medicare settings, including in hospitals, outpatient settings, and post-acute facilities. In many ways, beneficiaries with social risk factors may benefit the most from value-based purchasing programs and other delivery system reform efforts, since improved care coordination and provider cooperation will be of the highest utility to the most complex beneficiaries with the most care needs.

In the 2018 Medicare payment rules, CMS solicited comments on when and how the Medicare program should account for social risk in quality measures and programs.

The definition of social risk provided by the National Academies of Science, Engineering, and Medicine (NASEM) under contract to ASPE is being used for this request.

These social risk factors include:

1. Socioeconomic position (income, wealth, insurance status, education, occupation, food insecurity)
2. Race, ethnicity, and community context (race and ethnicity, language, nativity, acculturation)
3. Gender (gender identity, sexual orientation)
4. Social relationships (marital/partnership status, living alone, social support)
5. Residential and community context (physical environment, housing, and social environment)

In the first Report to Congress, ASPE found that beneficiaries with social risk factors were also medically complex. As part of the second Report to Congress, ASPE is looking at additional measures of medical risk, including disability, functional status, and frailty, and the interaction of medical and social risk.

Overall Question

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

Delivery of services

HHS is interested in understanding services targeted to Medicare beneficiaries with social risk factors. The 2016 Report to Congress found that providers that disproportionately cared for beneficiaries with social risk factors tended to perform worse than their peers on quality measures. However, in every setting, be it hospital, health plan, ACO, physician group, or facility, there were some providers that served a high proportion of beneficiaries with social risk factors who achieved high levels of performance.

To better understand these findings, ASPE asked the NASEM to identify best practices of high performing hospitals, health plans, and other providers that serve disproportionately higher shares of socioeconomically disadvantaged populations and compare those best practices to practices of low performing providers serving similar patient populations. The NASEM determined that the following six practices show promise for achieving high levels of performance for beneficiaries with social risk factors:

1. Commitment to health equity: Value and promote health equity and hold yourself accountable
2. Data and measurement: Understand your population's health, risk factors, and patterns of care
3. Comprehensive needs assessment: Identify, anticipate, and respond to clinical and social needs
4. Collaborative partnerships: Collaborate within and across provider teams and service sectors to deliver care
5. Care continuity: Plan care and care transitions to prepare for patients' changing clinical and social needs
6. Engaging patients in their care: Design individualized care to promote the health of individuals in the community setting

ASPE also contracted with RAND to conduct interviews and case studies with Medicare Advantage (MA) plans to understand how the plans address dually enrolled beneficiaries social and health needs. High performing, high-dual and special needs plans (SNP) were found to implement multi-pronged

approaches and strategies. Through this work, we developed a taxonomy for MA plans addressing social needs that includes strategies and interventions that focus on:

1. Needs identification and targeting
2. Care management and coordination
3. Directly addressing social needs
4. Integration of Medicare and Medicaid

HHS is requesting information on how providers and health plans are implementing these approaches and principles for Medicare beneficiaries with social risk factors. HHS is also interested in approaches beyond the NASEM principles and health plan taxonomy that work to improve care for Medicare 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?**
- **Are there especially promising strategies for improving care for patients with social risk?**
- **How are costs for targeting and providing those services evaluated?   What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?**
- **What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?**
- **What lessons have been learned about providing care for patients with social risk factors?**
- **What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?**
- **For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?**

Data

As part of the second Report to Congress, HHS is requesting information on how providers and health plans capture beneficiaries' social risk. The Medicare program captures limited information on beneficiary social risk, but there is potential for additional information to be collected by health plans or providers at the point of care. In particular, the NASEM identified electronic health records (EHRs) as a potential source of social risk data.7 In earlier work, a separate NASEM committee recommended that certain social and behavioral health domains be collected in EHRs.8

ASPE also contracted with NORC to conduct a qualitative study of EHR vendors' incorporation of social determinants of health in EHRs.9 Among the 6 vendors interviewed, all were incorporating social determinants of health into their systems in response to client demand, although the type of product varied greatly across the vendors.

HHS is requesting information on how providers and health plans are collecting and using data on Medicare beneficiaries' social risk factors:

- **Which social risk factors are most important to capture?**
- **Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?**
- **Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?**
- **What are barriers to collecting data about social risk? How can these barriers be overcome?**
- **What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**

Submitting Comments

Comments will be received until November 16, 2018.

Submit electronic comments via email to ASPEImpactStudy@hhs.gov

Note to commenters

This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant or cooperative agreement award. Further, HHS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement or program, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that HHS will not respond to questions about the policy issues raised in this RFI. HHS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses. Responses to this RFI are not offers and cannot be accepted by the Government to form a binding contract. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur costs for which payment would be required or sought. All submissions become Government property.

The Parkland Center for Clinical Innovation (PCCI) is an early stage data and technology research and development organization that is an affiliate of Parkland Health & Hospital System in Dallas ("Parkland"). Formed in 2016, PCCI consists of a highly experienced team of data scientists and physicians working together to address pressing health and healthcare issues facing hospitals, clinicians, patients, and communities. PCCI's work centers around three main areas of focus: 1) building and deploying predictive models to proactively identify high-impact patients; 2) establishing *Connected Communities of Care* by linking healthcare providers and community-based social service providers together via a state-of-the-art information exchange platform; and 3) developing and deploying approaches to encourage/enhance patient engagement. Because of the nature of this work and the fact that PCCI is a Bridge Organization participating in CMS's Accountable Health Communities (AHC) model, PCCI is intimately familiar with the challenges and opportunities of collecting and using measures of social determinants of health (SDOH) in research and development initiatives. We bring to this discussion a global perspective of how others in the healthcare industry are using SDOH as well as how community-based social service organizations, large and small, are viewing the heightened focus on SDOH. With this perspective, we provide the answers below to the questions posed in this Request for Information.

Q. Are social risk data being used to target services or provide outreach? If so, how?

Yes. PCCI has used three approaches to gather, analyze, and target outreach.

1. **Accountable Health Communities (AHC): Determination of Target Zip codes for Model Demonstration**

The AHC work is designed to improve the health of our community and reduce the cost and utilization of unnecessary care. Over four years, 75,000 beneficiaries must be screened and 3,000 navigated annually. We currently have four large health systems participating and over one hundred community-based service providers in the network and we will be adding another two hundred over the next few years.

We have used a variety of data sources to discern the best estimates of the population in the geographic area to meet the key milestones specified in the AHC program. These include:: 1) data provided by our health system and community-based service provider partners; 2) de-identified data from the Dallas Fort Worth Hospital Council (DFWHC); 3) census data; and 4) social sector data from our previous and existing collaborative projects.

PCCI identified the type and concentration of social risk needs in the areas with high penetration rates of AHC eligible beneficiaries through analysis of data and information gleaned from the following sources:
- Community Needs Assessment conducted for Dallas County
- Surveys from patients, residents, and health and social service providers in the Dallas metropolitan area
- A report from the Center for Nonprofit Management and the Communities Foundation of Texas. Seventeen of the 84 zip codes within Dallas County covered by the AHC program

include the zip codes with the highest concentrations of beneficiaries with unmet social needs.

2. Community Wide Data Initiative

In a collaboration with the Dallas branch of Texas Health and Human Services Commission, the University of Texas, Dallas – Institute for Urban Policy Research, and the Dallas Fort-Worth Hospital Council Foundation, we have begun ingesting diverse sources of social risk data into our cognitive computing platform to provide community and city leaders with real time data-driven insights to alleviate poverty and to improve the quality of life and the environment in the community. The data assets we are using to drive dynamic heat maps of social needs are:

- American Community Survey- Census Data
- 311 Service Requests
- 911 Crime and Safety reports
- Area Deprivation Index
- Housing and Transportation datasets
- Kindergarten readiness and school performance
- Dallas Central Appraisal District financial reports
- Food Insecurity- Feeding America reports
- Childcare availability reports
- Dallas Fort-Worth Hospital Council healthcare data sets

3. Community Needs Assessment

We also recently completed a comprehensive Community Needs Assessment with an emphasis on poverty for Dallas County. The sources of information included:

- Existing secondary databases/historical data
- Surveys of residents
- Surveys of service providers from five sectors
- Interviews with elected officials and other community leaders
- Focus group sessions with community residents

Q. How are beneficiaries with social risk factors identified?

PCCI has designed a standard operating protocol, currently in the pilot phase, to identify Medicare and Medicaid beneficiaries with health-related social needs presenting for health care at Dallas major providers (includes large volume ERs, Children's Hospital and a Medicaid mental health provider) serving community dwellers living in high social need areas defined previously in answer to question one. The anchoring tool for social risk is the CMS field-tested and validated Health-Related Social Needs (HRSN) Screening Tool.

Q. Are there especially promising strategies for improving care for patients with social risk?

PCCI's *Connected Communities of Care* (*CCC*) platform is designed to accomplish the critical alignment of providers and community-based social service organizations across a community to improve the care of patients. Designed and first implemented in Dallas County, Texas in 2014, the *CCC* platform serves as a comprehensive foundation for partnership between a community's clinical and social sectors and leverages a cloud-based information exchange/case management software platform providing seamless connection, communication, and coordination between healthcare providers and a wide array of community-based social service organizations, criminal justice entities, and various other community organizations, including non-collegiate educational systems.

Success of a *CCC* depends upon a sustainable technology infrastructure that supports information sharing among the providers and other community partners. PCCI's *CCC* technology partner is Pieces Technologies, Inc. ("Pieces"). Pieces Iris™ software is the cornerstone powering PCCI's *CCC* platform. Similar to an electronic medical record, the Pieces Iris™ software and applications capture, securely store, and appropriately provide access to vital information about individuals and service organization clients in a way that supports the unique, underlying workflows. If all participating organizations are on the *CCC* platform powered by Pieces Iris™, then they all are connected through the innovative closed loop referral system and are thus able to communicate and share information with each other. For organizations on a different platform, Pieces Iris™ offers connectivity through industry standard APIs and HL7 data feeds. PCCI's *Connected Communities of Care* not only connects community-based service providers via a secure, state-of-the–art two-way messaging platform, but *CCC* wraps around the technology a wealth of field-proven and leading clinical and social workflows to make services and coordination of community populations more effective and cost-efficient.

The *CCC* platform facilitates the secure exchange of critical case management information at various steps in the process, such as when an individual first seeks food assistance or requests emergency housing. The *CCC* lays the groundwork for an innovative system of assistance and broader social service delivery and creates a longitudinal record of care via referral tracking and increasing access to a broad array of services to improve individual well-being and community health. Ultimately, the *CCC* streamlines assistance efforts, reduces repeat crises and emergency funding requests, helps address disparities of care, and improves the health, safety, and well-being of the most vulnerable community residents.

Over a 2 ½ year period at Parkland Memorial Hospital, use of the *CCC* platform has resulted in savings of approximately $12 million, driven by a 40% reduction in hospitalizations and a 36% reduction in ED visits, with over 100 community-based social service organizations and over

251,000 unique individuals participating. During this same timeframe, more than 800,000 services were provided, including housing, job training, and food assistance. The current goal of the *CCC* is 300 participating community-based social service organizations

CASE STUDY ONE: Decreasing Socially Driven Readmission with Analytics Informed Transitions of Care Program

PCCI developed real time predictive models to risk stratify patients for 30-day readmission rates. The pivotal finding was that social risk factors contributed strongly to the risk of readmission. For example, patients with multiple home addresses in the last year were statistically more likely to be readmitted within 30 days (p<.05) than individuals with a single, stable home address. Consequently, a Transitional Care Unit was created to proactively prepare individuals at risk upon discharge for successful transition into the community. Case managers received breakdown scores based on common, chronic, high-need conditions, including CHF, AMI, pneumonia, and diabetes. Nurse educators and community navigators then contacted community service providers for warm handoffs post-discharge and continued to follow patients for a specific period of time. PCCI is currently analyzing and evaluating the results of the initiative.

CASE STUDY TWO: Data Across Sectors for Health-Community Chronic Disease support for food insecure diabetic and/or hypertensive patients

PCCI analyzed de-identified data from the *CCC* to determine the number of patients, over a defined time period, who received healthcare from Parkland Memorial Hospital and one of the food pantry participants in this collaborative. In 2014, 4,627 patients used services from both institutions. Of these, 2,700 (58%) patients had two or more ED visits to Parkland Memorial Hospital in 2014, while also receiving services to address unmet social needs provided by the food pantry.

This data informed a pilot project to decrease adverse health events among food insecure and under-resourced populations with hypertension or diabetes in the Dallas metropolitan area. The intervention was designed to improve multi-sector care coordination through data sharing and collaboration between Parkland and hunger relief agencies that regularly serve this population. The *CCC* platform (including its associated workflows) was leveraged to: 1) identify Parkland patients with diabetes and/or hypertension who regularly attend three participating food pantries in Dallas county; 2) provide the food pantries with a single-page health information summary sheet that will inform food bank case managers of any dietary needs of patients, and list current medications and upcoming appointments scheduled at Parkland Memorial Hospital and its affiliated primary care clinics; 3) train the food bank staff to guide patients' food choices based on their current health conditions, remind patients of upcoming appointments, and assess prescription pick-up status and adherence; and 4) provide relevant information back to Parkland case managers, including prescription status, types of food items picked up, and number of times patients visited the food bank in the prior month.

The pilot program resulted in an 8% drop in ED visits vs a 46% increase in the non-intervention group. Ninety percent of program participants agreed or strongly agreed that the program made

them more aware of their illness, better able to manage it, and more likely to keep clinic appointments, fill prescriptions, and adhere to medication orders.

Q. How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?

We are current analyzing cost and utilization data from our AHC model along with other *CCC* Dallas-based initiatives to address the aforementioned questions.

Q. What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

Several months of pilot trials using the HSRN CMS tool and referral workflows have resulted in the following key learnings. PCCI has presented these learnings to national audiences on several CMMI Cross Model Learning Network webinars over the past few months.

- Establish standardized and effective risk screening
- Review and ensure accurate assessment of screening information
- Assess patient willingness and motivation
- Seek compatibility between patient preferences and available services
- Engage social support and direct encouragement of patients to pursue and engage in services
- Develop and deploy an accurate, up-to-date, robust community resource inventory that includes the following components:
    1. Updated through crowd sourcing and direct contact verification to ascertain contact information, eligibility, scope of services, and any required documentation
    2. Mapping locations of services to assess the coverage capacity for targeted zip codes
    3. Automated output of an applicable service provider list after electronic entry of needs and preferences
- Ensure end-to-end closed loop referral process
- Tracking of social needs at an individual and aggregate level

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

Since starting work with vulnerable and under-served populations in the Dallas metropolitan area in 2014, PCCI has learned a great deal about what works and does not work when it comes to providing care for patients with social risk factors. Among others, the following represent some of the key learnings:

- Accurate and comprehensive determination of the exact needs of patients is essential, as patients have multiple intersecting needs
- Payment systems and metrics for social service providers are not developed so it is often difficult to provide for a patient's social needs, much less measure their impact
- The agendas of social service agencies often differ from those of healthcare providers and payers, thus making alignment difficult or impossible
- Engagement of the patient is critical, especially within these special need populations; however, these individuals are very difficult to engage, especially through traditional healthcare provider channels. Results from PCCI's various studies suggest using local staff at community-based social service organizations, rather than healthcare personnel, to help build engagement among vulnerable, under-served populations.

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

Again, because these populations are difficult to engage and manage, special attention (and funding) must be directed to tailoring services to patient needs and insuring that the tailored services are received by those most in need. Some of the barriers to effectively accomplish this include:
- Inadequate\Inaccurate assessment of social risk
- Community resources are unavailable or have too many eligibility requirements to satisfy needs.
- "Learned helplessness" may prevent patients from engaging with available and known resources; based on repeated unsuccessful attempts to secure services, an individual may feel a sense of powerlessness, passivity, and a lack of belief in personal success and, as a result, the individual will not bother trying to engage resources even though the resources are available and known to the individual.
- Lack of alignment and coordination among community-based social service providers themselves; thus, it is difficult to effectively coordinate delivery of services across multiple areas of need, such as food, housing, transportation, healthcare, etc.
- Lack of payment for many social services
- Difficulties in getting healthcare providers and community-based social service organizations to work together

Q. How can barriers be overcome?

The barriers are substantial but with forethought and perseverance they can be overcome. Based on examples from PCCI's experience working with healthcare and community-based social service organizations, the following are some methods that have proven successful:
- Assess social risk on several levels and at every opportunity using standard assessment tools to facilitate cross-sharing of data
- Establish a community advisory board, chaired by a well-known and respected community-based social service organization, to monitor beneficiary needs
- Align healthcare providers and community-based social service organizations

- Create and develop smart sharing of data from EHRs to social service organizations via closed loop referral systems, such as PCCI's *Connected Communities of Care* platform
- Develop payment systems and policies to support the delivery of critical social services for vulnerable and under-served populations

Q. For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?

We find that all of these factors worsen acute social risk needs and make the optimal delivery of social services to these subpopulations more challenging. To date, little research has been done on this topic and PCCI is not aware of any learnings from the field that adequately answer this question at the present time.

HHS is requesting information on how providers and health plans are collecting and using data on Medicare beneficiaries' social risk factors:

Q. Which social risk factors are most important to capture?

Based on PCCI's experience in the Dallas metropolitan area we believe these are the most important social risk factors to collect - ranked from most important to least important:

- Health-related social needs (housing, utilities, food, transport, personal safety)
- Socio-economic (education, employment, income/utility assistance)
- Social support (social networks, family structure, friends)
- Disabilities
- Disparities of care

Q. Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

Because we understand the importance of social determinant data, PCCI routinely collects data on social risk factors in all the projects we undertake beginning with our center-piece project the AHC. In the AHC protocol all beneficiaries presenting to partner healthcare entities for care are screened using the standard CMS HRSN tool. There is no limitation for number of screens over a time period, so beneficiaries are screen at each presentation to a participating healthcare facility or provider's office. The screen information is captured in PCCI's *Connected Communities of Care* platform. The screening protocol takes time and is an additional burden in already complex and lengthy workflows for providers. From the beneficiaries' standpoint, they are typically required to spend additional time during their healthcare encounter answering additional questions that they may or may not deem of importance to them at the time.

Q. Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

PCCI believes strongly that uniformly standardizing social risk data across the United States would be a major step forward in making the collection and use of social determinant data more acceptable and value-added. There are multiple frameworks available, published by national and state agencies that can be a starting point for creating a standardized taxonomy to capture these data elements. A few examples are:

- Framework contained in CMS AHC Screening Tool
- Social Determinants contained in the Leading Health Indicators (LHI) framework of Healthy People 2020 (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health).

Standardization can happen organically, especially if one of the large payers such as CMS working with an organization such as the National Quality Forum, creates a consortium of stakeholders to establish standardized measures and then requires some or all of these measures as a condition of participation. At the same time, the payer should endorse the value of the social determinant measures by funding delivery of services aimed at addressing social needs, risk and disparities of care

Q. What are barriers to collecting data about social risk? How can these barriers be overcome?

Barriers to collecting data about social risk fall into three categories. These include:
1. Workflow Tool Barriers- Primary workflow tools are designed to capture clinical risks – risks that can be addressed by some sort of clinical intervention (medication, procedure etc.). Tools that collect social risk are not commonly found in clinical settings. This barrier can be overcome by designing workflow tools that are specifically focused on capturing social risk of individuals.
2. Cultural and Training Barriers: Talking about social risks and social conditions is typically not part of a routine office visit. Since providers don't typically have social intervention options available to them (how many healthcare organizations have "food" as an order set in their EHR), social risk is not assess and captured. This is a harder barrier to overcome since cultural reorientation takes time. Many medical schools have started changing their programs to train new physicians and nurses regarding the importance of social risk factors. A number of healthcare organizations have also started partnering with food pantries so that providers can generate a "referral" to a food pantry or other social service (transportation, housing, etc.), as is the case here in Dallas at Parkland.
3. Scope and Scale Barriers: Most of the datasets that capture social risk data on neighborhoods are not very granular, and thus, not very useful in assessing an individual's social risk. Data at county level and zip code level is far too variable to apply to individuals and households. At the same time, effort involved in measuring those factors at the block or block group level is very time consuming and labor intensive. PCCI believes that this and other barriers mentioned above can only be removed when communities, providers, and payers start to better understand the implications of social

determinant data and how that data can portend risk and don't perceive this effort to be an expense but an investment that will help make their communities and the individuals in them healthier.

Q. What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

PCCI sees at least four promising opportunities for future data collection. These are:

- *Improving quality of primary data regarding patient's socio-economic environment.* This will happen because workflow tools like EHRs (and their corresponding patient facing applications) and social services applications will have more sophisticated and targeted questionnaires and patient entered data related to that domain.

- *Better extraction of social risk proxies from data that we collect currently*. This will happen when more sophisticated machine learning techniques can extract meaningful signals from free text, and generate more precise proxies from clinical and claims data.

- *Better and more precise understanding of an individual's physical environment and neighborhoods.* We will have a substantially better and more real time understanding of what an individual's environment looks like based on more precise understanding of their location. We will augment publicly available datasets such as census data, 911 data, 311 data with real time IoTs that will give us an understanding of environmental conditions, access to resources such as transportation, etc.

- *Use of social media data.* Within the appropriate boundaries of patient privacy rights, there will be opportunities to use publicly available social media data to assess quality of neighborhoods more quickly than survey based data such as census. That will allow communities and governments to respond more quickly to potential future issues. For example, Instagram data has geocoding embedding in it. Using deep neural networks, we can analyze photographs originating from a specific neighborhood to assess if that neighborhood has sidewalks that are in disrepair, housing stock that might be getting blighted etc. We can compare those photographs over time through machine learning and even predict the rate of deterioration.

