Proposed Social Needs and SDOH Principles for CMMI Payment Models

Background:

With more than 135 million people in the US receiving their health care coverage through Medicare and Medicaid, the CMS Innovation Center (CMMI) has an important opportunity to test and implement innovative payment and service delivery models that impact many Americans. CMMI's recent strategy refresh announced that the Center will focus on creating "a health system that achieves equitable outcomes through high quality, affordable, person-centered care" and has named advancing health equity as one of the 5 key strategic objectives underlying this mission. The National Alliance to Impact the Social Determinants of Health (NASDOH) encourages the CMMI to incorporate screening for and addressing health-related social needs into its future models in line with its key strategic goals.

Research affirms what we intuitively know: the ability of individuals and families to lead healthy and productive lives is influenced by a multitude of factors – including those commonly recognized like health behaviors, insurance coverage and access to medical care, but also the social determinants of health (SDOH). SDOH are the conditions in the environments where people are born, grow, live, work, and age that affect health outcomes and risks; and the broader systems that shape those conditions, including social, political, and economic programs, and policies.[1] When unfavorable or adverse, these underlying social drivers can lead to unmet non-medical needs – often referred to as social needs or health related social needs (HRSNs). Efforts to address social needs provide invaluable assistance – for example, providing food, housing, and transportation to a person or their family, which also directly influence health outcomes.[2] Due to their impact on access to care and health outcomes for all people, addressing adverse SDOH and unmet social needs are an important part of a health equity strategy[3] and can impact health outcomes, utilization and costs.[4] Further, Medicare and Medicaid beneficiaries are especially likely to report having unmet social needs. For example, a 2019 survey of Medicaid beneficiaries indicated that around two-thirds of survey respondents reported one or more unmet social needs.

Screening for and referring or providing services to beneficiaries with health-related social needs is a vital component of addressing equity, and therefore should be incorporated into all future models. NASDOH offers the following principles for CMMI's consideration.

[1] World Health Organization. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. World Health Organization.

[2] Castrucci, B., & Auerbach, J. (2019). Meeting individual social needs falls short of addressing social determinants of health. Health Affairs Blog, 10

[3] Center for Disease Control and Prevention (CDC). (n.d.). NCHHSTP Social Determinants of Health (SDH). Available at: https://www.cdc.gov/nchhstp/socialdeterminants/faq.html#addressing-role

[4] Thompson T, McQueen A, Croston M, Luke A, Caito N, Quinn K, Funaro J, Kreuter MW. Social Needs and Health-Related Outcomes Among Medicaid Beneficiaries. Health Educ Behav. 2019 Jun;46(3):436-444. doi: 10.1177/1090198118822724. Epub 2019 Jan 17. PMID: 30654655. Retrieved from https://pubmed.ncbi.nlm.nih.gov/30654655/

NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

Proposed Principles for CMMI Payment Models

CMMI RECENTLY ANNOUNCED THAT ALL MODEL PARTICIPANTS WILL BE REQUIRED TO HAVE A HEALTH EQUITY PLAN. THESE PLANS SHOULD INCLUDE A FOCUS ON ASSESSING AND ADDRESSING SOCIAL NEEDS AS A NECESSARY TACTIC TO ADVANCE EQUITY.

- A focus on assessing and addressing health-related social needs is essential to achieving equity and focusing on achieving the best health outcomes.
- Model participants should discuss how social needs will be identified, how social care will be coordinated and provided, and how participants will work to understand the underlying conditions which drive social needs for their attributed populations.
- Participants should be encouraged to use a clear, accountable, closed-loop path to refer individuals to social care providers after social needs have been identified.
- CMS should allow or require participants to pay social care providers for services offered following a referral.

ADDRESSING THE HEALTH-RELATED SOCIAL NEEDS OF INDIVIDUALS NEEDS TO BE TREATED AS AN ESSENTIAL BENEFIT TO BE PROVIDED IN ALL MODELS.

