August 31, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: CMS-4203-NC, Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure,

The National Alliance to Impact Social Determinants of Health (NASDOH) thanks you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) on improving Medicare Advantage (MA). NASDOH is a group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement. NASDOH brings together health care, public health and social services expertise, local community experience, community-convening competence, business and financial insight, technology innovation, data and analytics competencies, and policy and advocacy acumen to assess and address current regulatory frameworks, funding environments and opportunities, and practical challenges to implementing and sustaining efforts to address social determinants of health (SDOH). Additionally, NASDOH is committed to advancing health equity as a critical component to addressing social needs and SDOH and improving the health of individuals and communities.

NASDOH is greatly appreciative of CMS's Vision for Medicare putting the person at the center of care and its commitment to embedding health equity in its work. We are particularly grateful to see this RFI, demonstrating that CMS is not just supportive of health equity, but also willing to take the necessary steps to modify and update its own programs to ensure health inequities are identified and meaningfully addressed. Similarly, we support CMS' efforts to develop a comprehensive approach to measure and analyze disparities across its programs and policies. NASDOH recommends the following in response to the request for information:

<u>Solicitation of Public Comments on Advancing Health Equity</u>

CMS asked what steps it should take to better ensure that all MA enrollees, particularly underserved and minority groups, receive the care they need.

As CMS has cited in past proposed rules, studies show that belonging to a racial or ethnic minority group or being a member of the LGBTQ+ community is often associated with receiving lower quality of care, having a worse experience of care, and having worse health outcomes. Further, because of systemic and institutionalized racism and discrimination, these groups are also more likely to experience adverse SDOH which influence health risks and health outcomes. To uphold its vision to provide person-centered care and its commitment to health equity, NASDOH strongly encourages CMS to consider developing guidance on 1) methods to collect information stratified by demographic factors in order to identify disparities across groups with differing demographic factors, 2) strategies

to improve access to care specifically for those groups that face disproportionate access burdens or challenges, and 3) mechanisms to provide tailored care that matches the unique health care and social needs that each individual faces.

CMS solicitated comments on effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH).

NASDOH encourages CMS to consider the social needs of MA enrollees as a part of offering person-centered care. Evidence suggests that health-related social needs are highly prevalent among Medicare Advantage enrollees.[1] For example, a 2019 study reported thirty-seven percent of enrollees in large Medicare Advantage plans have high needs, requiring both medical and social services.[2] 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. 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 and can impact health outcomes, utilization and costs. Addressing these social needs begins with screening.

NASDOH strongly encourages CMS to issue guidance for SDOH screening across all of its programs, including screening of all MA enrollees. A standardized set of common screening elements should be developed and required, and 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. Additionally, NASDOH members note that plans and providers are managing multiple and often competing programmatic requirements. Standardized questions would reduce the burden associated with screening. As a starting point, NASDOH recommends that CMS apply to MA plans and providers its proposed approach of screening for five SDOH domains under the "Screening for Social Drivers of Health" inpatient measure. NASDOH encourages CMS to require that plans and providers who screen do so across food insecurity, housing instability, transportation needs, utility needs, and interpersonal needs at the least. There are other indicators, such as health literacy and language literacy, which are important assessors of SDOH that NASDOH encourages plans and providers screen for as well.

Regardless of the indicators that plans and providers choose to screen for in addition to the five baseline indicators referenced above, NASDOH strongly asserts that screening questions and processes must be standardized for consistent data reporting and analysis. However, we note that it is important that there continues to be flexibility for providers to pursue more in-depth screening in the clinical setting as they deem appropriate. There are clinical reasons for tailoring questions or conducting more in-depth screening; for example, screening that is tailored to a pediatric or adult population, and the ability to conduct a more in-depth screening once need is identified to inform interventions or care plans.