November 16, 2018

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

Parkland Health & Hospital System (Parkland) appreciates the opportunity to submit comments in response to the request for information related to the IMPACT Act's study on social risk factors by the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

Located in Dallas County, Texas, Parkland is one of the busiest safety-net health systems in the in the country. Our mission is to care for the indigent and uninsured residing in our hospital district. In addition, Parkland is home to premier services such as a level I trauma center, the largest level III neonatal intensive care unit in North Texas and one of the largest civilian burn centers in the nation. Parkland is the primary teaching hospital for the University of Texas Southwestern Medical Center training an estimated 40 percent of physicians within the greater Dallas area.

We provided more than $879 million in uncompensated care in fiscal year 2017 and saw over 1 million outpatient visits throughout our network of 20 primary care and women's health clinics, 12 school-based clinics and numerous other outreach activities throughout Dallas County. Our payor mix is about 75 percent uninsured or on Medicaid and 16 percent Medicare.

The following pages reflect comments from two perspectives: our health system and the Parkland Center for Clinical Innovation (PCCI) which is an affiliate to our health system. In addition to the submitting answers to the RFI, we are incorporating a document PCCI developed in conjunction with CMS's Center for Medicare and Medicaid Innovation (CMMI) Cross Model Learning Network.

Thank you for your consideration of these comments.

Sincerely

Katherine Yoder
Vice President of Government Relations

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

As a practicing geriatrician and medical director of multiple inner-city and hospital-based Skilled Nursing Facilities and Assisted Living Facilities, I am writing to share my perspective on the impact on social determinants of health on outcomes with respect to frail patient populations. I believe the focus on social determinants of health is important, though less so, in an institutionalized setting. Within assisted living and skilled nursing facilities, the traditional social determinants of health are less impactful on clinical outcomes as any deficits in these domains are well compensated for by the facility services and staff who engage the residents. These residents are already highly dependent and have been impacted by all the negative factors, essentially failing to remain in the community for a multitude of reasons far exceeding what supporting social determinants of health would mitigate. Once they are in the facility, these social determinants are no longer a factor. However, there is still value in recognizing and measuring certain psychosocial factors, yet this information is not readily accessible to the medical providers.

To address some of the informational gaps, I co-founded a company, Patient Pattern (patientpattern.com) to gather clinical data and patient condition tracking through an automated algorithm process using Minimum Data Set (MDS) and an in-person Health Risk Assessment performed at the bedside to compute an evidence-based frailty index that encompasses psychosocial, cognitive and functional data. To date, upon review of millions of records across the country, several insights become apparent:

1. We can reliably obtain extensive psychosocial information with respect to individual patients at scale using this approach
2. It turns out that cognitive and functional measures are significantly more predictive for poor outcomes than psychosocial factors in institutional settings.
3. Poor outcomes are exponentially more prevalent in patients that are above moderate degrees of frailty on the risk index.
4. By measuring frailty and trending it over time, it contextualizes patient risk for poor outcomes and likelihood for decline versus improvement.
5. Patients can have favorable outcomes in these care settings when approached based on their functional, cognitive, and psychosocial status.
6. Physician engagement is one of the most impactful metrics for yielding favorable outcomes. This can be measured by frequency of completing Advance Care Planning visits and documentation.
7. Alignment of patient and family expectations based on frailty risk has yielded the greatest cost-savings in terms of reducing unnecessary hospitalization and reduction in poly-pharmacy, thereby adverse events. Interestingly, our data shows that frail patients who receive increased frequency of palliative care encounters achieve not only lower hospitalization rates, but also longer life-expectancy at decreased resource utilization.
8. By identifying frailty, medical staff and health facility leadership can better allocate appropriate resources to mitigate risk for poor outcomes.
9. Studying hospital CMS bundle payment and Medicare Advantage claims data suggests that measuring functional, cognitive and psychosocial changes in condition (all encompassed in frailty index

assessment) in institutional settings has positively impacted one of the largest regional iSNP and hospital CMS bundle programs.

In summary, social risk data is not generally targeted to allocate resources in a skilled facility setting as these patients are relatively insulated to social factors by the time they are in a supported environment that compensates for these factors. While patients residing in primarily outpatient and more independent community settings, are sensitive to social determinants. Data capture of these factors can be reliably obtained at scale using timely MDS data and Health Risk Assessments.

Regards,
Steven Buslovich, MD

--

Steven Buslovich MD, MSHCPM
CEO, Co-Founder
steve@patientpattern.com | 212.201.1212
patientpattern.com | livepac.com

November 16, 2018

Submitted electronically to ASPEImpactStudy@hhs.gov

Attention: Assistant Secretary for Planning and Evaluation (ASPE)

Re: Request for Information; IMPACT Act Research Study: Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

These comments are submitted by the Pennsylvania Homecare Association (PHA) in response to the above named Request for Information (RFI). PHA is an industry trade association representing homecare, home health and hospice providers that serve Medicare and Medicaid beneficiaries in their homes. The nature of this care demands that providers be aware of and adjust for a patient's social risk factors. Clinicians are providing care in an individual's own home, surrounded by their family and, in the case of hospice services in particular, they are providing services to those family members as well. The risk factors identified by ASPE in the RFI—socioeconomic position, race, ethnicity, social relationships and residential/community context—have an impact on how homecare providers interact with the patient and their informal caregivers and how the agency structures a care plan that will meet the patient's needs.

As noted by ASPE, however, there continues to be gaps in this information and inconsistencies in how health plans and CMS collect and share this information with providers who need it.

Key Social Risk Factors for Home-Based Care

Because home-based care is delivered and coordinated right at home, providers have found that the most important risk factor to consider for the patients they serve is whether they live alone. The absence of informal caregivers and support often compounds these patients' chronic care needs and leaves them with less ability to perform activities of daily living without assistance from a provider agency. Patients who live on their own are more likely to experience poor living conditions and food insecurity, which can exacerbate their illness or lead to falls and other preventable injuries.

Homecare providers report that while information about living conditions is captured at the time of referral, it is not uniformly shared or tracked in a way that can show a statistical impact on care. Agencies document this information in the patient's record with the goal of better informing caregivers and clinicians who will be involved in that individual's care and visiting the home most often. However, there are no prepackaged interventions that are generally applied for patients who live alone. Rather, each agency has its own approach to caring for this

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population.

Aside from living alone, another risk factor that impacts the patient's homecare has to do with the neighborhood or location of their home and its effect on the ability to adequately staff all of the hours of care the individual requires. Dangerous neighborhoods, rural areas and unique cultural community needs are some of the data points that providers seek from referral sources in order to plan for the patient's care. For instance, the individual might live in a community where almost all residents speak just one language and an agency will attempt to accommodate those needs. The agency might need to plan sufficient travel time for clinicians to travel to secluded rural areas to staff the case. These needs are not always obvious upon referral, but could be the key to providing competent and complete care.

Barriers to Collecting & Tracking Social Data

The biggest barrier that providers report when collecting social risk data is the inability of electronic medical records to capture the information in a useful way. Many software systems offer a text or narrative field for providers to insert information like this, but this does not offer a mechanism for providers to aggregate and track data on their patient population and corresponding interventions and outcomes, if any. While agencies are asking patients and families for key information that will impact their care, as discussed above, they are not currently examining outcomes or trends because of the lack of uniformity in electronic records.

Another reason providers report for minimal activity in tracking social determinants of health is that payers and licensing bodies are not currently requiring it. Clinicians in the home are already stretched thin to collect all required information while providing person-centered care and putting patients ahead of paperwork. For example, the initial home health assessment could take two to three hours to complete under today's regulatory requirements. It is very difficult for clinicians to collect any additional information from a fatigued patient and family who are focused on getting well. The best way to secure information on social risk factors from all patients is for payers and CMS to mandate its collection as part of the agency's routine procedures.

Suggestions to Improve

No one in the healthcare industry would dispute that social risk factors have a great impact on a patient's wellbeing and the ability to care for Medicare and Medicaid beneficiaries. However, there are very few providers or payers that can analytically show how best to account for these needs and care gaps to compensate for the patient's socioeconomic circumstances. Below are some suggestions to improve the lack of data in this area:

- Work with state Medicaid agencies to aggregate and analyze data collected from dual-eligible beneficiaries as part of the nursing facility clinically eligible (NFCE) and financial determination assessments. These instruments collect valuable data related to income, living situation and other factors to understand how patients' financial health impacts

their physical health. The right information is already being collected by both Medicare and Medicaid, but there is very little crossover or opportunity for comparison.

- Aggregate OASIS data at a national level to better understand how a patient's living situation (M1100) impacts their care needs and outcomes.
- Insert standard, required fields on patient electronic medical records as a condition of federal funding so that providers and payers will be better able to track and trend this information rather than collecting it in narrative form on the patient's record.
- Fund pilot testing activities for payers and providers to develop best practices for tracking social risk factors and triggering certain health interventions to determine their impact.

Thank you for the opportunity to provide feedback on home-based care providers' experience with patient social risk factors. PHA applauds CMS and ASPE for continuing this work as it grows more and more vital each year as the senior population grows to address these needs for dual eligible and other Medicare beneficiaries.

Sincerely,

Vicki Hoak, CEO

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November 16, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation (ASPE)
Room 415 F
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

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

Dear Assistant Secretary Destro:

AMDA – The Society for Post-Acute and Long-Term Care Medicine appreciates the opportunity to provide our comments to the Request for Information (RFI) on the *IMPACT ACT Research Study: Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors.*

The Society is the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PALTC) settings. The Society's 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, continuing care retirement communities (CCRC), home care, hospice, PACE programs, and other settings. In serving this population, these clinicians care for the most high-risk and costly group of beneficiaries covered by Medicare and Medicaid programs.

We appreciate that Assistant Secretary for Planning and Evaluation (ASPE) is conducting this important study evaluating the effect of individuals socioeconomic status (SES) on quality measure and measures of resource use under the Medicare program. As noted in the RFI, there is growing recognition that social risk factors such as income, education, race and ethnicity play major role in health. However, many of the Society's members who serve the very frail patient populations in the PALTC settings would note that many of these factors are less impactful on clinical outcomes, as any deficits in these are compensated for by the facility services and staff.

These PALTC residents are already highly dependent and have been impacted by all the negative factors, essentially failing to remain in the community for a multitude of reasons far exceeding what supporting social determinants of health would mitigate. This patient population is risk adjusted which often fails to capture or address functional/cognitive decline Once they are in the facility, these social determinants are no longer a factor. However, there is still value in recognizing and measuring certain psychosocial factors, yet this information is not readily accessible to the medical providers.

To address some of the informational gaps, a company called Patient Pattern (patientpattern.com) gathered clinical data and patient condition tracking through an automated algorithm process using Minimum Data Set (MDS) and an in-person Health Risk Assessment performed at the bedside to compute an evidence-based frailty index that encompasses psychosocial, cognitive and functional data. To date, upon review of millions of records across the country, several insights become apparent:

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9. Studying hospital CMS bundle payment and Medicare Advantage claims data suggests that measuring functional, cognitive and psychosocial changes in condition (all encompassed in frailty index assessment) in institutional settings has positively impacted one of the largest regional iSNP and hospital CMS bundle programs.

Social risk data is not generally targeted to allocate resources in a skilled facility setting as these patients are relatively insulated to social factors by the time, they are in a supported environment that compensates for these factors. While patients residing in primarily outpatient and more independent community settings, are sensitive to social determinants. Data capture of these factors can be reliably obtained at scale using timely MDS data and Health Risk Assessments.

Sincerely,

Cari Levy, MD, PhD, CMD
President

November 16, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington DC, 20201

Submitted electronically through ASPEImpactStudy@hhs.gov

Attention: RFI Provider and Health Plan Approaches To Improve Care For Medicare
Beneficiaries With Social Risk Factors.

Dear Deputy Assistant Secretary Destro:

Medicare Advantage (MA) plans are taking advantage of new flexibilities and changes in the
uniformity requirements granted by the Centers for Medicare and Medicaid Services (CMS)
to offer supplemental benefits if they compensate for physical impairments, diminish the
impact of injuries or health conditions, and/or reduce avoidable emergency room
utilization.

An increasing number of plans, are offering non-emergency medical transportation
(NEMT) as a supplemental benefit. Avalere compared[1] benefits data in CMS's 2019 and
2018 plan benefit package (PBP) files and found a 22% increase in the number MA plans
offering transportation benefits in 2019. This increase means that one in four MA plans
will be offering transportation to some or all of their beneficiaries.

On the other hand, the NEMT benefit is a key element of a coordinated care plan for all
Medicaid beneficiaries. An analysis[2] of data from the largest manager or "broker" of

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[1] Creighton, Sean; Young, Joanna. "Medicare Advantage Beneficiaries Will See a Jump in New
Supplemental Benefit Offerings in 2019." Oct 19, 2018. http://avalere.com/expertise/managed-
care/insights/medicare-advantage-beneficiaries-will-see-a-jump-in-new-supplemental-benefi
[2] Kaiser Commission on Medicaid and the Uninsured. Medicaid Non-Emergency Medical
Transportation: Overview and Key Issues in Medicaid Expansion Waivers. February 24, 2016.

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Medicaid NEMT, LogistiCare Solutions, showed that the majority of NEMT services are for individuals requiring additional assistance with regularly scheduled transportation to coordinated care for behavioral health services, substance abuse treatment and dialysis services. LogistiCare Solutions also manages transportation for a number of Medicare Advantage (MA) plans.

The ASPE RFI asks for information on the Return on Investment (ROI) for providing services to improve care for Medicare beneficiaries with social risk factors. While not focusing on MA plans, a recent study on behalf of the Medical Transportation Access Coalition[3] (MTAC) uses Medicaid claims data and a survey of nearly 1,000 Medicaid beneficiaries to determine the ROI in NEMT for three common conditions and their corresponding treatments. As summarized by the study authors[4]:

- Dialysis for kidney disease:
  - Survey respondents reported attending an average of 12.0 dialysis treatments a month using non-emergency medical transportation and said they would expect to attend only 4.1 treatments a month without it.
  - The analysis calculated that NEMT saves Medicaid $3,423 per month for each individual with kidney failure receiving dialysis, or $41,076 per year.
- Diabetic wound care:
  - Survey respondents reported attending an average of 5.5 wound care treatments a month using NEMT but expected to attend only 1.3 treatments a month without it.
  - The analysis calculated that Medicaid would avoid spending $792 per member per month, or $9,504 per year, by keeping patients on a path to receive all necessary wound care treatments.
- Substance use disorder treatment:
  - NEMT did not appear to save Medicaid money for patients with substance use disorder, in part because the survey methods did not identify the full range of costs avoided.
  - It is possible that different study parameters (such as longer claims analysis period, consideration of relapse rates, and quantification of social costs such as increased employment and productivity) would likely lead to a positive ROI.

Many of these chronic conditions occur with similar frequency among the MA population. For example, according to the Medicare Payment and Advisory Commission (MedPAC), half

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https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/

[3]LogistiCare Solutions is a founding member of the Medical Transportation Access Coalition; https://mtaccoalition.org/

[4] Adelberg, Michael; Salber, Patricia; and Cohen, Michael. "Curtailing Medicaid's transportation benefit is 'penny-wise and pound-foolish." StatNews. July30, 2018. https://www.statnews.com/2018/07/30/curtailing-medicaid-transportation-benefit-pennywise-pound-foolish/

of the end stage renal disease (ESRD) Medicare beneficiaries are dual eligible. Thus, it is highly likely that MA plans will see similar ROIs associated with providing NEMT to beneficiaries with chronic conditions and social risk factors.

Simon&Co appreciates the opportunity to provide ASPE with the MTAC study and its methodology.[5]

Please contact us if you have any questions.

Sincerely,

Marsha Simon, PhD
President
Simon&Co.

Attachments

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[5] "Study Reveals Non-Emergency Medical Transportation (NEMT) is Extremely Cost-Effective and Life-Saving to Medicaid Program." https://mtaccoalition.org/study-reveals-non-emergency-medical-transportation-nemt-is-extremely-cost-effective-and-life-saving-to-medicaid-program/

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Project Overview

- GreatBlue was commissioned by Faegre Baker Daniels, on behalf of the Medical Transportation Access Coalition (MTAC), to conduct a study to measure the need for Non-Emergency Medical Transportation, or NEMT, services among a sampling of patients who currently receive these transportation services.

- The primary goal for this research study was to measure patient reliance on NEMT services, frequency of usage of NEMT services, and measure the effect on patients in the event these NEMT services were eliminated.

- In order to service this need, a telephone survey was conducted among patients currently utilizing NEMT services who are receiving either dialysis or kidney disease, wound care for diabetes, or treatment for substance abuse.

- The outcome of this research will enable MTAC personnel to a) bring awareness to the significance and need for NEMT services among patients and b) effectively measure the return on investment of NEMT services.

Areas of Investigation

The 2018 Faegre Baker Daniels NEMT Study leveraged a quantitative research methodology to address the following areas of investigation:

- Patients' ability to attend appointments with NEMT services
- Ability to attend appointments without NEMT services
- Types of medical rides utilized most frequently
- Access to alternative transportation
- Impact of NEMT on patients' costs
- Impact of NEMT services on patients' health

Research Methodology Snapshot

Methodology Telephone**	**No. of Completes** 977 2018 Composite	206 Diabetes 460 Kidney Disease 311 Substance Abuse	**No. of Questions** 25*	**Sample** Provided by LogistiCare Solutions, LLC
Target Patients who utilize NEMT services	**Margin of Error*** +/- 3.1% 2018 Composite	+/- 6.8% Diabetes +/- 4.5% Kidney Disease +/- 5.5% Substance Abuse	**Confidence Level** 95%	**Research Dates** April 23 - May 25

* This represents the total possible number of questions; not all respondents will answer all questions based on skip patterns and other instrument bias.

**Supervisory personnel in addition to computer-aided interviewing platform ensure the integrity of the data set.

***Margin of error values above apply to percent of response calculations. Margin of error for average response calculations at 95% confidence level is less than 1.