- To do so, providers need clear guidance and examples of the interventions that are allowable expenditures under program rules.
- A standardized set of common screening elements should be developed and required. Screening should link to allowable interventions; that is, beneficiaries should be asked about needs that can actually be met within program authorities or through partnerships.
- A newly defined set of “Essential Community Social Care Providers” should be established to include the organizations that deliver essential social care services that meet social needs of patients, and participants in models should be required to include such providers in their contracted or referral networks.

MODELS SHOULD FACILITATE CROSS-SECTOR PARTNERSHIPS AND RELATED INFRASTRUCTURE, INCLUDING INTEROPERABLE SYSTEMS FOR DATA AND INFORMATION SHARING, THAT ENABLES HEALTH CARE, PUBLIC HEALTH, AND SOCIAL CARE TO WORK TOGETHER.

- Infrastructure for connectivity with social care providers, and for data sharing with public health, should be supported and incentivized in models.
- CMS can provide clarity on how these partnerships can be pursued and funded within existing frameworks (e.g., safe harbor guidance under Stark, guidance on interpreting HIPAA for sharing medical data with social services providers).

MODELS SHOULD ALLOW FOR THE FINANCIAL SUPPORT TO DEVELOP AND SUSTAIN “BACKBONE” ORGANIZATIONS THAT CAN HELP ADDRESS SOCIAL NEEDS, AND INTEGRATE PROGRAMS AND POOL FUNDING FROM FEDERAL, STATE, AND PRIVATE SOURCES FOR MAXIMUM BENEFIT

- Social service providers should be active participants in models and included as potential backbone organizations.

- CMS should develop a roadmap that provides for maximum braiding of Federal funding streams administered at the state level, including but not limited to aligning eligibility determination and the integration of services to program participants.

MODELS SHOULD BE DESIGNED TO CAPTURE AND MAKE THE BEST USE OF FEDERAL RESOURCES WITHIN AND OUTSIDE HHS TO EFFECTIVELY ADDRESS HEALTH-RELATED SOCIAL NEEDS.

- As an agency with a great deal of influence and authority, CMS has the opportunity and power to coordinate with other agencies that address health-related social needs within and outside HHS to bring existing funding streams from across agencies into models.

WAIVERS AND FLEXIBILITIES PROVIDED UNDER THE PUBLIC HEALTH EMERGENCY THAT WERE FOUND TO BE EFFECTIVE IN IMPROVING ACCESS TO OR PROVISION OF CARE SHOULD BE ENABLED TO THE EXTENT POSSIBLE IN NEW MODELS.

- For example, effective changes in health benefits to accommodate new or altered treatment modalities, such as telehealth services, during the public health emergency should be allowed in all models, and especially new models.
- CMS should examine its own regulations and requirements that can make it difficult for model participants to provide social care services and provide waivers or guidance about how to work within program requirements.

MODELS SHOULD BE SUSTAINED FOR A SUFFICIENT TIME PERIOD TO ALLOW CRITICAL OBJECTIVES TO BE REALIZED AND MEASURED.

- Timing that allows model participants to track and capture the impacts of social needs-related interventions, which tend to span longer periods than that needed to observe the impacts of clinical interventions, should be embedded in models.
- CMS should act in the near term to embed interim measures into models short of health outcomes that allow for learning while also sustaining models to collect longer-term underlying health outcome measures.
- Further, NASDOH strongly encourages CMMI to publish learnings early and often, and establish or expand existing learning collaboratives so that successful initiatives in any model can be rapidly disseminated and adopted by others.

OUTCOMES MEASURES SHOULD BE AS BROAD AS POSSIBLE WITHIN PROGRAM AUTHORITIES, EXPANDING BEYOND PROCESS AND SHORT-TERM COST SAVINGS METRICS TO INCLUDE LONGER-TERM HEALTH AND WELL-BEING OUTCOMES.

- Outcome measures should include the impact of the model on social needs and overall well-being of program participants.
- Measurement should be facilitated by requirements for greater detail and validity of race, ethnicity, and other relevant data to assess health equity.