For MA plans and providers that partner with local community-based organizations (for example, food banks, housing agencies, community action agencies, Area Agencies on Aging, Centers for Independent Living, other social service organizations) and/or support services workers (for example, community health

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[1] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01547#:~:text=Abstract,quality%20the%20most%20commonly%20reported.

[2] https://www.commonwealthfund.org/sites/default/files/2019-02/DuGoff_targeting_high-need_beneficiaries_ib_0.pdf

workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, CMS asked how compensation arrangements are structured?

With member organizations from across sectors, NASDOH recognizes the importance of MA plans partnering with community-based organizations (CBOs) and utilizing support service workers to address enrollees' SDOH. CBOs are often well positioned in the community to screen for individuals' social needs given their familiarity with the communities they serve and the trust they've built. Additionally, many arrangements exist in which CBOs receive referrals for social-needs related services and offer those services to address the social needs that another entity (for example, a health care provider or an MA plan) screened for and identified. Given the critical role CBOs often play in addressing individuals' SDOH, it is important that CBOs are fairly and properly compensated for the services they deliver. Moreover, MA plans have a financial incentive to ensure that enrollees' social needs are met and therefore should be encouraged to assist in covering the cost of social-needs related services that CBOs administer.

MA plans that are interested in partnering with CBOs to address SDOH should engage in a systematic process with several key elements including: issuing a call for proposals for partnerships with CBOs; developing a contract with CBO partners to ensure mutual agreement on a compensation scale for referrals and service delivery; and developing data-sharing agreements to track service delivery.

How have MA plans and providers used ***algorithms*** *to identify enrollees that need additional services or supports, such as* ***care management or care coordination****?*

Many of NASDOH's members have firsthand experience using algorithms and predictive analytics to support care management and address both individuals' social needs and the systemic drivers of health. We offer an example from one of our members, Intermountain Healthcare, to illustrate the technical capabilities this integrated health system uses which can shed light on these capabilities for use by MA plans.

Intermountain Healthcare is a Utah-based not-for-profit integrated delivery system dedicated to helping people live the healthiest lives possible. Intermountain not only delivers health care services, but also prioritizes access to social supports that address SDOH and seek to improve equity. Intermountain employs both social needs screening tools and predictive analytics to assess the social needs or social drivers that are impacting the health status of its patients. In some cases, an individual may come to Intermountain for a health care service, at which point Intermountain screens for a range of social factors that impact health, including, as an example, food insecurity. Intermountain is also using predictive analytic capabilities to determine which patients may be at risk for certain social needs like food insecurity, and then conducts individual outreach to validate the need and help connect patients to community-based resources.

Though Intermountain is developing innovative approaches using algorithms and analytic capabilities to address patients' social needs, many challenges persist. For example, privacy protections and other administrative compliance barriers make it difficult to systematically share a patient's protected health information in referrals to community-based assistance providers, which perpetuates the siloed nature of health care and social care delivery to remain. Further, Patient Inducement regulations offer safe harbors that allow the provision of food assistance to Medicare and Medicaid beneficiaries, but they are administratively and operationally difficult to implement. Finally, while Intermountain has created relationships with other organizations, there remains no systematic way for Intermountain to seamlessly enroll eligible individuals into other federally funded programs, like Medicaid, SNAP or WIC, when they come to Intermountain for healthcare-related services and a

social need around hunger or nutrition is identified. The challenges Intermountain faces and the lessons it has learned to overcome these challenges and stand up predictive analytics to address patients' needs and offer care management in a person-centered way offer insights for MA plans. NASDOH believes that addressing SDOH in a holistic way for both individuals and communities entails commitments and efforts, such as those Intermountain has undertaken, from all parties involved in delivering and paying for health- and social-needs related care.

NASDOH appreciates the opportunity to comment on this RFI. For more information on NASDOH and our members, please visit our website at www.nasdoh.org or contact Sara Singleton at Sara.Singleton@leavittpartners.com.

Sincerely,

Sara Singleton

Sara Singleton
Principal, Leavitt Partners and Advisor to NASDOH