Respondent Snapshot

This slide quantifies select data points to provide context for this research study. The data is not meant to be statistically significant, rather to provide an empirical view into the demographic profile of the participants.
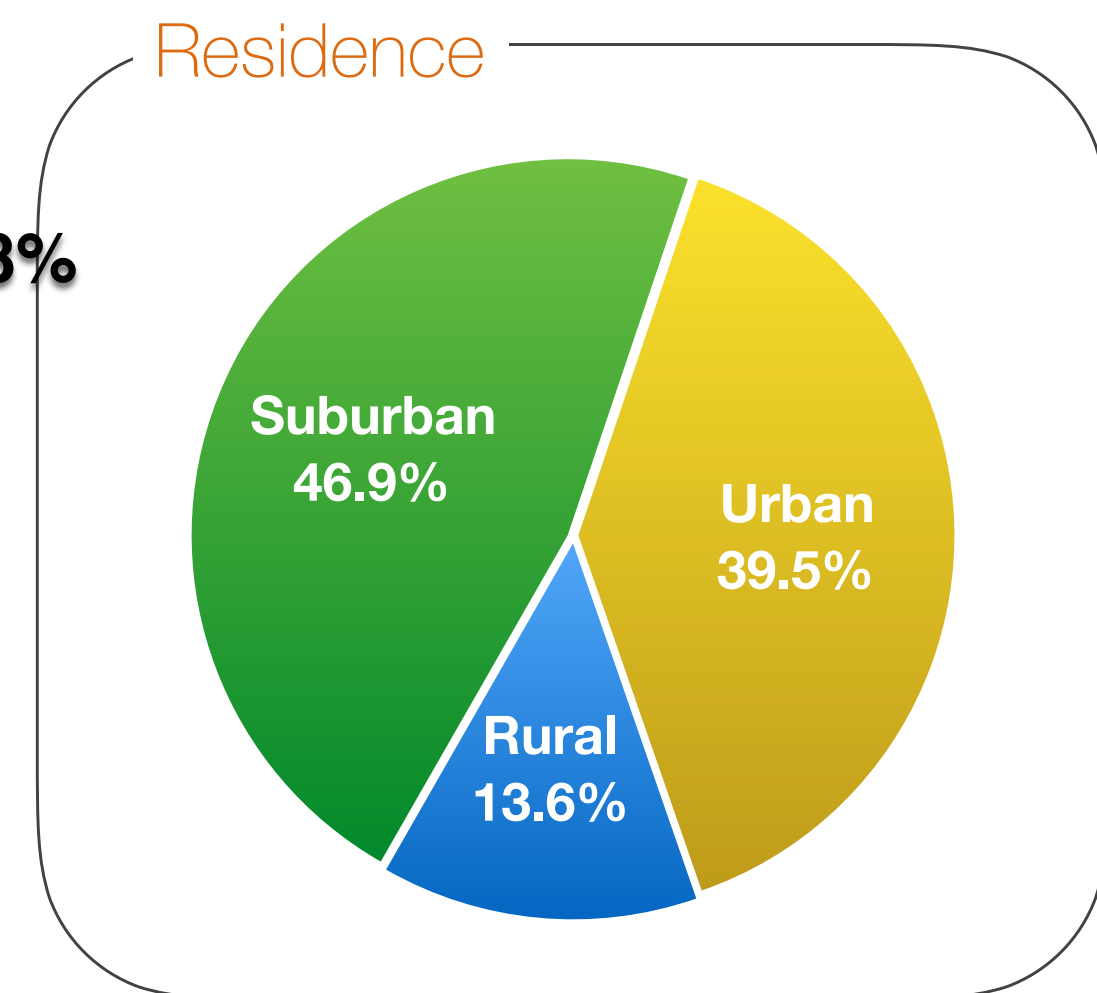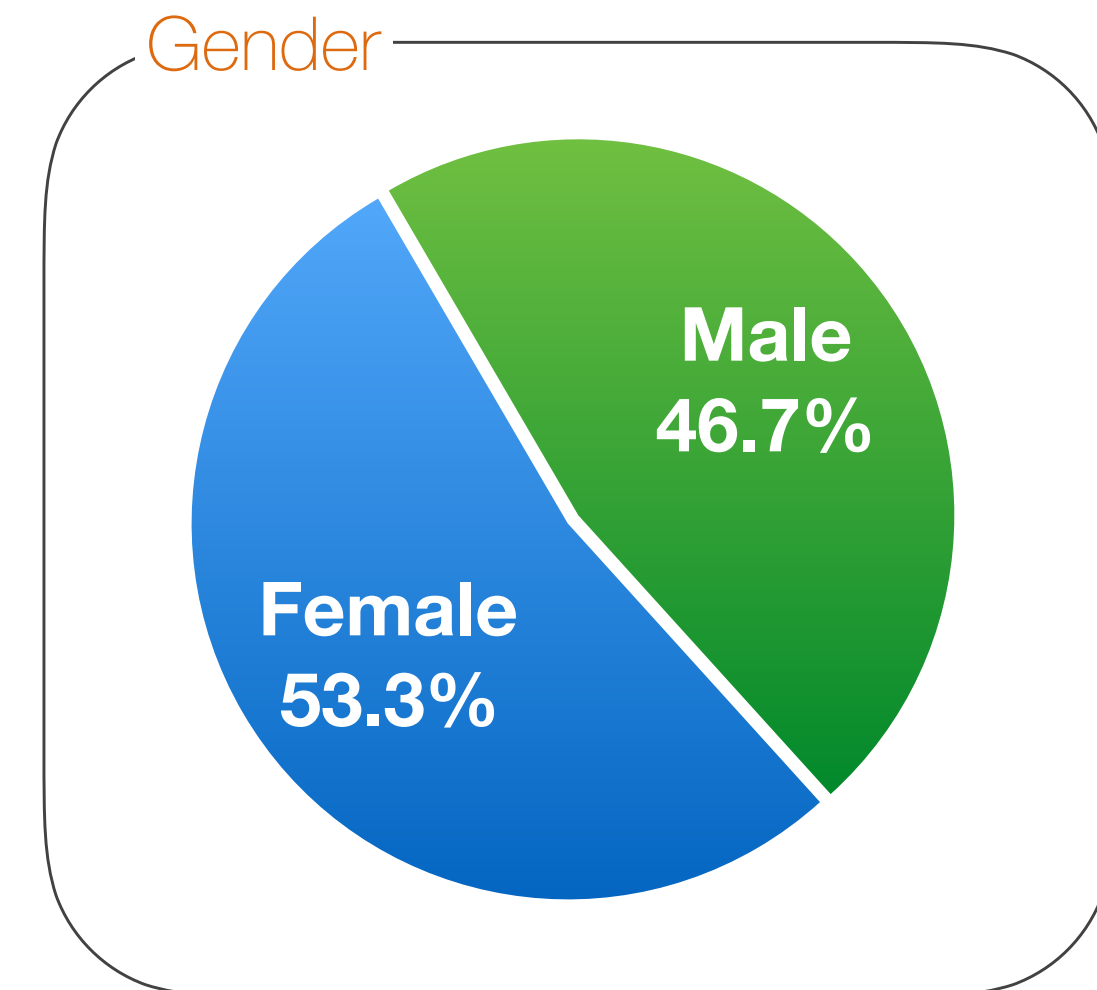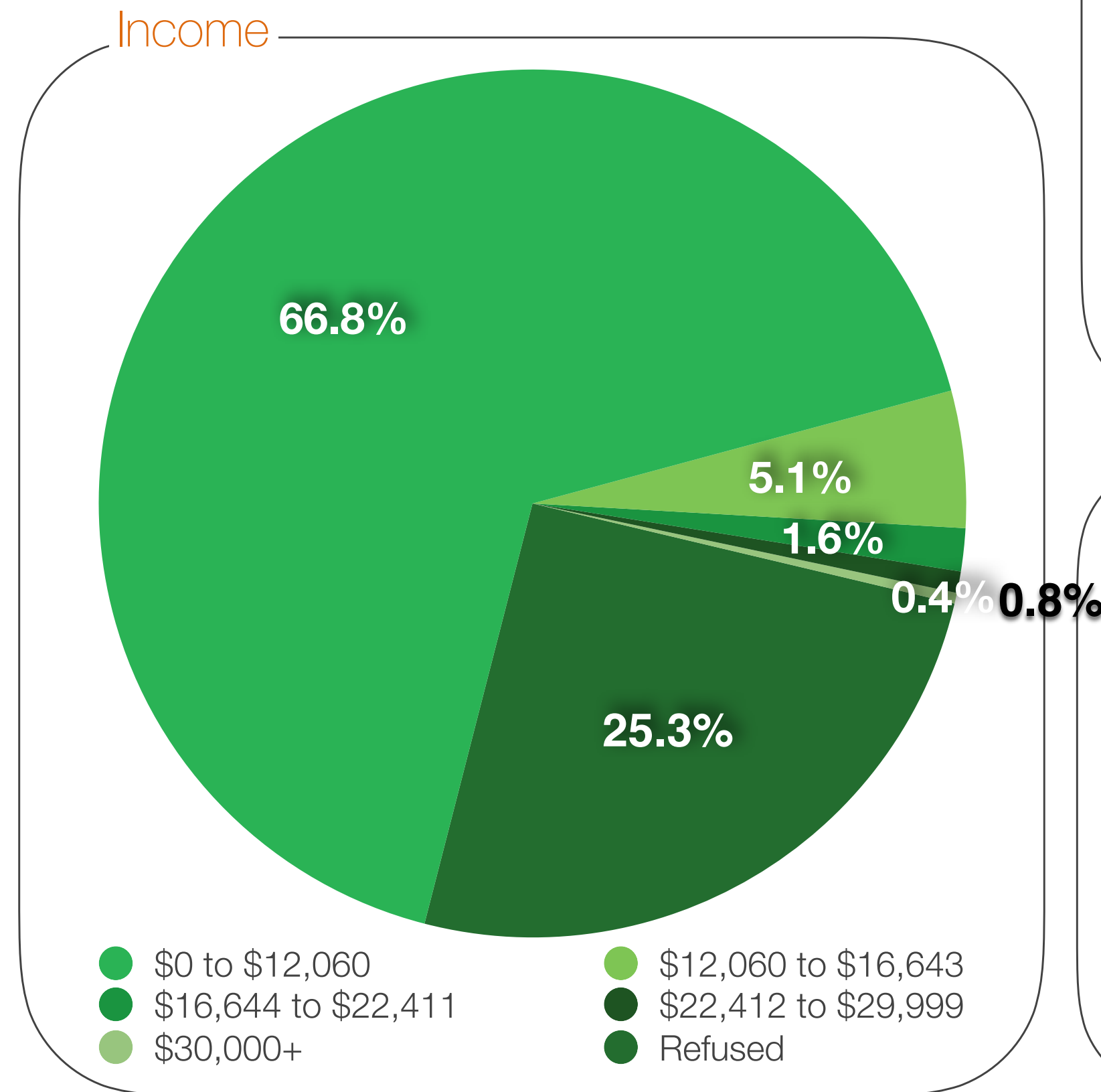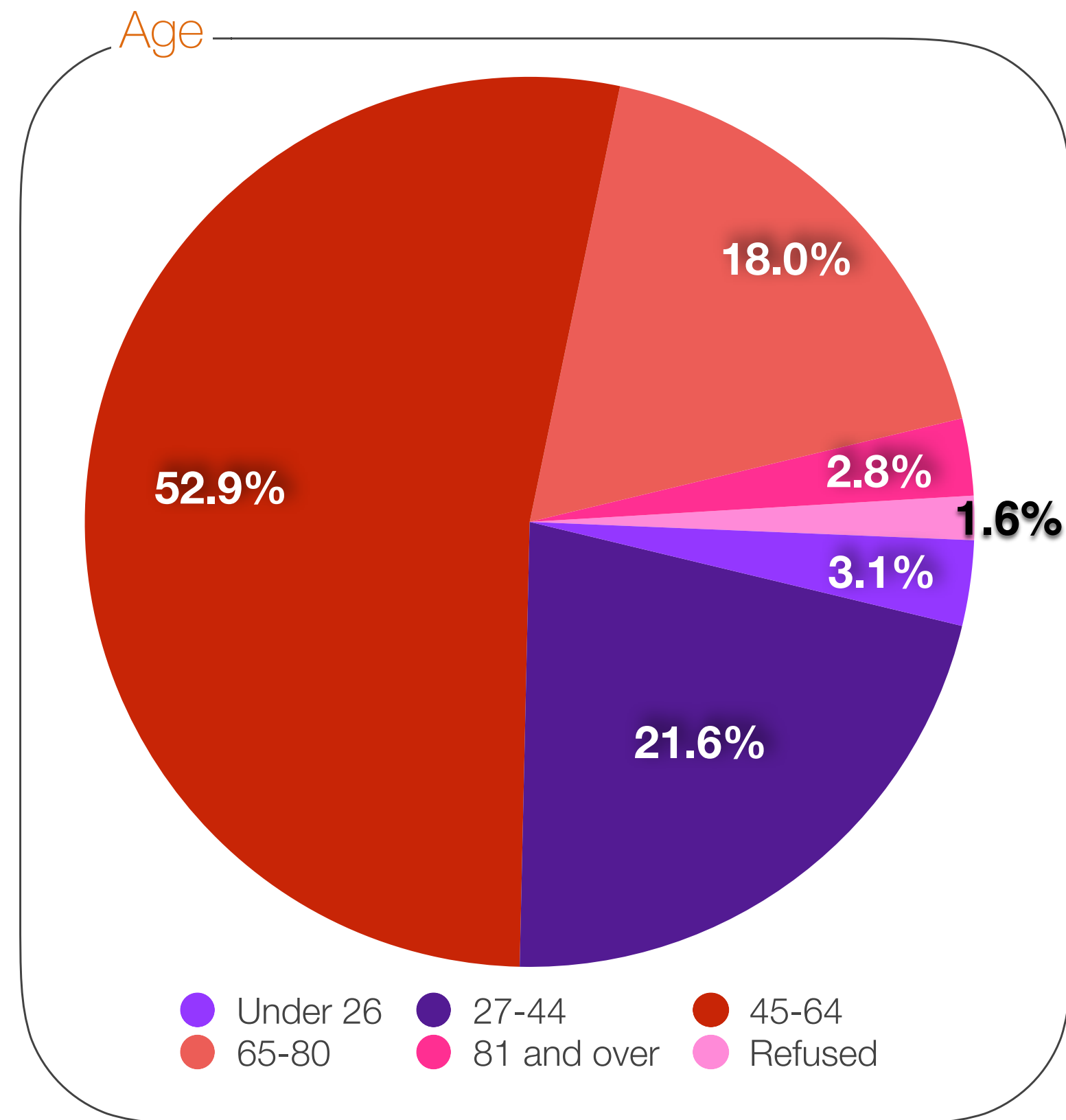
Age

- 52.9%
- 18.0%
- 2.8%
- 1.6%
- 3.1%
- 21.6%

Under 26 | 27-44 | 45-64
65-80 | 81 and over | Refused

Income

- 66.8%
- 5.1%
- 1.6%
- 0.4%
- 0.8%
- 25.3%

$0 to $12,060 | $12,060 to $16,643
$16,644 to $22,411 | $22,412 to $29,999
$30,000+ | Refused

Gender

- Male 46.7%
- Female 53.3%

Residence

- Suburban 46.9%
- Urban 39.5%
- Rural 13.6%

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Key Study Findings

- Overall a vast majority of patients surveyed (92.7%) reported their health would be "much worse" (85.3%) or "slightly worse" (7.4%) without access to medical rides through NEMT services.

- The most frequently used type of medical ride among patients was a van or sedan (55.2%), while roughly one-quarter of patients with kidney disease (23.5%) and approximately one-third of patients with diabetes (31.1%) also used wheel-chair accessible vehicles. Over one-quarter of patients receiving treatment for substance abuse use public transportation (28.3%).

- Without access to NEMT services, 66.5% of patients receiving treatment for wound care for diabetes, 58.8% of patients receiving treatment for substance abuse, and 52.8% of dialysis patients would not be able to attend any medical appointments per month.

- On average, patients across all three treatment categories reported that they would miss approximately 70% of their appointments without NEMT services.

Key Study Findings

- Over three-quarters (82.6%) of patients said they would have to pay more out of pocket if they did not have access to medical rides, and approximately two-thirds (66.6%) have no other form of personal or public transportation that they could use to attend appointments as an alternative.

  - Among those without access to another form of personal or public transportation, 67.6% of those respondents would not be able to attend any medical appointments per month compared to only 37.7% with access to alternative transportation.

  - Further, 85.7% of rural patients would be required to pay more out of pocket without access to NEMT services.

- Nearly one-third of respondents (31.4%) reported having a travel time of greater than 30 minutes to get to an appointment.

  - 88.8% of patients with a travel time of longer than 30 minutes reported their health would be much worse without NEMT services and 60.7% reported they would not be able to attend any medical appointments.

- Finally, in a series of open-ended questions, patients reported that medical rides help maintain their health and manage their conditions, while also helping them receive the medical treatment that they require. Further, without these medical rides, patients noted that they would likely be unable to attend appointments, and their health would worsen as a result.

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NEMT critical to appointments and health

Respondents clearly indicated that NEMT services were a key component to their overall health. Over nine-tenths of respondents (92.7%) reported their health would be "much worse" (85.3%) or "slightly worse" (7.4%). Further, a majority of patients receiving treatment for wound care for diabetes (66.5%), for substance abuse (58.8%), or for dialysis (52.8%) all reported they would be unable to attend any appointments without NEMT services.

How would your health change without medical rides?

- Health would be slightly better
- Health would be much better
- Health would not change
- Health would be slightly worse
- Health would be much worse

0.2%   0.2%   7.0%   7.4%   85.3%

Composite

If you did not have access to medical rides, how many of your monthly appointments do you believe you would attend?

52.8% of those receiving dialysis for kidney disease **WOULD NOT** be able to attend any appointments

66.5% of those receiving wound care for diabetes **WOULD NOT** be able to attend any appointments

58.8% of those receiving treatment for substance abuse **WOULD NOT** be able to attend any appointments
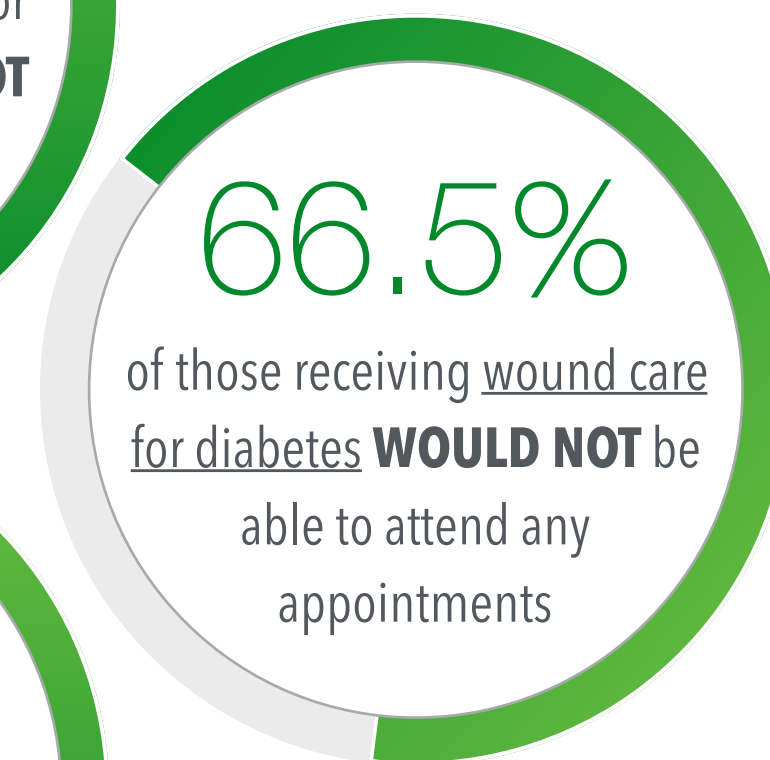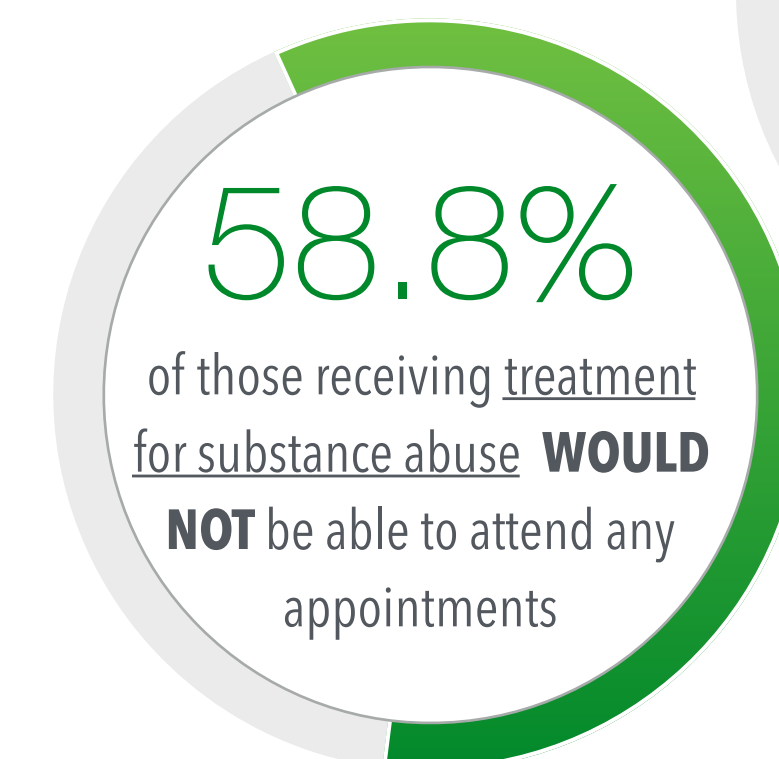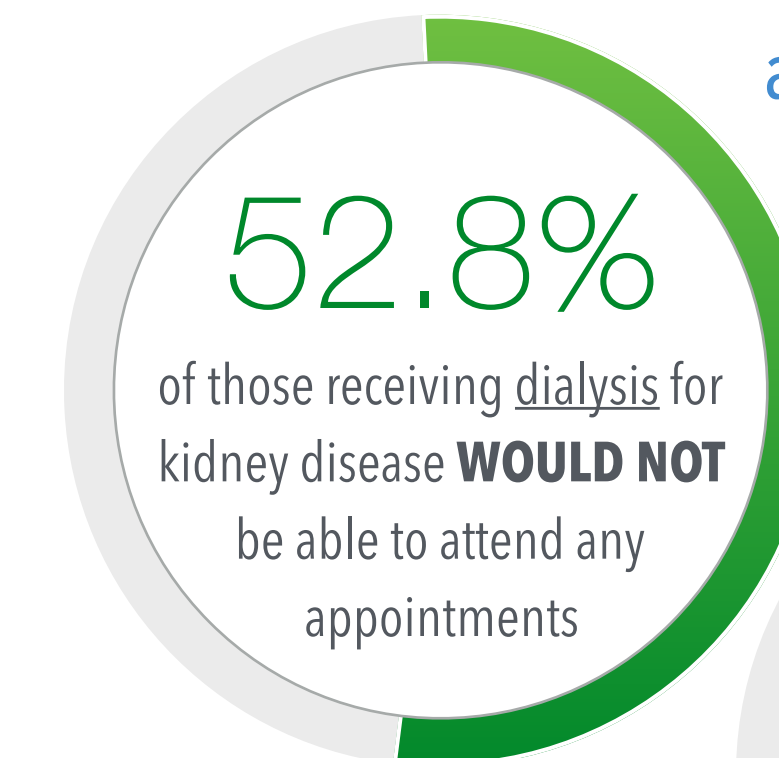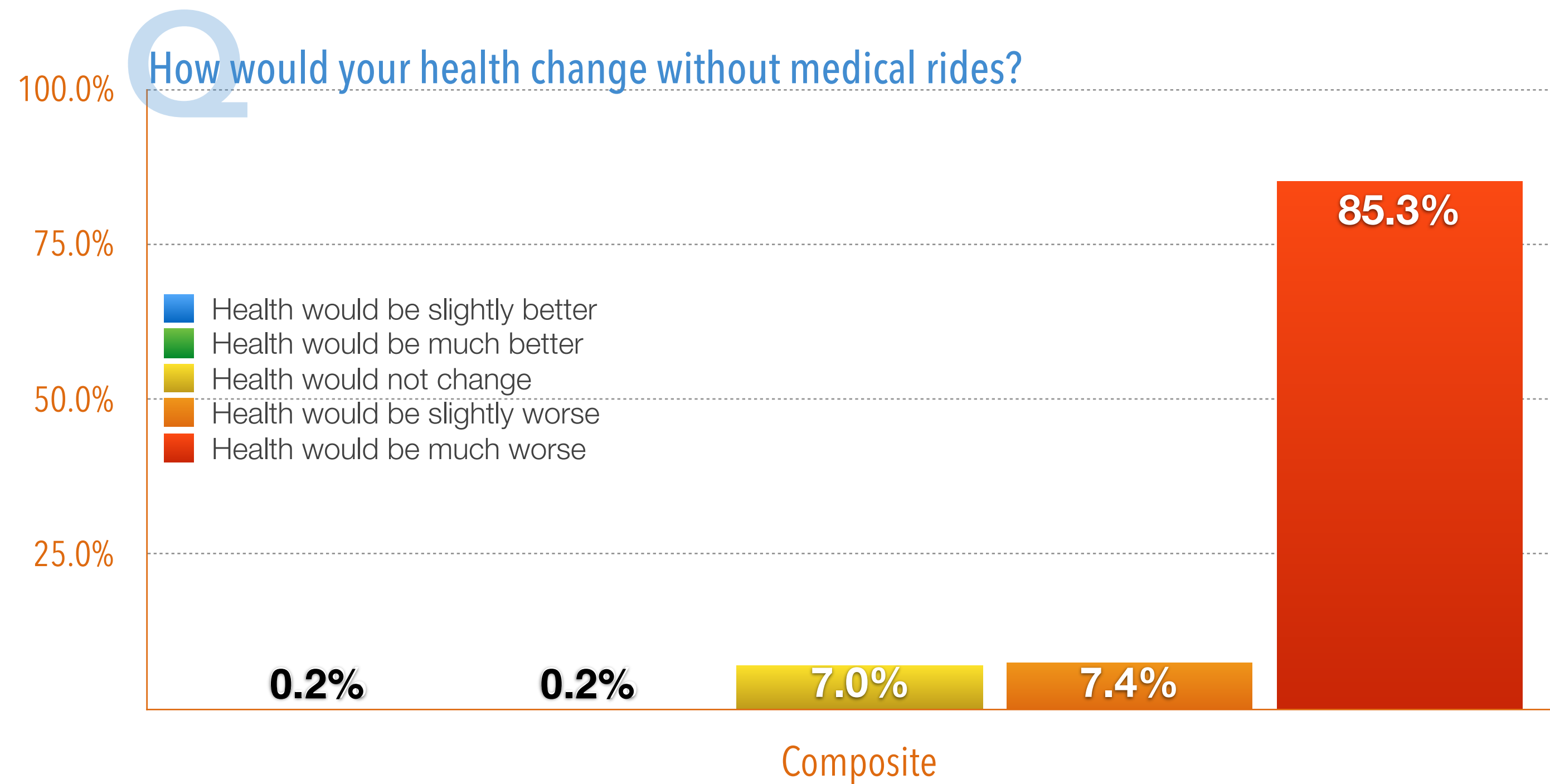
Vans and sedans most popular ride service

What type of medical ride do you use most frequently?

Among all patients surveyed in 2018, the majority reported most frequently utilizing a "van or sedan" (55.2%) to get to their medical appointment. This was followed by "wheelchair-accessible vehicle" for their medical ride (19.2%).

Interestingly, a high rate of patients receiving treatment of substance abuse reported using "public transportation" to get to medical appointments (28.3%).

Ride Services	Composite	Dialysis for Kidney Disease	Wound Care for Diabetes	Treatment for Substance Abuse
Van or sedan (not taxi)	55.2	57.8	56.3	50.5
Wheelchair-accessible vehicle	19.2	23.5	31.1	5.1
Public transportation	11.1	2.8	3.4	28.3
Reimbursement for miles on your own vehicle	4.8	3.0	1.0	10.0
Stretcher-accessible vehicle	2.9	4.8	2.9	0.0
Lyft or Uber	2.8	3.5	1.9	2.3
Taxi	2.0	2.8	1.9	1.0
Other	1.9	1.7	1.5	2.6
Family or friend	0.1	0.0	0.0	0.3

Effect of NEMT transportation on all patients…

Across all patients surveyed, over two-thirds of respondents reported "scheduling" (73.1%) and "going to" (72.3%) over ten (10) appointments per month. However, when asked how many appointments respondents would be able to attend without NEMT services, a majority (57.6%) reported they would not be able to attend any appointments. The average number of appointments fell from 12.03 appointments per month to 3.58 appointments per month without NEMT services.
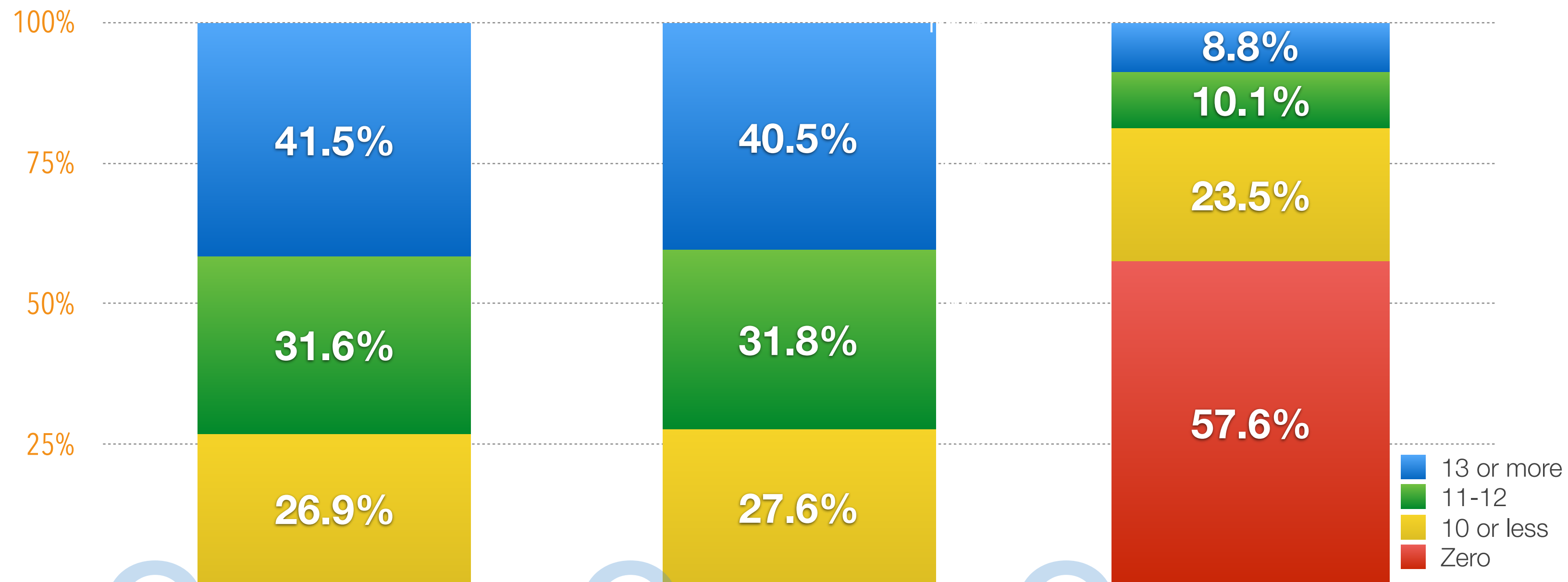
How many medical appointments, per month, do you typically have scheduled to treat your condition?

How many of those medical appointments, per month, would you say that you go to?

If you did not have access to medical rides, how many monthly appointments do you believe you would attend?

Average number of treatments patients are able to attend…

Dialysis patients…

Across dialysis patients surveyed, over nine-tenths of respondents reported "scheduling" (94.3%) and "going to" (93.0%) over ten (10) appointments per month. However, when asked how many appointments respondents would be able to attend without NEMT services, a majority (52.8%) reported they would not be able to attend any appointments. The average number of appointments fell from 11.97 appointments per month to 4.05 appointments per month without NEMT services.

Average number of treatments patients are able to attend…

11.97
With Transportation

4.05
Without Transportation

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

How many medical appointments, per month, do you typically have scheduled to treat your condition?
- 33.3%
- 61.0%
- 5.7%

How many of those medical appointments, per month, would you say that you go to?
- 32.6%
- 60.4%
- 7.0%

If you did not have access to medical rides, how many monthly appointments do you believe you would attend?
- 7.2%
- 18.9%
- 21.1%
- 52.8%

Legend:
- 13 or more
- 11-12
- 10 or less
- Zero

Wound care for diabetes patients…

Across diabetes patients surveyed, over four-fifths of respondents reported "scheduling" (84.0%) and "going to" (84.4%) ten (10) appointments or less per month. However, when asked how many appointments respondents would be able to attend without NEMT services, almost two-thirds (66.5%) reported they would not be able to attend any appointments. The average number of appointments fell from 5.56 appointments per month to 1.37 appointments per month without NEMT services.

Average number of treatments patients are able to attend…

Legend:
- 13 or more
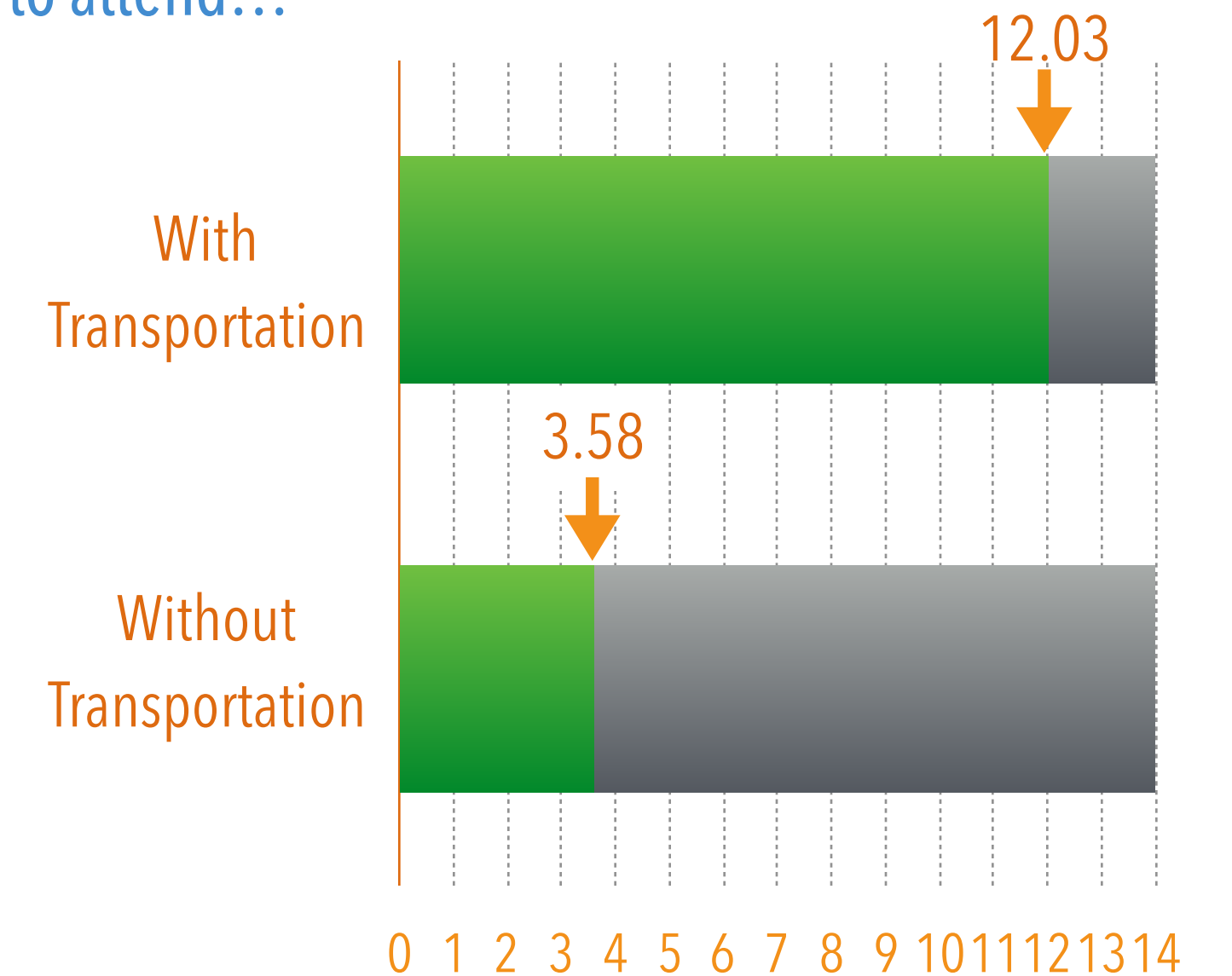- 11-12
- 10 or less
- Zero

How many medical appointments, per month, do you typically have scheduled to treat your condition?

How many of those medical appointments, per month, would you say that you go to?
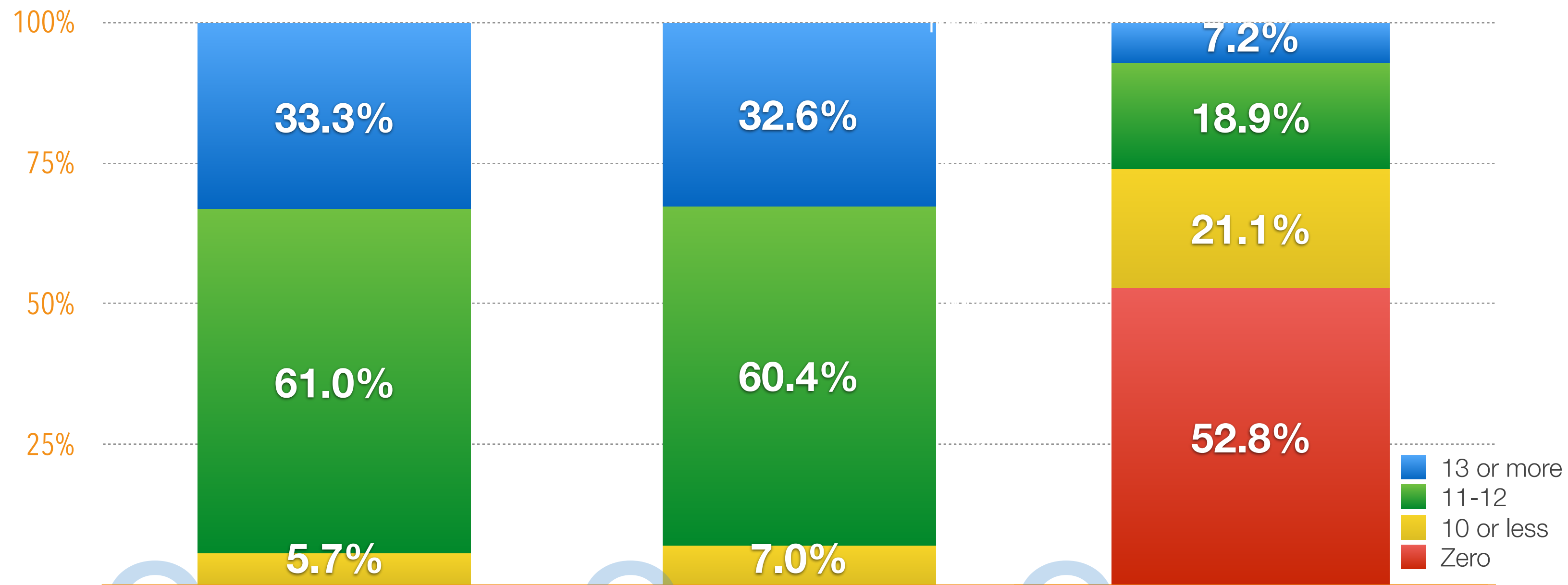
If you did not have access to medical rides, how many monthly appointments do you believe you would attend?
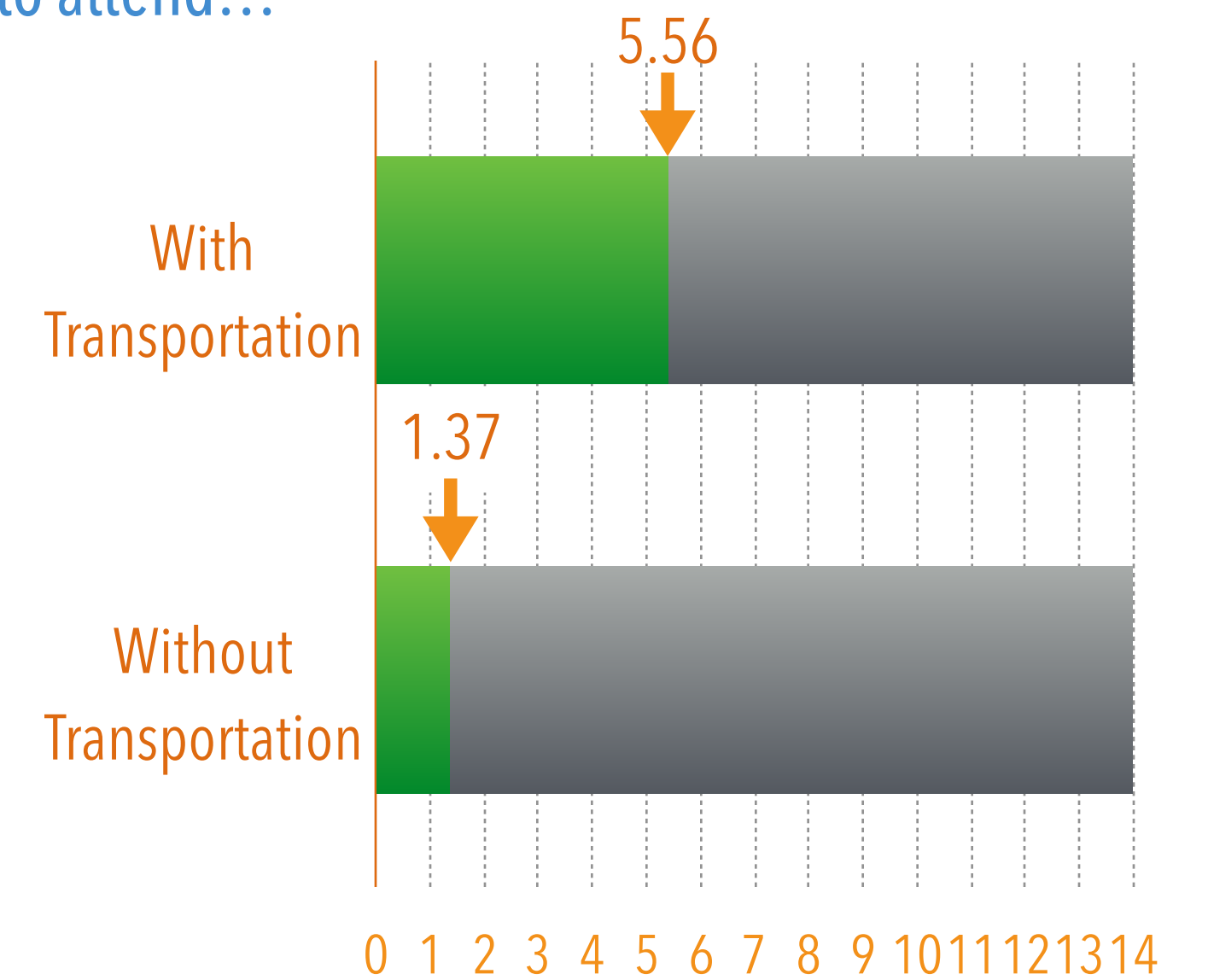
Substance abuse patients…

Across dialysis patients surveyed, over three-quarters of respondents reported "scheduling" (79.4%) and "going to" (79.4%) over ten (10) appointments per month. However, when asked how many appointments respondents would be able to attend without NEMT services, a majority (58.8%) reported they would not be able to attend any appointments. The average number of appointments fell from 16.40 appointments per month to 4.36 appointments per month without NEMT services.
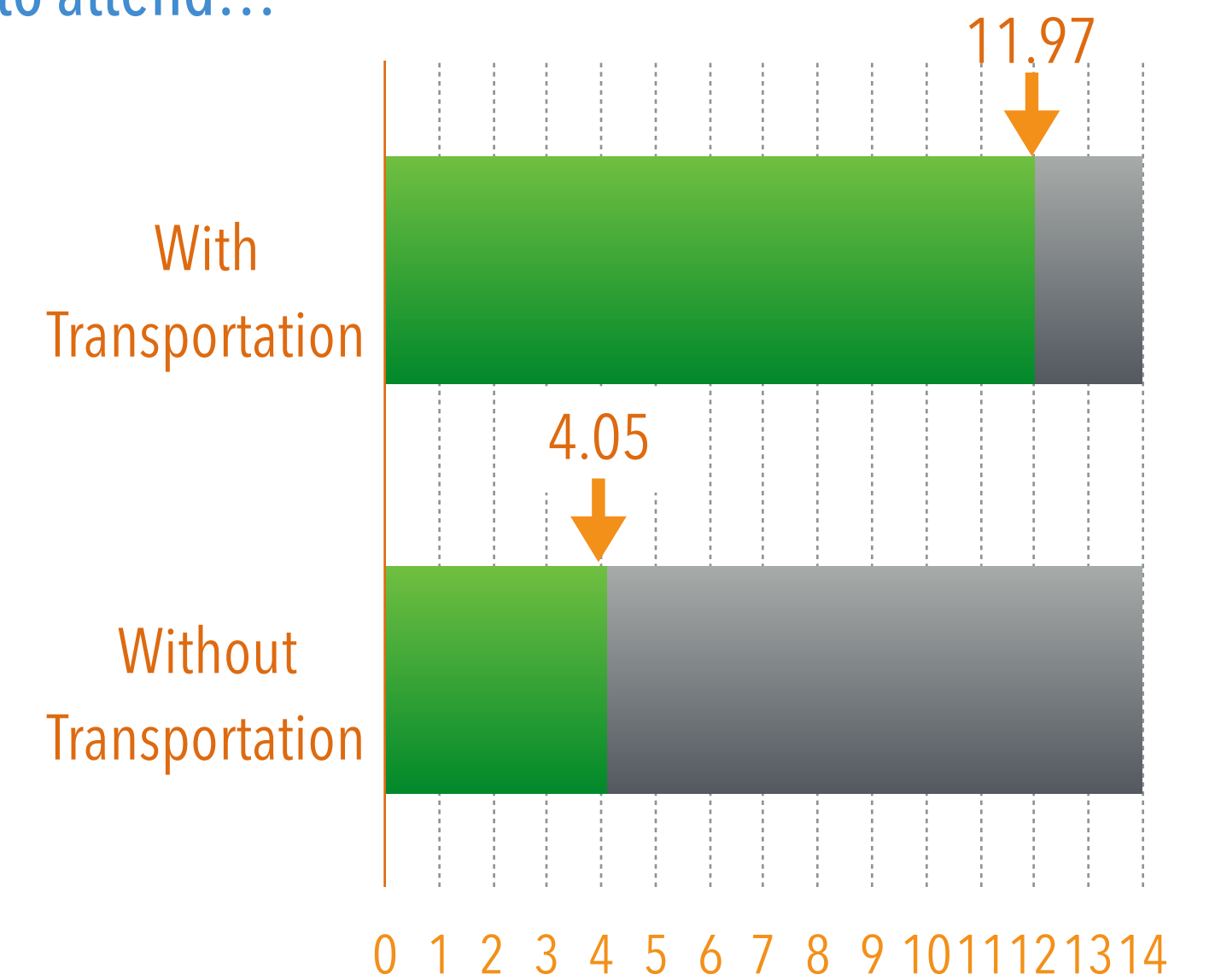

How many medical appointments, per month, do you typically have scheduled to treat your condition?

How many of those medical appointments, per month, would you say that you go to?
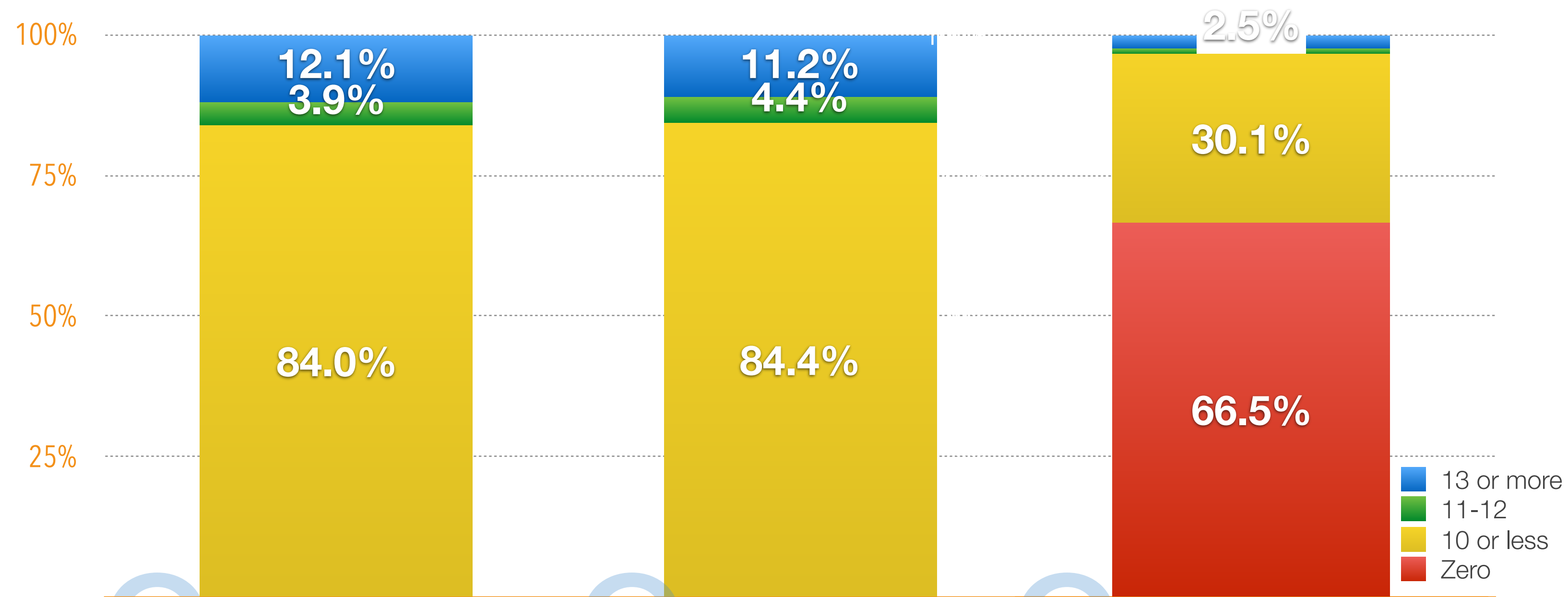
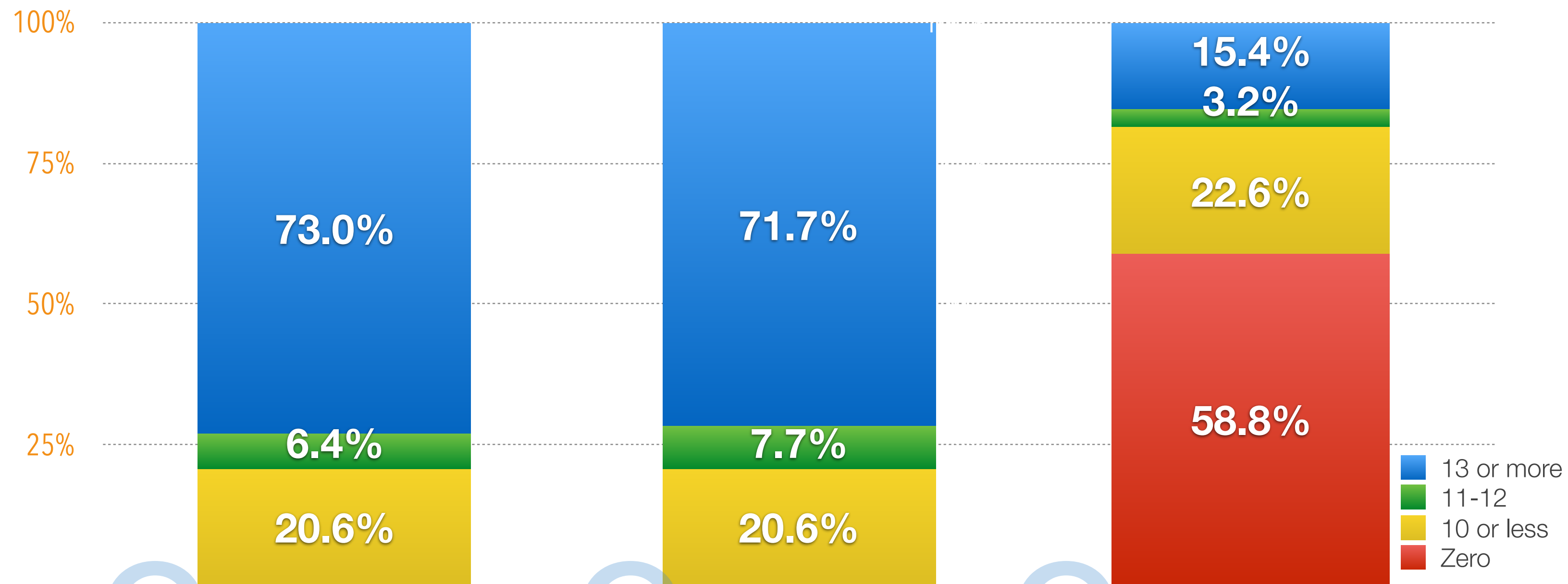If you did not have access to medical rides, how many monthly appointments do you believe you would attend?

Legend:
- 13 or more
- 11-12
- 10 or less
- Zero

Average number of treatments patients are able to attend…

With Transportation — 16.40
Without Transportation — 4.36
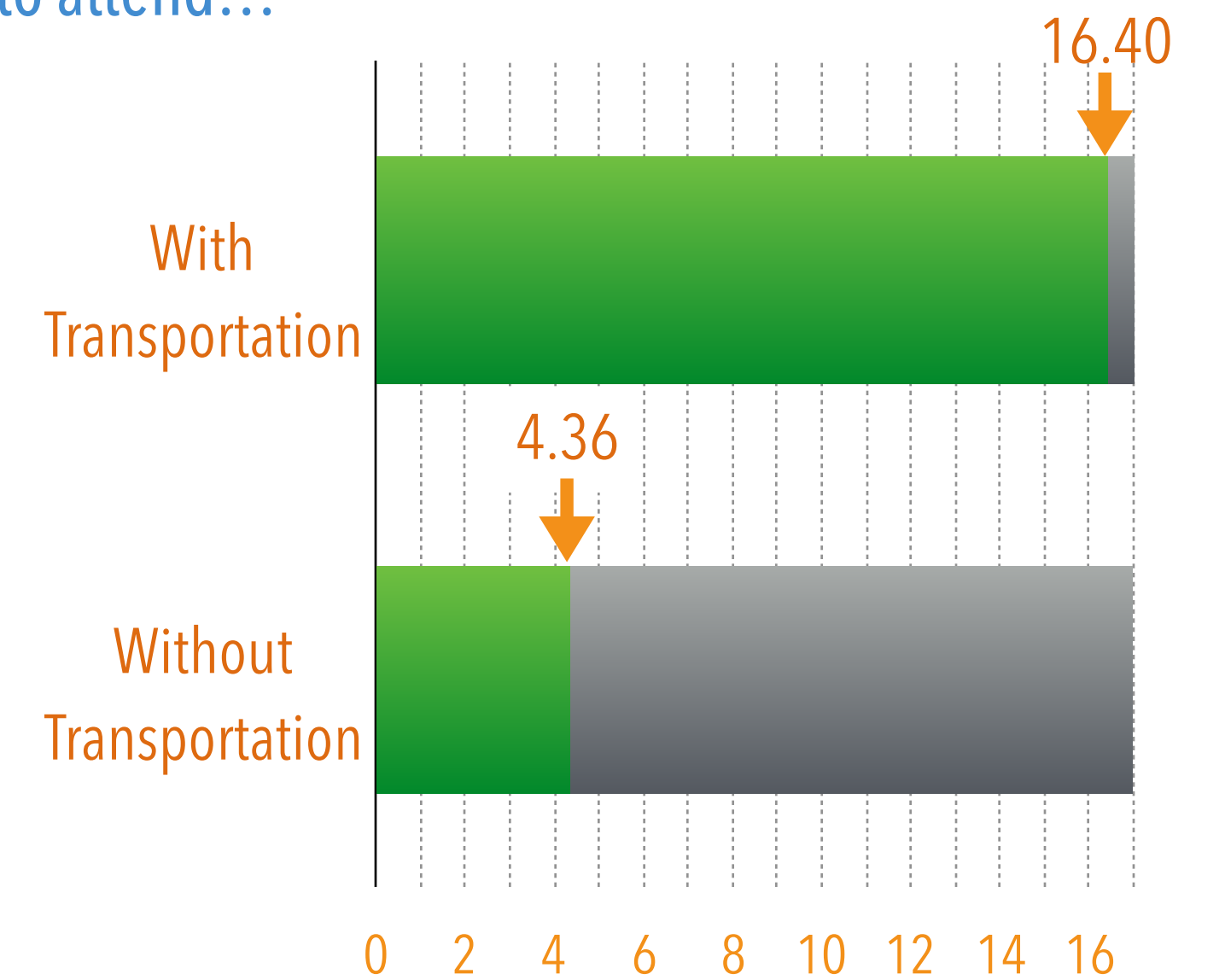
Lack of options for alternative transportation

One-third of all patients surveyed (33.4%) reported having access to personal or public transportation to get to medical appointments, which implies that 651 of the 977 patients surveyed would not have access to personal or public transportation to get to medical appointments. Among those patients without other transportation options, 67.6% would not be able to attend any medical appointments without NEMT services.

Can you use personal or public transportation to get to your medical appointments?

	Yes	No
Dialysis for kidney disease	29.1%	70.9%
Wound care for diabetes	25.2%	74.8%
Treatment for substance use	45.0%	55.0%
Composite		33.4%

Chart y-axis: 100.0%, 75.0%, 50.0%, 25.0%

67.6%
of those <u>without access to public or private transportation</u> **WOULD NOT** be able to attend any appointments

compared to

37.7%
of those <u>with access to public or transportation</u>
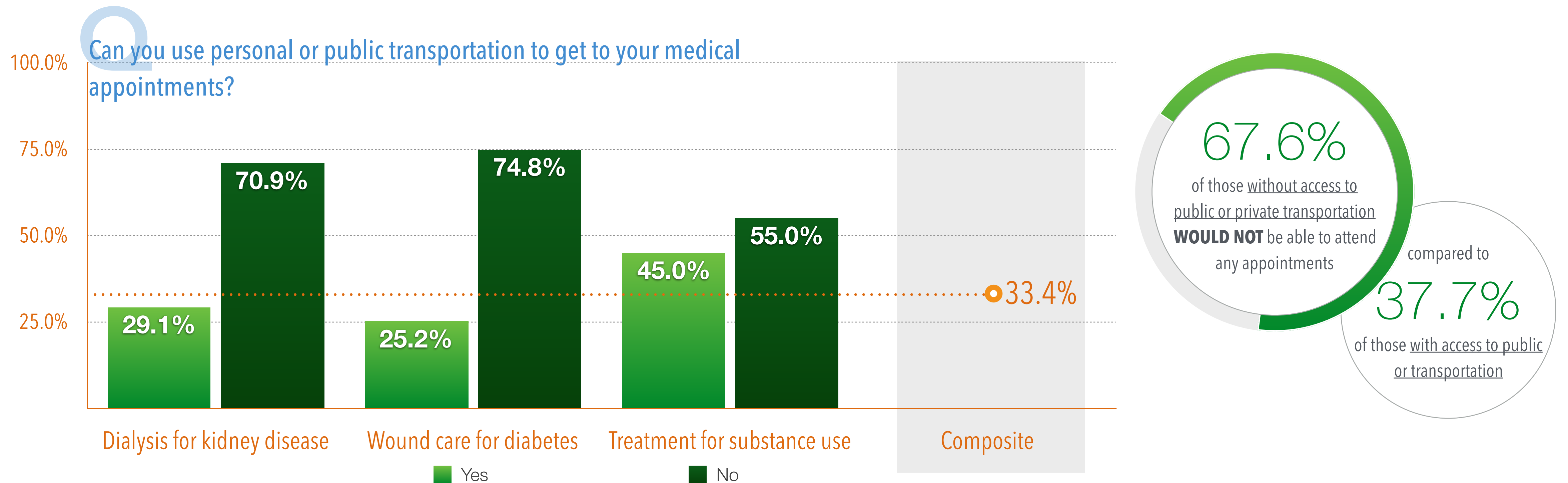
Distance traveled impacts health concerns

Slightly less than one-third of patients reported traveling over 30 minutes for their medical appointments. Among those with an extended travel time, 88.8% reported their health would be much worse and 60.7% would not be able to attend any appointments without NEMT services. Further, two-thirds of rural respondents (66.7%) reported they would not be able to attend any appointments without NEMT services.

Q How long does it take you to travel one-way to your medical appointment?

	Less than 15 mins	15 to 30 mins	31 to 60 mins	More than 60 mins
Dialysis for kidney disease	32.6%	47.2%	17.4%	2.8%
Wound care for diabetes	11.7%	55.8%	23.3%	9.2%
Treatment for substance use	10.6%	42.4%	35.0%	11.9%
Average	21.2%	47.5%	24.3%	7.1%

25.0%   50.0%   75.0%   100.0%

■ Less than 15 mins   ■ 15 to 30 mins   ■ 31 to 60 mins   ■ More than 60 mins

88.8% of those with 30 minutes or more of travel time report there health would be **MUCH WORSE** without transportation

60.7% of those with 30 minutes or more of travel time **WOULD NOT** be able to attend any appointments

66.7% of rural respondents **WOULD NOT** be able to attend any appointments

Out of pocket costs increase

The majority of patients reported that they would be required to pay more out of pocket without access to medical rides (82.6%). Further, a higher rate of respondents receiving treatment for substance abuse (86.2%) and rural respondents (85.7%) reported having to pay more out of pocket without access to rides.

If you did not have access to your medical rides, would you need to pay more out of your own pocket?

	Dialysis for kidney disease	Wound care for diabetes	Treatment for substance use	Composite
Yes	80.0%	83.0%	86.2%	82.6%
No	20.0%	17.0%	13.8%	

85.7%
of rural respondents **WOULD** have to pay more out of pocket without access to rides

compared to

81.6%
of urban respondents

Demographic breakdown

Average number of treatments patients are able to attend… **RESIDENCE**

With Transportation — 11.56
Rural (n=133)

Without Transportation — 2.45

With Transportation — 12.30
Suburban (n=458)

Without Transportation — 3.81

With Transportation — 11.87
Urban (n=386)

Without Transportation — 3.72

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

Suburban 46.9%
Urban 39.5%
Rural 13.6%

Average number of treatments patients are able to attend… **GENDER**

With Transportation — 11.97
Male (n=456)

Without Transportation — 3.80

With Transportation — 12.10
Female (n=521)

Without Transportation — 3.40

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

Male 46.7%
Female 53.3%

Demographic breakdown

Demographic breakdown

Pie chart legend:
- Under 26
- 27-44
- 45-64
- 65-80
- 81 and over
- Refused

Pie chart values:
- 52.9%
- 18.0%
- 2.8%
- 1.6%
- 3.1%
- 21.6%

Average number of treatments patients are able to attend…

AGE

18 and under (n=2)
- With Transportation: 9.50
- Without Transportation: 3.00

19-26 (n=28)
- With Transportation: 13.03
- Without Transportation: 3.29

27-44 (n=211)
- With Transportation: 13.44
- Without Transportation: 3.48

45-64 (n=517)
- With Transportation: 12.13
- Without Transportation: 3.99

65-80 (n=176)
- With Transportation: 10.60
- Without Transportation: 2.98

81 and over (n=27)
- With Transportation: 9.37
- Without Transportation: 2.56

Axis: 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

Demographic breakdown

Average number of treatments patients are able to attend… RACE

White/Caucasian · Black/African American · Asian · American Indian · Hispanic · Refused

Pie chart values: 48.8%, 30.3%, 6.7%, 12.6%, 1.4%, 0.2%

	With Transportation	Without Transportation
White/Caucasian (n=289)	12.45	3.39
Black/African American (n=466)	11.75	3.79
Asian (n=14)	13.14	3.93
American Indian (n=2)	12.00	6.00
Hispanic	13.08	3.68
Other	11.05	2.63

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

Demographic breakdown

Pie chart legend: None (80.8%), 1 (11.2%), 2 (5.3%), 3 (1.7%), 4 (0.6%), 5+ (0.4%)

Average number of treatments patients are able to attend…

DEPENDENTS

No dependents (n=789)
- With Transportation: 12.04
- Without Transportation: 3.55

1 child dependent (n=109)
- With Transportation: 12.13
- Without Transportation: 4.28

2 child dependents (n=52)
- With Transportation: 11.13
- Without Transportation: 3.12

3 child dependents (n=17)
- With Transportation: 13.06
- Without Transportation: 3.76

4 child dependents (n=6)
- With Transportation: 13.33
- Without Transportation: 2.67

5+ child dependents (n=4)
- With Transportation: 13.00
- Without Transportation: 0.25

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Non-Emergency Medical Transportation: Findings from a Return on Investment Study

Americans with low incomes may lack access to reliable transportation, and lack reliable of transportation can lead to missed medical appointments and poor health outcomes. To check this problem, Non-Emergency Medical Transportation ("NEMT")—free or low-cost transport to medical appointments for beneficiaries who need it—has been a mandatory Medicaid benefit since the program's inception in 1966. It is codified in regulation.[1] States can limit its availability through federal waivers. The Trump Administration's budget would allow states to limit the benefit without seeking a waiver.[2] Indiana and Iowa do not provide the benefit to a most beneficiaries within their Medicaid expansion populations, and Kentucky and Massachusetts plan to do so.[3]

We face an unusual moment where NEMT is being expanded across multiple health insurance markets even as it faces curtailment in Medicaid.[4] Perhaps this is because we lack strong evidence of the financial benefit of NEMT, although a few studies have offered positive savings frameworks.[5] Because there is limited research on the financial benefit of NEMT, the Medical Transportation Access Coalition commissioned Faegre Baker Daniels Consulting, Wakely Consulting Group, and Patricia Salber, M.D., to conduct a first of its kind study to examine NEMT's return on investment. The findings suggest that NEMT more than pays for itself as part of a care management strategy for people with chronic diseases, resulting in a total positive return on investment of over $40 million per month ($480 million annually) per 30,000 Medicaid beneficiaries. The methodology used to conduct the study and calculate disease specific results is detailed below.

Methodology Used to Calculate ROI

The financial benefit of NEMT is likely to be shown most clearly in the costs avoided due to increased utilization of lower cost medical services (i.e., physician appointments) to increase adherent treatment care. The theory goes: missed medical appointments lead to deviations from clinical guidelines which, in turn, lead to complications and increased expensive medical services, such as hospitalizations. Therefore, for each disease and corresponding treatment, our ROI methodology involved: (1) determining the present-state treatment volumes of NEMT users and expected future-state treatment volumes if NEMT were not provided; (2) calculating the difference in total medical costs at the present-state and future-state treatment volume levels; (3) subtracting the cost of NEMT from change in total medical costs; and (4) extrapolating the per member per month ROI to the appropriate disease population.

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[1] See: https://www.healthaffairs.org/do/10.1377/hblog20180608.971229/full/ . See also: 42 CFR § 431.53: "Assurance of transportation. A State plan must—(a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and (b) Describe the methods that the agency will use to meet this requirement."

[2] Per the President's budget: "Make Medicaid Non-Emergency Medical Transportation Optional: Under current regulations, states are required to provide Non-Emergency Medical Transportation to all Medicaid beneficiaries. The Budget commits to using regulatory authority to change provision of this benefit from mandatory to optional." See also: https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

[3] Iowa, Indiana, and Kentucky eliminate the benefit for most non-medically frail adults covered by Medicaid expansion; Massachusetts and Arizona may implement similar cuts.

[4] See: https://www.healthaffairs.org/do/10.1377/hblog20170920.062063/full/

[5] A 2008 study conducted by Florida State University concluded that if only 1 percent of the medical trips funded resulted in the avoidance of an emergency department visit, the payback to the State would be 1108 percent. A 2013 study in the *Journal of Health Economics and Outcomes Research* examined the high costs of ambulance transportation and suggested that greater use of public transportation and NEMT might save as much as $1 billion a year.
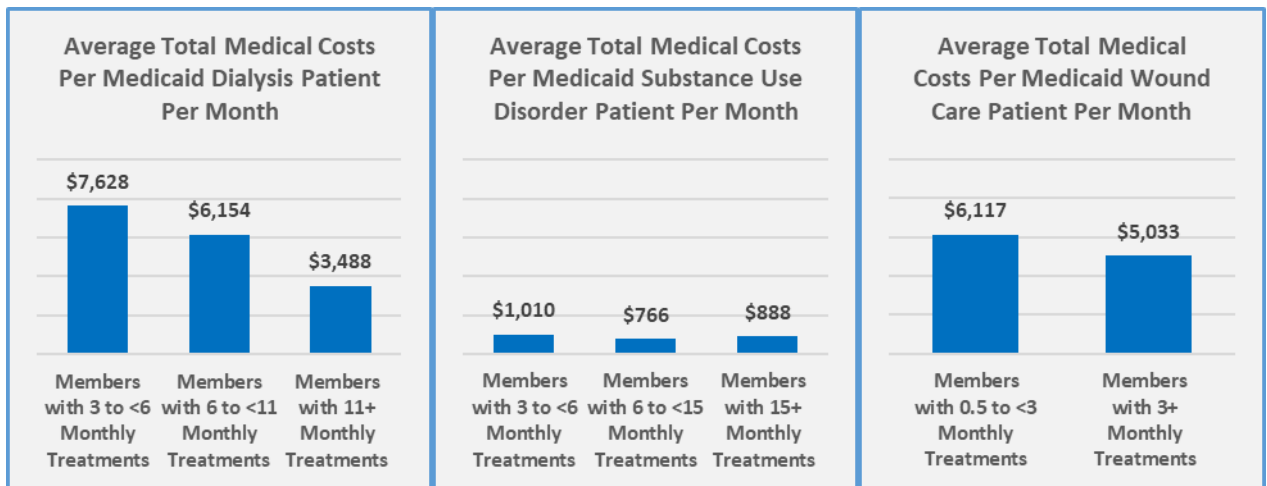
Calculating Medical Costs by Treatment Volumes

Six diseases and corresponding treatments were identified as potentially having sufficient monthly treatment volumes to be evaluated for this study: (1) wound care for diabetic wounds, (2) dialysis for kidney disease, (3) treatment for bipolar disorder, (4) treatment for schizophrenia, (5) adult day care for dementia, and (6) treatment for substance use disorder. We reviewed 2014 and 2015 Medicaid claims for each type of treatment using the Truven Health MarketScan® Database. For each disease and treatment, medical claims, pharmacy claims, and long-term care claims for members[6] enrolled during the 24-month period were processed based on the following logic:

1. Members were identified based on an initial indicator claim and the earliest date of treatment was recorded (the "identification date"). Members whose identification date was after August 31, 2015, were excluded from the analysis. This restriction was included to ensure that an adequate number of months were used to determine the monthly adherence rate (defined below).

2. Adherence events occurring after the identification date were counted and recorded, and members were segmented by the number of days containing an adherence event post-identification divided by the member months post-identification (the "monthly adherence rate").

3. All medical costs for each monthly adherence rate segment were summed together and divided by the total number of member months for the segment to determine the average total medical costs per member per month for the segment.

4. Finally, monthly adherence rate segments were combined based on clinical treatment protocols and medical cost changes, and very low volume treatment segments were excluded.

Additional parameters were used for dialysis and diabetic wound care. Members identified as having had a kidney transplant were removed from the analysis at the date of transplant. Members with wound care treatments spanning fewer than sixty days were not included in this study and the observation window used to calculate the monthly adherence rate for the remaining members was limited to sixteen weeks during the 24-month period after the initial treatment, since regular treatment for a wound is generally limited to 16 weeks. We did not find credible population sizes or claims for bipolar disorder, schizophrenia, and adult day care for dementia. Hence, these diseases were dropped from the analysis. The following charts show the average total medical costs for each of the remaining conditions by monthly adherence rate categories.

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[6] We use the term "members" in this paper in the interest of conforming with common health insurance industry terminology (i.e., per-member per-month). Use of this term is not meant to imply that this study controlled for a managed care delivery system. Rather, both the claims dataset and survey included a mix of fee-for-service and managed care enrollees.

Average Total Medical Costs Per Medicaid Dialysis Patient Per Month

$7,628 — Members with 3 to <6 Monthly Treatments
$6,154 — Members with 6 to <11 Monthly Treatments
$3,488 — Members with 11+ Monthly Treatments

Average Total Medical Costs Per Medicaid Substance Use Disorder Patient Per Month

$1,010 — Members with 3 to <6 Monthly Treatments
$766 — Members with 6 to <15 Monthly Treatments
$888 — Members with 15+ Monthly Treatments

Average Total Medical Costs Per Medicaid Wound Care Patient Per Month

$6,117 — Members with 0.5 to <3 Monthly Treatments
$5,033 — Members with 3+ Monthly Treatments

Survey to Determine Treatment Volumes with and without NEMT

To determine the present-state treatment volumes of NEMT users and expected future-state treatment volumes if NEMT were not provided, we surveyed Medicaid beneficiaries who use NEMT to attend their medical appointments. We surveyed Medicaid beneficiaries in New Jersey, Louisiana, and Michigan who use NEMT services provided by LogistiCare, the nation's largest NEMT broker.

We asked survey participants the following questions: what disease treatment he or she uses NEMT to attend; whether he or she has access to public or private transportation; what type of NEMT he or she uses; how many treatments he or she attends per month and uses NEMT to attend; how many treatments he or she would attend per month absent the availability of NEMT; how his or her health has been affected by NEMT; and what would happen if NEMT were not provided.

The survey vendor collected 460 surveys from respondents who self-identified as dialysis patients, 311 who self-identified as substance use disorder patients, and 206 who self-identified as diabetic wound care patients. We then calculated the self-reported average treatment volumes with and without NEMT per disease/treatment. See the averages and standard deviations below. (Note: nearly all survey respondents reported that they used NEMT to attend all of their treatments.)

Dialysis			Treatment for SUD			Wound Care		
Survey Count	Average Treatments per Month with NEMT (SD)	Average Expected Treatments per Month without NEMT (SD)	Survey Count	Average Treatments per Month with NEMT (SD)	Average Expected Treatments per Month without NEMT (SD)	Survey Count	Average Treatments per Month with NEMT (SD)	Average Expected Treatments per Month without NEMT (SD)
460	12.0 (1.5)	4.1 (5.3)	311	16.4 (6.1)	4.3 (7.2)	206	5.5 (3.7)	1.3 (2.7)

Overall, 58% of respondents reported that they would make none of their treatments if NEMT were not provided, 22% reported that they would make all of their treatments if NEMT were not provided, and

20% reported that they would make less than all but more than none of their treatments if NEMT were not provided. Importantly, in open-ended response to the question "what would happen if you did not have the transportation ride services you currently receive," 103 respondents (10%) reported that they would die or probably die.

We found limited variation in the survey data by different demographics. No significant variations were found between members in different states, different genders, different marital statuses, different ethnicities, different living environments (urban/rural/suburban), or different age ranges. The only significant variations were found between members that responded "yes" or "no" to the question "do you have access to public or private transportation. "Yes" respondents were approximately two times higher on average than "no" respondents in projecting the number of expected treatments per month without NEMT.

Specific Disease Results

A positive ROI was found for both dialysis for kidney disease and wound care for diabetes. The study failed to determine a positive ROI for SUD, though we believe our methods were ill-suited for SUD treatment and might have had better results under different study parameters.

Survey respondents reported attending 12.0 dialysis treatments per month on average with NEMT and would expect to attend 4.1 treatments per month without NEMT. The Medicaid cost analysis shows that dialysis patients who attend 3 to 6 dialysis treatments per month incur on average $4,140 more per month in total medical costs than dialysis patients who attend 11+ dialysis treatments per month.[7] The cost of the average round trip of NEMT for dialysis patients (based on private broker data) is $60.24, so the average cost of NEMT per survey respondent per month for dialysis is 11.9[8] x $60.24 = $717.25. Therefore, the Medicaid cost avoided due to NEMT per survey respondent per month is $4,140 – $717.25 = $3,423. Assuming that the survey represents at least 10,000 like Medicaid members, the ROI of NEMT for treating kidney disease with dialysis per 10,000 members per month is $34,229,448.

Survey respondents reported attending 16.4 treatments for SUD per month on average with NEMT and would expect to attend 4.3 treatments for SUD per month without NEMT. The Medicaid cost analysis shows that SUD members who attend 3 to 6 treatments per month incur on average $123 more per month in total medical costs than SUD members who attend 15+ SUD treatments per month. The cost of the average round trip of NEMT for SUD patients (based on private broker data) is $20.47, so the average cost of NEMT per survey respondent per month for SUD is 16.3 x $20.47 = $333.71. Therefore, the Medicaid cost avoided due to NEMT per survey respondent per month is $123 – $333.71 = ($211). Assuming that the survey represents at least 10,000 like Medicaid members, the ROI of NEMT for treating SUD per 10,000 members per month is ($2,109,779). While our analysis does not yield positive ROI for SUD transportation, we believe different study parameters, i.e., a longer claims analysis period, relapse rates, quantification of social costs (e.g., increased employment and productivity, less law enforcement and judicial system costs, less strain on child services agencies and foster care system), likely would have led to positive ROI.

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[7] We note that alignment with the survey results with the similar average bucket is a simplifying assumption as the distribution may be non-normal. However, given data limitations, we believe this assumption is appropriate.

[8] The average NEMT round trips per member per month (11.9) is slightly less than average treatments per member per month for dialysis (12) since a few dialysis survey respondents reported that they used NEMT to attend less than all of their treatments.

For diabetic wound care, survey respondents reported attending 5.5 wound care treatments per month on average with NEMT and would expect to attend 1.3 treatments per month without NEMT. The Medicaid cost analysis shows that wound care patients who attend 0.5 to 3 wound care treatments per month incur on average $1,084 more monthly medical costs than wound care patients who attend 3+ wound care treatments per month. The cost of the average round trip of NEMT for wound care patients (based on private broker data) is $53.25, so the average cost of NEMT per survey respondent per month for wound care is 5.5 x $53.25 = $291.96. Therefore, the Medicaid cost avoided due to NEMT per survey respondent per month is $1,084 – $291.96 = $792. Assuming that the survey represents at least 10,000 like Medicaid members, the ROI of NEMT for attending diabetic wound care treatments per 10,000 members per month is $7,920,635.

Disease/ Treatment	Average Treat. per Month with NEMT	Average Monthly Medical Cost with NEMT	Average Treat. per Month without NEMT	Average Monthly Medical Cost without NEMT	Average Monthly Medical Cost Increase without NEMT	Average Cost per NEMT Round Trip	Average NEMT Round Trips PMPM	Total Cost of NEMT PMPM	Avg. ROI of NEMT PMPM	ROI Per 10,000 Members Per Month
Dialysis for Kidney Disease	12.0	$3,488	4.1	$7,628	$4,140	$60.24	11.9	$717.25	$3,423	$34,229,448
Treatment for Substance Use	16.4	$888	4.3	$1,010	$123	$20.47	16.3	$333.71	($211)	($2,109,779)
Wound Care for Diabetes	5.5	$5,033	1.3	$6,117	$1,084	$53.25	5.5	$291.96	$792	$7,920,635

For all conditions, the total ROI per month is $40,040,304 (per 30,000 members; 10,000 in each condition).

Policy Implications

The significant positive ROI associated with dialysis and wound care transport demonstrate that, at least for these conditions and presumably others (such as asthma and heart disease), curtailing NEMT is penny-wise, pound-foolish. While our analysis does not yield positive ROI for SUD transportation, we believe that speaks to study limitations rather than the value of the benefit. The data presented above offers a strong indication that NEMT more than pays for itself as part of a care management strategy for people with chronic diseases within and outside of Medicaid.

To learn more about this study, contact: Tricia Beckmann Tricia.Beckmann@faegrebd.com.
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SNP Alliance
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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From: Tim <tim@kauffmanpt.com>
Sent: Friday, October 26, 2018 2:32 PM
To: ASPE SES IMPACT Study (OS/ASPE)
Subject: Impact Act Research Study

To whom it may concern:

I am responding to your request for comments about the Impact Act.

The biggest problem that I experience as a provider is that many of the Medicare replacement plan require beneficiaries to pay large co-pays ($25-$50) for each episode of care. In rehabilitation, most patients need 2-3 times weekly care in order to achieve goals of care. The social risk is that many retirees cannot afford these high copays and as a result they attain only poor to fair outcomes of care. Their medical risk increases because of the lack of proper care.

When going to a physician once a month or every 6 months the copays are easier to make. However, proper care in rehabilitation of 2-3 times weekly is not acceptable. I suggest that the copay for rehab be reduced to $10.00 for persons with low incomes and for persons who pay a higher premium for standard Medicare the copay can be higher. Another option would be a single monthly copay.

Thank you for working to improve care for Americans.

— Timothy L. Kauffman PT, PhD, FAPTA, FGSA

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]

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[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.

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.

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:

- - o Notes from hospital social workers, therapists and dieticians are often times not sent to outpatient providers
    - o 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:
    - o Facility discharge summary problem list
    - o Specialist notes problem list
    - o Health plan list of chronic conditions
    - o 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

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[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.

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[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

November 16, 2018

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

> RE: RFI: IMPACT Act Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

> *Submitted electronically via* ASPEImpactStudy@hhs.gov

UnityPoint Health ("UPH") appreciates this opportunity to provide feedback on the request for information. UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 38 hospitals in metropolitan and rural communities and 15 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits. In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Health Accountable Care (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program as well as providers from the Pioneer ACO Model.

UPH respectfully offers the following comments.

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

It is widely accepted that social determinants of health greatly impact an individual's health and quality of life. As an integrated healthcare system, our goal is to collaborate with community partner organizations to provide the right care, at the right time, without defect or duplication for our patients and their families, and improving reliability in care coordination across the care continuum. Our care delivery footprint lies in nine regions across three states and our efforts at standardizing holistic patient assessment and care coordination is ongoing. Our workplan targets:

- o   Connection to primary care physicians
- o   Cross-continuum care plans to share information

- o   Standard approach to patient and caregiver education
- o   No wrong door policy
- o   Mechanism for targeted case management
- o   Risk stratification for disease process, social determinants and social programing
- o   Organizational sustainability
- o   Ability to contribute in measurable applicable standardized quality benchmarks

The implementation of our approach relies heavily on the skills of our social workers (embedded throughout our healthcare system in a variety of roles) and preferred providers, is supported by data and various decision support tools and is dependent upon the robustness of available community resources.

Given our largely rural geography, we would like to emphasize that rural communities have additional challenges when addressing social risk factors – both in healthcare and community supports. In Iowa, UPH is participating in the Iowa SIM Healthcare Innovation and Visioning Roundtable, which was established in recognition that "socio-economic challenges in providing access to high quality healthcare in Iowa's communities threaten the sustainability of the healthcare system and the health of Iowans."[1] The variability of resources across geographies is a real concern that does not lend itself to uniform, prescriptive requirements for social risk interventions. Not every community has public transportation or available and affordable housing stock and food deserts (even in our agricultural state) are prevalent. In addition, the rural population itself generally is older, more medically complex, and less affluent. **We would encourage that any recommendations be evaluated for impact on rural beneficiaries and consider gaps in the distribution of publicly available resources.** We were encouraged by the release of the first CMS strategy related rural health this spring and would urge that CMS tap into that Rural Health Council and relevant stakeholders to assure appropriate fit within rural communities.

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

A traditional medical view of a patient using Evaluation and Management (E/M) coding, ACO metric capture and other commonalities are available for capture. These include presence of falls, depression, substance abuse, tobacco use, enrollment in Medicaid, and dual eligibility status to list a few. Various indicators are then automatically transferred to our EPIC common care plan updated by navigators and coordinators.

- **Are there especially promising strategies for improving care for patients with social risk?**

In Iowa, the Medicaid Integrated Health Home (IHH) program has been particularly successful for adults who meet the criteria for a Serious Mental Illness or children who meet the criteria for a Serious Emotional Disturbance.[2] This program is authorized through a State Plan Amendment. The IHH provides care coordination through a team of professionals, including access to Family and Peer Support services, and

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[1] Healthcare Innovation and Visioning Roundtable, Recommendations to Governor Reynolds on Improving the Health of Iowans, September 2018, p 2 accessed at https://dhs.iowa.gov/sites/default/files/SIM_RoundTable_Recommendations_Sept2018.pdf
[2] State Plan Amendment - https://dhs.iowa.gov/sites/default/files/Attachment%203%201-H%20-%20SPMI%20Page%201-50%20as%20of%20030416.pdf; and Iowa Medicaid Enterprise informational webpage - https://dhs.iowa.gov/ime/providers/integrated-home-health

across all aspects of an individual's life, including coordination of physical health care and successful transitions from inpatient and other residential treatment. Community Mental Health Centers (CMHC) are among the organizations that provide this intensive care coordination service. Due to the investment of resources within our CMHCs and the trust that they have built within their communities, we are investigating **an expanded IHH model for the entire population in which CMHCs would retain a lead agency role**. Features of such a model include outreach within the community and staffing levels would equal about 1 community support specialist FTE per 150 patients.

Another promising strategy is to **strengthen our ability to leverage social service organizations** to best utilize expertise and scarce resources. We cannot overstate the importance of public health departments and area agencies on aging in this respect. When we make a community handoff, we need to be confident that the individual referred will have a central point of contact and that the point of contact accepts responsibility for that individual and perhaps the family. We have moved the needle in Fort Dodge, Iowa, where the Webster County Health Department is responsible for follow-up assessments and care coordination for individuals with social determinants of health needs. In other regions, we are involved in "basic needs" groups, which are collectives of health and social services agencies, which monitor the use of wrap-around services, strive for efficiencies and identify service gaps.

- **How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?**

Although this question focuses on costs, the Iowa Healthcare Innovation and Visioning Roundtable has suggested that **Healthy Communities should demonstrate value more broadly through valid and reliable metrics that measure desired outcomes**.[3] These metrics are:

- Unnecessary or potentially preventable ED use
- Potentially preventable hospitalizations
- Cost (e.g. total cost of care)
- Linkage with appropriate primary behavioral health care
- Other institutional care
- Appropriate care and patient outcomes
- Health improvement
- Community care

- **What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?**

We believe that referral best practices should involve referrals to reputable agencies with capacity to provide appropriate supports in a timely manner. In Iowa and Wisconsin, the United Way organizations sponsor the 2-1-1 service. This service is available by phone, text and internet – it is free, available 24-7, and identifies local human services and health resources and services. The Area Agencies on Aging have also been updating the functionality of the Aging and Disability Resource Center (ADRC) database. We believe that there is much potential to more specifically customize the ADRC database to provide more

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[3] https://dhs.iowa.gov/sites/default/files/SIM_Roundtable-HealthyCommunitiesWorkgroupBreakout_06142018.pdf

robust decision support when services are needed. As part of this effort, we are working with the Iowa Department on Aging to explore community management options.

Given the shortcomings of current solutions, many health systems and health plans, including Medicaid managed care organizations, have invested in creating their own community support profiles/databases. These usually attempt to identify those agencies with capacity and particularly look to leverage community organizations with public funding (federal, state and local) as well as private grants and sustainable funding sources. It appears that there are numerous well-intended, but duplicative, efforts in this area, which may benefit from federal leadership.

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

Our workplan, referenced in response to the initial overall question, incorporates action steps from our lessons learned and evidence-based practices. In terms of population health, we need to serve this population where they are, as our ability to steer care or services is limited by social risk factors. In terms of resources, we need to partner with community liaisons who are trusted within the community. While a couple of our urban regions are employing a community health worker model, this model has not been widely tested in our rural areas.

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

Lack of community resources: For rural areas, resources may not exist. It is disingenuous to make referrals to agencies without capacity or ability to timely respond. To mitigate this barrier, we would suggest that CMS be clear regarding expectations for providers to directly address social needs and further that gap analyses could be undertaken to identify service / resource deficiencies and assure that resources are allocated accordingly. We believe this gap analysis could be incorporated with some standardized elements within Community Health Needs assessments.

Impact of multiple social risk factors: Similar to a patient with complex, compounding conditions, it has been our experience that individuals often have several social risk factors. Multiple risk factors make community hand-offs more difficult. The presence of multiple factors often manifests itself by individuals moving from one crisis to another - paying rent, getting food, finding work, locating transportation, paying for medication, etc. Fragmented service delivery makes it difficult for organizations to stay connected with individuals over time and results in a relatively short window of time in which to influence this population. This short timeframe is hampered by this population's more transient nature, not only in physical location but also with frequently changing phone contacts. These concerns would be mitigated by a centralized agency or point of contract that can address and coordinate multiple social service needs. We would suggest that a more global support payment rather than individual subsidies in housing, subsidies in food, and other compounding needs would be a much better use of the actual resources versus the administrative structures duplicated from agency to agency

- **For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?**

It would be our contention that within the greater burden of poverty there lies the need to assess individual or family unit needs. Depending on that individual's support structure, the ability to give right care, right services, right place and right time is often highly individualized.

COLLECTION AND USE OF DATA
- **Which social risk factors are most important to capture?**

We recommend a two-tiered approach, under which an initial capture of a small set of information could be extracted from the EHR as the result of the annual wellness visit or social history within the E/M documentation (and outside a separate assessment tool). Per guidance of the American Academy of Family Physicians, the Past, Family, Social History component of the CPT code for E/M visits creates an opportunity to record these data points.[4] Social History is described as age appropriate review of patient activities (substance use, living arrangements, sexual history, employment, education, etc.) and it is specifically noted that Medical Decision Making refers to the complexity of establishing a diagnosis and/or *determining a management option* (italics added). While notations of specific social determinants of health is not mandated, they can push a patient into the high complexity category due to the factors surrounding the patient's situation. Below is a list of social risk factors that may be contained within the EHR and should serve as a starting point.

Data Points	When Collected	Notes
Employment	At registration if insurance is on employer plan	
Insurance status	At registration	
Transportation	E/M	"who brought you today?"; "do you have a way to get back home and to pick up the medications I've prescribed?"
Nutrition	Required as part of the BMI discussion	Noted on After Visit Summary
Personal safety / falls prevention	In falls protocol	
Ability to afford medications		Quality indicator in the CG-CAHPS "stewardship of patient resources"
Housing	Triggered if home safety concerns	Addressed as home safety falls
Physical activity	E/M	
Substance use	E/M	Includes tobacco
Mental health	Separate depression screening at visits	
Disabilities	HCC and updated problem list	

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[4] https://www.aafp.org/practice-management/payment/coding/evaluation-management.html

Family and community support	Updated if care navigator or coordinator	

Given that the above are already documented, we are not convinced that CMS needs to require the capture of additional screening data points and would not support the addition of a separate initial social risk questionnaire to an already arduous rooming process. Of course, if these EHR screening data trigger a more robust evaluation, we would support follow up via further assessment and/or referrals.

- **Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?**

It is our opinion that **registration into an EHR (requirement in interoperability, meaningful use and E/M visits) already provide a platform to collect basic social risk screening data**. We do not dispute that social determinants of health impact health outcomes and quality of life. The challenge with requiring healthcare providers to collect additional data internally is that we don't know the most useful social risk data to collect and collecting a very comprehensive record has come with almost infeasible administrative burden. We would remind CMS that should these documentation requirements change to become more specific, this will result in EHR vendor report builds and associated costs and training efforts.

- **Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?**

There is quite a lot in the Meaningful Use standards. We would request that CMS distinguish the requirements in the medical record itself versus the EHR platform.

- **What are barriers to collecting data about social risk? How can these barriers be overcome?**

Social risk factors are maintained by multiple service organization and data platforms. Interoperability and privacy concerns are issues inherent with sharing information to coordinate care and resources. In some instances, community organizations may not have online platforms. Further challenges to collecting data is that existing platforms are not standardized and the data contained lack consistency, accuracy and completeness. To minimize these challenges, states or the federal government could institute data standards as a condition of receiving public funds.

- **What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?**

In one of our regions, we are piloting an artificial intelligence solution to reduce readmissions or avoidable ambulatory conditions. This tool utilizes social and public data (in public domain and purchased databases), creates geographic clusters based on zip+4, makes assumptions based on the data and then offers a list of interventions. The region in the pilot experienced a reduction in readmissions and the tool supported our social workers to perform targeted triage/interventions. That said, it is unclear that the addition of social risk data at the Census block or higher level of aggregation results in performance gains in identification when considered alongside clinical EHR data.

Instead of requiring providers or health plans to track data from multiple sources for screening, we would suggest that HHS explore the potential for using public databases (federal and state) to establish a social risk screening score. Data could include heating assistance, food assistance, unemployment, and rental assistance. Similar to an HCC score, CMS could create a social risk score that triggers interventions or further assessments.

We are pleased to provide input on this request for information. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Pamela M. Halvorson
Lead Executive Next Generation ACO
UnityPoint Accountable Care

Sabra Rosener
VP, Government & External Affairs
UnityPoint Health

University of Maryland Health Advantage Comments for:
ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Dual-eligible elderly live at, or near, poverty levels, and therefore are more likely to be home bound, be socially isolated, have poor nutrition, require more social supports and be at risk of institutional level of care. These social factors contribute to the complexity of impacting clinical outcomes for chronic conditions with this subpopulation. The most prevalent chronic diagnoses among this vulnerable population are:

- Diabetes
- Heart disease
- Lung disease
- Mental illness or Alzheimer's disease

In identifying this vulnerable population there is specific focus on multiple domains including: claims data; medical records data including but not limited to pharmacy and lab results; beneficiary outreach, and assessments covering: medical, mental health, psychosocial, functional, cognitive and nutritional needs. During assessment and re-assessment, our clinicians will strive for cost savings by avoiding duplicative services and allowing the beneficiary to remain in the least restrictive environment, example-home versus nursing home.

University of Maryland Health Advantage's approach in identifying the most vulnerable beneficiaries utilizes a comprehensive Health Risk Assessment Tool (HRAT) which gathers information pertinent to a beneficiary's overall health status, as well as identify health risks in the following categories:

- Barriers: to meet the goals and /or comply with the individualized care plan

- Behavioral/Lifestyle: tobacco, alcohol and drug usage; physical activity, nutrition, and oral health

- Benefits/Coordination of Benefits: benefits available and level of understanding; work status; disability

- Cognitive Status: educational level, understanding of health conditions, and ability to follow self-management instructions regarding health; memory/thought processing issues

- Communication: language, visual or hearing limitations, preference or needs

- Cultural/Religious: complementary and alternative medicine utilized; any religious or cultural needs, preferences or limitations that may impact healthcare and/or the individualized care plan

- Functional Level: activities of daily living (ADLs), instrumental ADLs, history of falls; elimination, pain and sleep issues; DME usage/needs

- Health Status/Clinical History: General health history, co-morbidities, allergies, and treatment/surgical history

- Internal Care Management Process: member contact information; HIPAA considerations; consent for engagement/participation; marital status; living arrangement; Care Management status

- Life Planning: Healthcare power of attorney, advance directives, living will, life goals

- Preventative Health/Key Metrics: Sexual health, preventative screenings, and immunizations

- Psychosocial/Mental Health Status: Coping status; depressions/stress/anger; loneliness/risk for social isolation; family and social support

- Resources & Support: Caregiver resources/ level of involvement, external resources utilized

- Safety: health and personal well-being issues: safety concerns

- Utilization/ Treatment: Inpatient and Emergency Department (ED) utilizations, PCP and specialist utilization, current treatment plan and planned interventions

The care management application utilizes analytical tools identified in the complex case management data to proactively identify case management opportunities for those beneficiaries who will gain the greatest benefit from more intensive coordination of care. Regardless of opportunities identified, every dual eligible beneficiary is contacted to offer case management services due to the population's high vulnerability identified above. Once engaged, those beneficiaries that can be located, and/or consent to case management services, are engaged in the next steps for case management.

Beneficiaries, who consent to case management services, are further engaged to ensure they have input into the case management opportunities/barriers identified for the ongoing care plan agreement. Beneficiaries and the UMHA Case Manager also agree to the intensity of their care management support. Beneficiaries are sent a copy of the agreed upon care plan. The beneficiaries also agree to have their primary care physician (PCP) allow input into the care plan by having the completed document shared with them for their input. The beneficiary and/or health plan case manager agree to share this document for the PCP input. Sharing will occur via U.S. mail, follow up input to or from the PCP via telephonic notes and/or during the visit of the beneficiary with their PCP.

The intensity of case management contacts is based on the following definitions:

High Risk Members – Beneficiaries with high resource use and risk, including high frequency of visits, more than 3 hospitalizations or ED visits within three months, treatments, multiple co-morbid conditions, non-adherence with treatment, adults with special needs, and poly-pharmacy.

Medium Risk Members – Beneficiaries with a moderate resource use and risk, and a combination of the following: usually beneficiaries with limited number of co-morbidities (typically 3 or less),

1-2 visits to the ED or inpatient hospitalization within previous 90 days, and limited number of gaps in care.

Low Risk Members – Beneficiaries with a low resource use and risk, and a combination of the following: usually individuals with 2 or less co-morbidities, less than 2 ED visits or inpatient within the previous 90 days, and limited number or no gaps in care.

University of Maryland Health Advantage's Population Management programs for Asthma, Diabetes and Chronic Heart conditions take a population-based approach to the clinical and quality management of these conditions. This approach identifies individuals with chronic conditions, and through the use of disease-specific interventions, attempts to alter the course of the disease. Referrals may be received from a number of sources: University of Maryland Health Advantage staff, practitioners, facility staff, vendors, or self-referral by a beneficiary or caregiver. The Disease Management team works collaboratively with other clinicians and licensed professionals at University of Maryland Health Advantage to improve disease state outcomes and maximize individual member functioning.

All dual beneficiaries are referred to our Case Management program for assessment of their needs. Program components include mailed educational materials, provider education on evidence-based clinical guidelines, telephonic member education, and care coordination. The clinical basis for our program was established by using both the State of Maryland and University of Maryland Health Advantage guidelines for chronic conditions.

Dual-eligible beneficiaries are among the sickest and poorest individuals covered by Medicare and Medicaid. The dual-eligible beneficiaries living in our service areas reflect national data and to have significant medical, behavioral health, and social service needs. Past research has demonstrated that there is considerable diversity within the dual-eligible population in Maryland. This diversity has important implications for these beneficiaries' health spending especially between our target population; FBDEs and QMBs. About three-quarters of dual-eligibles are "full duals" and entitled to all Medicaid benefits, including long-term care services. In addition, Medicaid pays Medicare cost sharing for the FBDEs. The balance of dual-eligibles that are called partial duals such as the QMBs, they do not receive Medicaid benefits except for help with Medicare cost sharing. Dual-eligible beneficiaries are at greater risk for having more chronic conditions, mental illness, and impaired functional abilities putting them at greater risk for nursing home admissions as well as an increased utilization of emergency room, inpatient stays and readmissions. Within this dual population, there are vulnerable subpopulations that require additional services. These include frail beneficiaries having multiple, complex and/or chronic conditions, the disabled (both under 65 and over 65), those with end stage illnesses such as cardiovascular and respiratory, and beneficiaries near the end of life. Due to the specialized needs of this identified population there is a need to prioritize beneficiaries through stratification.

Dual-eligible beneficiaries who are under 65 tend to have a higher rate of serious physical, behavioral, or mental illness and have more comorbidities, are socially isolated, and are more

likely to have difficulty with permanent housing, and higher rate of substance abuse. Language barriers and deficits in health care knowledge of the beneficiary can be obstacles in providing the best care possible.   All of these factors have an impact to the health outcomes of our DSNP population. Our multi-faceted clinical team (clinicians, special needs coordinators and social workers) assesses these potential obstacles and uses tools and resources to adjust in these situations. University of Maryland Health Advantage has implemented special provisions to accommodate the beneficiaries in their preferred communication method. Bilingual staff is available as well as a language line and TTY services to better communicate with beneficiaries and caregivers. Also, the staff are trained in using basic medical language to ensure that beneficiary understands the nature of the conversation. In addition, the following is a brief description of some of the specialized benefits which are available to our beneficiaries which are designed to meet the needs of, and improve health outcomes for our vulnerable members:

- Dental Services: Including but not limited to the following services: preventive care (such as cleaning, routine dental exams, and dental x-rays), emergency care visits, including X-rays, dentures, and oral surgery.
- Durable Medical Equipment: Including but not limited to such items as canes, wheelchairs, walkers, commodes, special beds, and monitoring equipment.
- Medical/Surgical Supplies: Including but not limited to items such as urinary catheters, wound dressings, glucose monitors, and diapers.
- Home Delivered Meals, post discharge: A value added benefit which includes preparing, packaging, and delivering meals to member homes during critical transitions of care.
- Home Health: All home health care services, including durable medical equipment (DME) associated with such services; part-time or intermittent skilled nursing care and home health services; physical, occupational, and speech language therapy; and medical social services.
- Transportation: Ambulance services for emergency and for non-emergent medical reasons to doctor appointments by taxi or car transportation
- Vision Care Services: Including the professional services needed for the purpose of diagnosing and treating all pathological conditions of the eye, including eye examinations, vision training, prescriptions, and glasses and contact lenses.
- Over-the-Counter products allowance
- 24/7 Nursing Hotline
- Annual Physical Exam

Due to the complexity of the population across multiple variables including demographic, social and disease burden parameters, University of Maryland Health Advantage places special emphasis on supporting the beneficiaries in the highest risk category exhibiting impactable behaviors that when changed, can support ongoing health and wellness.

University of Maryland Health Advantage has established partnerships with various community organizations that assist in identifying resources for the most vulnerable beneficiaries and/or their caregiver(s). Working closely with community partners and local health departments, our team is able to assist the vulnerable beneficiaries and/or their caregivers in accessing community

services and receiving additional support as needed. After identifying a service need, our team actively solicits, in person or by telephone, a relationship with a service agency if one is not already established. University of Maryland Health Advantage provides the beneficiary and/or caregivers with information including contact name and location. Appointment coordination and/or transportation assistance is also available through University of Maryland Health Advantage.

These established partnerships include, but are not limited to, the following agencies serving adults and seniors:
- ➤ Local health departments by county
- ➤ Adult day services
- ➤ Respite care
- ➤ Residential care
- ➤ Home delivered meals
- ➤ Homemaker services
- ➤ Adult companion services
- ➤ Transportation
- ➤ Health clinics
- ➤ Women's health
- ➤ Men's health
- ➤ Substance Abuse
- ➤ Mental health clinics
- ➤ Domestic violence
- ➤ Specialty health clinics (i.e. Asthma, HIV/AIDs)
- ➤ Specialized medical and supplies and office equipment
- ➤ Immunizations
- ➤ Cognitive development centers
- ➤ Senior community centers
- ➤ Transitional support services
- ➤ Family and caregiver training and education services

If there is already an established relationship between a beneficiary/caregiver(s) with a community resource or agency, the University of Maryland Health Advantage team ensures that relationship is maintained in order to facilitate continuity of care. Each beneficiary's case manager will reach out and coordinate contact information in order to ensure the lines of communication are established.

November 15, 2018

BY ELECTRONIC SUBMISSION

ASPEImpactStudy@hhs.gov

Assistant Secretary for Planning and Evaluation

Department of Health and Human Services

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

To Whom It May Concern:

I am writing in response to the Assistant Secretary for Planning and Evaluation's Request for Information (RFI) on provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors.

I am an Assistant Professor, general medicine physician, and health services researcher at the University of Michigan. My research focuses on assessing policies and programs to improve the health of low socioeconomic status, aging and other vulnerable populations. Part of my work assesses whether and how primary care practices screen patients for social determinants of health. My research findings inform my recommendations below for how to improve care for Medicare beneficiaries with social risk factors. While I conduct my work at the university, my comments do not necessarily reflect the position of the University of Michigan.

I summarize my recommendations for incorporating identification of and addressing social determinants of health into an Enhanced Medicare Annual Wellness Visit (AWV) here:

SUMMARY OF RECOMMENDATIONS:

Practices

- Enhance the Medicare AWV by expanding screening and counseling for social determinants of health.
- Utilize screening tools that include fewer than 10 elements such as the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE, http://www.nachc.org/research-and-data/prapare/) or Accountable Health Communities (https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf) tools.

Payment

- Provide an enhanced payment to safety-net practices that conduct Enhanced AWVs to support new team members and incentivize use of Enhanced AWVs in safety-net practices.

Alignment

- Encourage primary care practices to partner with local Area Agencies on Aging to better address social risks in Medicare beneficiaries.

I provide more detail on my rationale for these recommendations below:

Practices

Several screening tools are available to assess multiple domains of social determinants of health and could be incorporated into an Enhanced AWV. Two prime examples are:

1. *1. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment tool*, which was developed by the National Association of Community Health Centers (http://www.nachc.org/research-and-data/prapare/) and pilot tested in four states before being disseminated in community health centers across the country (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5705433/). PRAPARE core measures include race/ethnicity, education, income, employment, language, migrant status, veteran status, insurance status, socioeconomic status (including income, education and employment), material resource needs (such as food or utilities), housing instability, transportation, neighborhood, stress, and social integration and support. Optional measures include assessments of home and neighborhood safety, domestic violence, refugee status and incarceration history. The developers have created electronic health record templates for this tool in systems such as Epic.

2. *2. The Accountable Health Communities screening tool*, which was developed by the Center for Medicare and Medicaid Innovation (CMMI, https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf). The CMMI tool includes 5 core domains (housing instability, food insecurity, transportation problems, utility needs, interpersonal safety) and 8 supplemental domains (financial strain, employment, family/community support, education, physical activity, substance use, mental health, disabilities).

For efficiency's sake, the screening tool for an Enhanced AWV should contain fewer than 10 elements and enhanced screening requirements should be broad and customizable to individual patient and practice needs. The two screening tools described here emphasize different items, with the PRAPARE tool focusing on identifying actionable needs within safety-net clinics and the CMMI tool focusing on needs that can be associated with excess health care utilization. The PRAPARE tool may be currently easier to integrate into clinical workflows, as it has electronic health record templates, though electronic templates for the Accountable Health Communities tool may also be developed in the future.

To change practices for an Enhanced AWV, it will be important to include all health care team members, including nurse practitioners, physician assistants, nurses, or health coaches who can already perform AWVs within primary care practices. Another type of health care worker that is growing in importance in safety-net clinics is the community health worker, a team member with expert knowledge of the patient's community who serves as a liaison connecting the patient to health and social services (https://www.apha.org/apha-communities/member-sections/community-health-workers). Employing community health workers may be a cost-effective approach to implement an Enhanced Medicare AWV in safety-net settings.

Payment

In its current form, the Medicare Annual Wellness Visit (AWV) is not reaching most older Americans, particularly lower-income or minority adults and those served by safety-net providers (https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1130).

To accommodate potential costs associated with the hiring of new care team members to both screen for and address social determinants of health, Medicare should provide an enhanced payment for community health

centers and similar safety-net practices that conduct Enhanced AWVs, as these practices disproportionately serve older adults with greater social needs. An enhanced payment could also entice other safety-net practices, which are currently less likely to conduct traditional AWVs, to adopt Enhanced AWVs.

Alignment

Programming for addressing social determinants in health care should be coordinated across Medicare, Medicaid and the Aging Services Network to efficiently direct funding toward addressing older adults' individual, social and behavioral needs. For example, local agencies within the Aging Services Network could serve as a key potential partner for primary care practices conducting an Enhanced AWV. As social needs are identified by practices, older adults may be referred to case managers in these local agencies to connect to resources. Area Agencies on Aging provide for a wide variety of services to support older adults in the community, including food assistance, transportation to services, legal assistance, personal care and caregiver support, and social support groups.

CONCLUSION:

To improve care of Medicare beneficiaries with social risk factors, an Enhanced Medicare Annual Wellness Visit should be developed to identify and address social determinants of health. By using efficient social determinant screening tools, including community health care workers in the health care team, enhancing payments to safety-net practices conducting such enhanced visits, and aligning identification of social needs in primary care practices with addressing those needs in Area Agencies on Aging, the health and health care of all Medicare beneficiaries will be significantly improved.

Sincerely,

Renuka Tipirneni, MD, MSc
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Via Electronic Submission (ASPEImpactStudy@hhs.gov)
November 16th, 2018
Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 415-F
Washington, D.C. 20201

RE: Assistant Secretary for Planning and Evaluation (ASPE) Request for Information: IMPACT ACT Research Study: Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Dear Ms. Destro:

On behalf of the Virginia Commonwealth University Health System Authority (VCU Health System), I appreciate the opportunity to respond to ASPE's above-referenced request for information.

VCU Health System is a public body corporate, political subdivision, and instrumentality of the Commonwealth of Virginia. Our missions include, in part, providing indigent care for the citizens of Virginia, serving as an academic medical center, and acting as the principal training hospital for health care profession students of Virginia Commonwealth University. Within the overall system there are several hospitals: VCU Health System, also known as VCU Medical Center/MCV Hospitals, an acute care hospital and Level 1 Trauma Center located in the urban center of Richmond, Virginia; Children's Hospital of Richmond at VCU – Brook Road, a pediatric specialty hospital with long-term care beds and various outpatient clinics providing physical, occupational, and speech therapy; and Community Memorial Hospital, located in rural South Hill, Virginia with acute and long-term care beds.

Additionally, the system includes a faculty physician group (MCV Physicians) and a Managed Care Organization, Virginia Premier Health Plan, which currently covers Medicaid, Medicare and dual eligible lives in the Commonwealth of Virginia. As a quaternary care academic medical center, we provide care to high acuity patients with the most complex needs while serving as the largest safety net hospital in the Commonwealth.

As a safety net hospital, VCU Health System is acutely aware of the relationship between socioeconomic status (SES) factors and health outcomes. This comment includes a review of the activities VCU Health System has undertaken to incorporate SES factors into our delivery of services, VCU Health System's collection and use of data to address patients' SES factors, and ideas that may be useful as ASPE considers how the Medicare program can better account for SES factors in its value-based care programs.

Incorporating SES Factors into Delivery of Service

The request for information asks providers to share how they target services to Medicare beneficiaries with social risk factors. Several VCU Health System initiatives meet this description. These initiatives are detailed below:

Accountable Health Communities

VCU Health System's participation in the Center for Medicare and Medicaid Innovation's (CMMI) Accountable Health Communities (AHC) model is our largest effort to incorporate SES factors in our delivery of services to date. According to CMMI, "the Accountable Health Communities Model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization."[1]

Specifically, the model requires providers to screen Medicare and Medicaid beneficiaries for five health-related social needs:

1. Food insecurity;
2. Homelessness;
3. Difficulty paying utility bills;
4. Transportation needs; and
5. Interpersonal violence

Beneficiaries who screen positive for one or more health-related social need receive a list of community resources that are filtered by their needs and zip codes. Beneficiaries who screen positive for one or more health-related social need and have visited the emergency department in the twelve months preceding the survey also receive a list of community resources. In addition, these patients are referred to a "navigator" who provides one-on-one assistance to the beneficiary for up to a year to help that individual resolve his or her health-related social needs.

VCU Health System student volunteers began screening and referring eligible patients for navigation services in August 2018. Screenings are taking place in seven locations throughout the health system.[2] To date, 2550 patients have received an offer to be screened, and 580 patients have been referred for navigation services. While it is too early to determine with statistical certainty if the model has reduced health care expenditures, we are confident that connecting emergency department heavy utilizers with one or more SES factors to relevant community resources will improve their health outcomes while reducing costs.

Complex Care Clinic

VCU Health System established the Complex Care Clinic in 2011 to care for its sickest and costliest patients. Eligible patients must meet one or more of the following clinical criteria: "(1) have multiple chronic conditions; experience complications from diabetes; receive a referral from a community primary care provider; or (4) have frequent emergency department visits or hospitalizations during a single year."[3] The eligibility criteria also accounts for SES factors, namely income and insurance status. Eligibility for the clinic is limited to uninsured or publically insured individuals with incomes below 100 percent of the Federal Poverty Line.[4] While the clinic does not exclusively serve Medicare beneficiaries, many of its patients are dually eligible for Medicare and Medicaid.

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[1] Center for Medicare and Medicaid Innovation, "Accountable Health Communities Mode," https://innovation.cms.gov/initiatives/ahcm/
[2] Accountable Health Communities are taking place in the emergency, labor and delivery, and inpatient psychiatry departments as well as four outpatient clinics.
[3] DePuccio, M., Farhat, N., Boone, E., Piri, S., Hall, L. (2018). Impact of an Interdisciplinary Care Management Program on Hospital Utilization and Costs. Short Report. Virginia Commonwealth University Office of Health Innovation, pp. 1-18.
[4] DePuccio et al.

The Complex Care Clinic utilizes an interdisciplinary care approach that considers the SES factors of its patients. In addition to providing primary care services, the clinic employs nurses and case managers to provide patients mental health case management services as well as encouragement to access community resources that may alleviate their health-related social needs.[5]

This model has shown promising results. In its first year, researchers found a 44 percent reduction in inpatient admissions, a 38 percent decrease in emergency department utilization, and a 49 percent reduction in total hospital costs among the clinic's patients.[6] More recently, VCU researchers estimated that the clinic saved VCU Health System, on average, $5,253 per patient per year.[7] They also reported a 27 percent decrease in inpatient admissions, a 40.8 percent decrease in inpatient length of stay, a 15.6 percent decrease in emergency department visits, and a 45.3 percent decrease in outpatient visits outside of the Complex Care Clinic.

Finally, the Complex Care Clinic integrated the Accountable Health Communities initiative into its care model in August 2018. This integration will reinforce the clinic's focus on SES factors in its delivery of service.

The Center for Advanced Care Management

The Center for Advanced Health Management (CAHM) also serves medically complex patients, including many Medicare, Medicaid, and dual eligible beneficiaries. In addition to providing facility-based primary care, CAHM offers intensive, home- and office-based case management services for patients with social needs.

CAHM's focus on case management and whole-person care has had a significant positive impact on patients since the facility opened in 2014. One anecdote is particularly telling. A patient who routinely visited the Emergency Department arrived at her first CAHM visit with over 40 prescribed medications. The CAHM care team reviewed her needs and was able to consolidate this regimen into just eight medications.[8]

CAHM is also a base for VCU Health System's participation in CMMI's Independence at Home (IAH) initiative. Through this initiative, CAHM clinicians make house calls for patients who are less mobile, have post-acute or post-ambulatory needs, or who otherwise cannot transport themselves to the office. The Mid-Atlantic Consortium, the IAH practice group in which CAHM participates, achieved per beneficiary per month expenditures 12 percent below CMS's target in its most recent performance year for which data is available.[9]

CAHM has also integrated the Accountable Health Communities initiative into its care model.

Virginia Coordinated Care Program

VCU Health System established the Virginia Coordinated Care (VCC) program in November 2000 to deliver care to uninsured adults living in the Richmond metropolitan area.[10] Under the VCC model, eligible individuals are assigned to a primary care provider in their community. VCU Health System reimburses these providers for providing service to VCC enrollees.

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[5] Ibid.

[6] Unpublished data analysis.

[7] Ibid.

[8] "Progress Notes," *Virginia Commonwealth University Department of Internal Medicine*, (2015)

[9] "Fact Sheet: Independence at Home Demonstration Corrected Performance Year 2 Results," *Centers for Medicare & Medicaid Services*, (2018).

[10] Bradley, C., Gandhi, S., Neumark, D., Garland, S., Retchin, S. "Lessons for Coverage Expansion: A Virginia Primary Care Program for the Uninsured Reduced Utilization and Cut Costs," *Health Affairs*, 31, No. 2 (2012): pp. 350-359.

Patients must re-enroll every year to remain in the program. To be eligible, an individual must be uninsured, have an income at or below 200 percent of the Federal Poverty Line, and be a U.S. citizen residing in VCU Health System's primary service area. The program serves roughly 10,000 individuals.

While the VCC program does not serve Medicare beneficiaries, our experience with it should be useful to ASPE because of its focus on low-income individuals. While VCC does not explicitly screen patients for SES factors other than insurance status and income, most of these individuals suffer from multiple chronic diseases and health-related social needs.

According to one study published in Health Affairs, the average total cost per year per VCC enrollee fell from $8,899 to $4,569 for individuals who remained in the program for three consecutive years.[11] Emergency Department utilization fell by 38 percent and inpatient hospitalizations fell by 45 percent. Critically, the data suggests that continuous enrollment leads to additional savings over time, suggesting that VCC and similar models are increasingly valuable in the long-run.

Challenges and Opportunities

Despite VCU Health System's progress in caring for patients' social needs, significant challenges remain. This section identifies two major challenges and proposes ideas to address them.

Systematic and Standardized Collection of SES Data

Perhaps the most significant challenge to addressing patients' social needs is that there is no single systematic or standardized method to collect data on Medicare beneficiaries' SES factors. There is significant variation how providers screen for SES factors among, and even within hospitals. Moreover, there is no standard method for providers to enter and track that data. These overlapping challenges makes it difficult for providers to follow-up on patients' needs. They also makes it difficult for CMS to use SES data to inform policy and payment initiatives.

One solution is for CMS to encourage providers, perhaps via a value-based payment, to utilize a universal SES screening tool. CMS has already taken a step in that direction with the Accountable Health Communities model. AHC participants must use the same screening tool to collect data on five health-related social needs. The screening tool also includes optional questions for other social needs such as unemployment and education level. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) survey is another potential option for a universal SES screening tool.

Providers must also be able to systematically enter and track SES data in addition to collecting it. One option is to use ICD-10 Z-codes. These codes, which cover diagnoses that influence health status and contact with health services, are available but not widely used. Using Z-codes has several advantages. First, they are standardized. Second, they are available as data fields in all major electronic health record platforms. Finally, they can be regularly updated according to the internationally recognized ICD revision process.

Risk-Adjustment for Hospital Value-Based Care Programs

Currently, CMS generally does not account for SES factors in its hospital value-based care programs. The Hospital Readmission Reduction Program (HRRP) is an exception – Congress required CMS to begin adjusting hospitals' performance scores to account for the proportion of dual eligible patients served during the performance year. While this proxy measure is a

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[11] Bradley et al.

useful starting point, there are several limitations. For instance, low Medicaid participation rates mean many individuals who should be accounted for in this proxy measure are excluded. Moreover, Medicaid financial eligibility requirements vary by state. An individual dealing with multiple SES factors may not be a dual eligible if he or she lives in a state with particularly restrictive eligibility criteria.

One solution is to consider community-wide SES data instead of relying solely on individual assessment when risk-adjusting hospital value-based care program performance scores. Research conducted at Virginia Commonwealth University suggests this is a feasible approach. In October 2018, VCU's Center on Society and Health published a report, "Uneven Opportunities: How Conditions for Wellness Vary Across the Metropolitan Washington Region." The report introduces the idea of a Healthy Place Index (HPI). The HPI is a weighted, snapshot measure of 64 SES indicators in a census tract that, when aggregated, are associated with life expectancy. [12]

Researchers categorized 48 SES indicators into six domains: air quality, economic/other household resources, education, health care access, housing, and transportation. They also categorized 16 additional SES indicators regarding race, ethnicity, and immigrant status into a seventh domain.

They ran the model twice, once with the 16 race, ethnicity, and immigrant status indicators and once without them. Table 6, taken from the report's technical appendix, shows the results. [13]

Table 6. Change in the Metropolitan Washington Healthy Places Index (HPI) domain weights with and without the race/ethnicity domain in the model.

Domain	Domain weight as a % of HPI (race/ethnicity domain NOT in the model)	Domain weight as a % of HPI (race/ethnicity domain in the model)[1]	Absolute change in domain weight	% change in domain weight
Transportation	10.0%	1.5%	-8.5%	-85.0%
Housing	16.1%	5.3%	-10.8%	-67.1%
Economic/Other Household Resources	25.7%	13.4%	-12.3%	-47.9%
Education	33.8%	21.5%	-12.3%	-36.4%
Air Quality	8.8%	5.7%	-3.1%	-35.2%
Health Care Access	5.6%	5.5%	-0.1%	-1.8%
Race/Ethnicity	-	47.0%		

[1]The weights in this column reflect changes to the final HPI weights in each domain with the addition of the race/ethnicity domain in the model. These were computed to show the variation when race/ethnicity was added to the analysis (highlighting the degree to which differential exposures experienced by racial and ethnic groups and immigrants impact census tract variations in life expectancy).

Crucially, the researchers found that the overall model is highly correlated with life expectancy, ($r=0.77$; $r^2=0.59$), indicating that the HPI index is a strong predictor of life expectancy. This study is important because it demonstrates that a model that measures community-wide SES factors instead of individual SES factors can be a strong predictor of a physical health outcome. Notably, even better educated, more affluent people living in areas with a low HPI score experienced reduced longevity compared to people with similar characteristics living in areas with high HPI scores.

[12] Woolf, S., Chapman, D., Hill, L., Schoomaker, H., Wheeler, D., Snellings, L., Lee, J. "Uneven Opportunities: How Conditions for Wellness Vary Across the Metropolitan Washington Region," *Virginia Commonwealth University Center on Society and Health*, (2018).

[13] Chapman, D., Wheeler, D., Hill, L., Woolf, S. "Uneven Opportunities: Technical Appendix: The Metropolitan Washington Healthy Places Index (HPI) Methods and Data," *Virginia Commonwealth University Center on Society and Health; Virginia Commonwealth University Department of Biostatistics*, (2018).

A performance score adjustment based on an index of community-wide SES factors may be better able to strike the balance between accurately accounting for social risk factors in value-based payment programs without increasing administrative burden. A community-wide measure such as the HPI index would not exclude individuals nor would it be as susceptible to state policy decisions. Meanwhile, data on many community-wide SES factors, including most of the indicators included in the HPI index, are publically available and easily accessible. A key challenge to adjusting value-based performance scores on individually-based factors is that either the individual or the hospital has to take action. As discussed above, there are many challenges in collecting and reporting social risk data in a routine and systematic fashion. Using an index of aggregated, community-wide data can overcome this challenge.
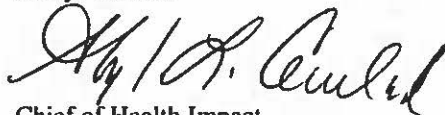
Recommendations

Thank you again for the opportunity to respond to this request for information. We are pleased to submit the following two recommendations for ASPE's consideration:

1. CMS should encourage, via value-based payment, adoption of a single SES screening tool for Medicare beneficiaries. CMS should use these screening results to inform Z-code diagnoses, which in turn can be used for risk-adjustment in hospital value-based care programs.

2. CMS should risk-adjust hospitals' value-based care performance scores using a synthesis of community-wide and individual risk assessment data, such as the HPI index and Z-codes, instead of dual eligibility.

Please contact Karah Gunther, Director of Government Relations and Health Policy, at klgunther@vcu.edu or 804-828-6879 should you have any questions.

Sheryl Garland

Chief of Health Impact
Virginia Commonwealth University Health System

November 16, 2018

Assistant Secretary for Planning and Evaluation, Room 415F
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

To Whom It May Concern:

WellCare Health Plans (WellCare) is pleased to submit the enclosed information in response to the request for information (RFI) opportunity "IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors."

For more than 30 years, WellCare has served families, children, seniors and individuals with complex medical needs. We partner with state and federal governments to coordinate managed care services for those eligible for Medicaid, Medicare Advantage, Medicare Prescription Drug Plans and Medicare ACO beneficiaries.

Founded in 1985 by a group of physicians in Tampa, Florida, today, WellCare serves more than 5.5 million members as well as ~160,000 Medicare ACO beneficiaries and partners with more than 636,000 healthcare providers and 68,000 pharmacies across the country.

WellCare's vision is to be a leader in government-sponsored healthcare programs in collaboration with our members, providers, government partners and social resource organizations. We have a long-standing commitment to our federal and state partners to deliver value, access, quality, cost savings, and budget predictability. It is from this vantage point that we offer these responses.

<u>Overall Question</u>

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

WellCare is working to improve outcomes for our members and communities by deploying an integrated care model that harnesses both supplemental benefits and social services outside of the benefit structure to address the needs of members and their households. We do not disentangle social and medical risks; instead, we assess members holistically to determine all of their co-morbidities (including social needs) and deploy tailored, integrated solutions for their specific needs.

On the front end, we assess the needs of our members by administering a health risk assessment (HRA). We then layer on the Protocol for Responding to and Assessing Patients' Assets, Risks, and

Experiences (PRAPARE) assessment tool, if needed, to assess the member's social service needs. Finally, we use our own internal risk assessment and screening process to determine the member and their household's eligibility for wrap-around social services.

Based on the results of this exercise, we are able to provide members and their households with a package of both benefited and non-benefited services that work in tandem to improve their health outcomes and wellbeing. By leveraging both supplemental benefits and social services and tracking the detailed interactions associated with each, we are able to reach beyond the individual to power national systemic transformation.

Delivery of Services

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 and social resource utilization data are being used in tandem to target engagement strategies as well as identification and stratification. Additionally, public social health data are leveraged to predict gaps in available social resources in our communities.

Members with social risk factors are identified based on the results of the HRA and PRAPARE tool assessments described in the prior question. A member may also self-identify by calling our Community Connections Help Line directly for assistance. The Community Connections Help Line is national call center for members, their families and the community-at-large to find and connect with social resources. WellCare's Community Connections model spans 70 different topics including housing, food, transportation, medication assistance, employment/training, volunteerism, and literacy.

Are there especially promising strategies for improving care for patients with social risk?

WellCare's Community Connections model offers particularly promising strategies for improving care in three areas:

1) WellCare employs a team of community coaches to engage with callers to our Community Connections Help Line. Hired through workforce innovation programs, our community coaches bring lived experience to their roles. For example, to ensure we have all beneficiary peer groups represented, the ages on our team range from 18 through 72 years old, they may have a disability themselves or care for someone enrolled on Medicare, Medicare or both and so on. WellCare employs more than 100 people to support the Community Connections model.

2) Supplemental benefits present a valuable opportunity for plans to provide benefits that address social risk factors, even if they are not covered by traditional Medicare. Using flexible supplement benefits, health plans may provide benefits to members that support their ability to live more independently. Examples of WellCare's benefit offering includes, in-home

support services, Personal Emergency Response System, and in-home fitness for those who cannot go to a gym.

Overall, high-performing Care Coordination and Care Management (CC/CM) programs are fundamental to WellCare's approach. We employ a fully integrated model customized for a wide variety of geographies, cultures, and diverse settings of care. Our care model, WellCare at Home, includes addressing social determinants of health through local Care Management. The WellCare at Home fully integrated care model factors in a member's physical health, behavioral health (BH), pharmacy, long-term services and supports (LTSS), and unmet social service needs under a single fully in-sourced infrastructure with a single line of accountability, single integrated technology system, and fully integrated local and national staff. WellCare at Home is grounded in our organizational mission to help members live better, healthier lives. Person-centered care reflects the choice and voice of each member and their family/caregiver and addresses a member's personal goals.

How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?

WellCare tracks social service use by consumer, by organization, and by intervention. Using this information, we have evaluated the impact of removing social barriers on cost, quality, and access. We looked at data on over 100,000 consumers that were referred to more than 350,000 services over a 7year period. We have found:

- Reduction in Cost. Removing a social barrier led to an aggregated savings from:
    - Reduced inpatient spending (53%)
    - Reduced emergency department use (17%)
    - Reduced emergency department spending (26%)
- Improved Access and Outcomes. Members with a social barrier removed are:
    - 4.8x more likely to schedule and visit their annual PCP visit
    - 2.4x more likely to have a better adult BMI score
    - 2.2x more likely to have completed a diabetes retinal exam
    - 1.9x more likely have complete a colorectal cancer exam

Additionally, WellCare collaborated with the University of South Florida to complete a study[1] that found that members who received social service assistance through our model experienced a $2,443 per-member-per-year savings after social needs were met. This study was also cited in the HHS

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[1] Pruitt, Zachary, Nnadozie Emechebe, Troy Quast, Pamme Taylor, and Kristopher Bryant, "Expenditure Reductions Associated with a Social Service Referral Program," Population Health Management, April 2018, pp. 1–8.

ASPE research report entitled "Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans".

Thus far, our model has been recognized as advanced in over 10 peer-reviewed studies.

What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

WellCare's offer the following best practices to support beneficiaries in effectively seeking and using social resources.

1) WellCare employs a team of community coaches to engage with callers to our Community Connections Help Line. Hired through workforce innovation programs, our community coaches bring lived experience to their roles. For example, to ensure we have all beneficiary peer groups represented, the ages on our team range from 18 through 72 years old, they may have a disability themselves or care for someone enrolled on Medicare, Medicare or both and so on. WellCare employs more than 100 people to support the Community Connections model.

2) WellCare also partners with social resource organizations to capture details on when beneficiaries seek social support directly. When a beneficiary approaches a partner organization for assistance, the organization will collection information, including whether the beneficiary is a current WellCare member. Our social resource partners share this and other relevant information with WellCare. We are able to leverage this information to inform how we target members for services that address their social risk factors.

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

One key learning from our model has been that social service organizations have different infrastructures, lexicons and payment models from managed care. This can create barriers for organizations that are trying to build relationships and interoperability with social service providers. Through our experience, we have been able to learn how to meet social service organizations where they are, while teaching them how to work with managed care and migrate to a managed care environment. This has been especially important as it relates to collecting social service data that informs member care.

Another learning has been that the gaps reported by members might not always directly tie to the needed solution. For instance, if a member self-reports that they are recently unemployed, we might instead focus on how to introduce stability to their household through the provision of food, transportation, and housing assistance. In doing so, we can provide the member with the relevant supports needed to enable them to focus fully on their job hunt.

As previously mentioned, WellCare provides social service support to members outside of the benefit structure. For that reason, we cannot assume an individual's eligibility for social services. As a result,

we have created a screening process for the member and their household to determine their potential eligibility for social resources across 70 different categories of support including housing, food, transportation, and so on.

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

Barriers to tailoring services to members include the managed care payment structure, social service industry structure, individual level social risk barriers, and limitations to information sharing among stakeholders.

For patients with social risk factors, how does patients' disability, functional status, or frailty affect the provision of services?

In WellCare's experience, an individual's disability, functional status, and/or frailty does not affect the provision of services. However, it could affect their eligibility for various services and how we are able to connect them. For example, an individual with a disability and/or unable to work could be eligible for a different range of services than someone able-bodied.

Data

Which social risk factors are most important to capture?

WellCare currently screens and determines eligibility for 70 different social risk factors, including housing, healthy food access, medication assistance, non-medical transportation, child care, social engagement to combat isolation, education support, and more.

Although social service needs vary by individual and geography, our highest volume social support topics include:

- Transportation: 18% (of all social resource connections)
- Financial Assistance (like car payments, mobile phone, etc.): 15%
- Healthy Food Options: 14%
- Medication Assistance: 12%
- Housing / Shelter: 10%

Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?

WellCare routinely collects basic demographic data on every enrollee (traditional MA and DSNP) via the HRA. We ask members questions about transportation (ability to get to the grocery store and

medical appointments), language preferences (primary language spoken at home and preferred language), tobacco and alcohol use, and questions regarding dependence.

Members who are eligible and choose to enroll in case management complete a more comprehensive assessment with their case manager. This assessment includes additional questions regarding their level of dependence, as well as an assessment on basic activities such as eating, bathing, toileting, and cleaning. WellCare has an algorithm that runs monthly data checks on items such as utilization patterns, pharmacy fills, and hospital discharges, to identify additional members for case management.

WellCare also houses a database that connects members to needed social supports outside of the medical benefit. As described earlier, we use HRA and PRAPARE tools to capture need. Then, we capture social resource use within a dedicated social resource electronic health record (SSEHR) that links to our centralized directory of more than 300,000 social support resource available across the United States.

Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

Standardizing data elements of EHRs would be helpful in collecting social risk data. Nonetheless, determining how this information could be shared among stakeholders and used to determine social service eligibility would be also be relevant considerations.

Additionally, we should consider how standardizing data elements could help facilitate the codification of social services in the managed care payment structure.

What are barriers to collecting data about social risk? How can these barriers be overcome?

Medicare Star ratings present a barrier to collecting data. Specifically, HRA completion rates impact our scores. We historically conducted an extensive HRA with members. It included questions about a member's living arrangements and whether they had a caretaker. We have since removed some of these questions and shortened the HRA in an attempt to increase our completion rate.

Additionally, the nature of the select questions posed in the HRA also present a barrier. Some members are hesitant to share personal information about their circumstances via the HRA. It can also be difficult to collect this information within the first 90 days of the member's enrollment, especially if the member has a distrust of the healthcare system.

What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

Opportunities for improving data collection include evolving to a more sophisticated level of data sharing among all managed care and social service stakeholders and developing a common system for capturing social service requests and utilization. In terms of using data, we believe there is

opportunity to continue using data to ascertain risk while also increasingly leveraging it to screen for social service eligibility.
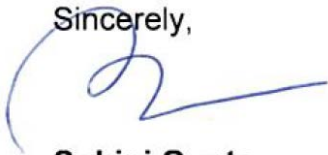
Additional Comments

Discussion of social risk factors should evolve to address managed care payment models. Since social services are not codified in managed care, plans are sometimes subject to financial risk because payments are not adjusted to represent the social risk factors of members. As a result, the administrative costs of linking members to social services is not reimbursed. Additionally, we look forward to the continued discussion on how to increasingly incorporate social risk factors into quality measures.

Conclusion

WellCare appreciates the opportunity to provide comments on these important issues and to partner with ASPE and HHS. If your staff would like further detail on any of our information, please feel free to contact me at (202) 902-2918. Thank you.

Sincerely,

Sohini Gupta
Vice President, Federal Government Affairs & Advocacy