NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

June 14, 2024

The Honorable Ron Wyden
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC, 20510

The Honorable Mike Crapo
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC, 20510

Dear Chairman Wyden and Ranking Member Crapo,

The National Alliance to Impact the Social Determinants of Health (NASDOH) appreciates the opportunity to respond to the policies and questions included in the white paper "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B. We are pleased to offer our recommendations on how Medicare can better serve older Americans.

About NASDOH

Founded in 2018 by Governor Mike Leavitt and Dr. Karen DeSalvo, NASDOH is a multi-sector coalition of stakeholders working to advance widespread adoption of effective policies and programs to address health-related social needs as well as the underlying social and economic conditions in which people live—often called social drivers of health (SDOH). NASDOH brings together stakeholders from different geographic regions with expertise in health care, public health, social services, patient and consumer perspectives, information technology, and business to share learnings, develop policy recommendations, and build consensus on solutions to address SDOH. NASDOH's work focuses on improving regulatory and reimbursement frameworks, supporting funding opportunities, and addressing practical challenges to implementing and sustaining public and private sector efforts to address SDOH as a core component of advancing health equity.

Medicare Fee For Service (FFS)

The Senate Finance Committee white paper notes that "While the CHRONIC Care Act allows MA plans to cover certain non-medical, health related services (such as transportation to medical appointments, meals, and minor home modifications to prevent falls), Medicare FFS generally does not cover these types of services" and asks about services that provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill.

NASDOH appreciates the Chair and Ranking Member's interest in addressing health-related social needs that can reduce downstream costs and improve health outcomes for seniors. Social determinants of health account for more health outcomes, including cost, than medical care alone. For this reason, it is critical that continued movement towards value-driven care recognizes the importance of addressing SDOH.

For many years, NASDOH has supported the use of Special Supplemental Benefits for the Chronically Ill (SSBCI) in MA to meet seniors' health related social needs (HRSNs). In 2024, the number of MA plans offering benefits under SSBCI is almost five times more than the number of

plans offering these benefits in 2020.[1] Enrollment in MA has grown over the past two decades since the Medicare Modernization Act of 2003 created stronger incentives for plans to participate in the program. In 2023, more than 30 million, or 51% of the eligible Medicare population was enrolled in a MA plan. [2]However, this leaves the other half of beneficiaries enrolled in traditional Medicare without an equivalent pathway to access to these same kinds of SDOH related services.

There is wide geographic variation with nearly one third (31%) of Medicare beneficiaries living in a county where at least 60 percent of all Medicare beneficiaries are enrolled in Medicare Advantage plans, while 10% live in a county where less than one third of all Medicare beneficiaries are enrolled in Medicare Advantage plans.[3]

Addressing health-related social needs in Medicare FFS is also critical because seniors in rural areas are less likely to be covered by innovative payment models[4] or Medicare Advantage that can provide services to address health-related social needs that are not covered by traditional Medicare.[5] Beneficiaries in traditional Medicare should not be left behind as health care providers and payers move towards addressing HRSN as a part of high quality care.

This disparity in access to HRSN benefits is exacerbated for people living in rural areas, who are more likely to have chronic diseases such as heart disease, obesity, and diabetes, in comparison to non-rural residents, and face additional challenges in accessing health care and improving health outcomes. Issues such as hospital closures, transportation barriers, food insecurity and access to healthy foods, and availability of broadband all impact health disparities in rural communities. For example, people living in rural areas often have to drive further to receive care. A study from the University of Washington found that median travel to access care for rural Medicare beneficiaries in small rural communities was 22.5 miles (31 minutes), whereas urban Medicare beneficiaries traveled 9.2 miles (18 minutes). This is a substantial barrier for beneficiaries who do not have access to reliable transportation as missed appointments can result in adverse health conditions and transportation can also impact decision-making about whether to make an appointment out of town or to see a specialist. While a MA plan may be able to arrange for a ride to an appointment, a beneficiary in FFS Medicare may not have access to this kind of service.

Additionally, the prevalence of food insecurity, which is associated with obesity in adults and children,[6] in rural areas was 10.8 percent in 2021.[7] Although this is similar to the prevalence of food insecurity in urban areas, healthy food is less accessible in rural communities.[8]

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[1] Chartbook: 2024 Nonmedical Supplemental Benefits in Medicare Advantage: https://atiadvisory.com/resources/advancing-non-medical-supplemental-benefits-in-medicare-advantage/.
[2] Kaiser Family Foundation, Medicare Advantage in 2023: Enrollment Update and Key Trends. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.
[3] Ibid.
[4] CMS Innovation Center Strategy Refresh: https://www.cms.gov/priorities/innovation/strategic-directionwhitepaper.
[5] Medicare Advantage Enrollment, Plan Availability and Premiums in Rural Areas: https://www.kff.org/medicare/issue-brief/medicare-advantage-enrollment-plan-availability-and-premiums-inrural-areas/#:~:text=In%202023%2C%20a%20smaller%20share,and%2053%25%2C%20respectively.
[6] Healthy People 2030: Food Insecurity: https://health.gov/healthypeople/priority-areas/social-determinantshealth/literature-summaries/food-insecurity#cit21.
[7] USDA Household Food Security in the United States in 2021: https://www.ers.usda.gov/webdocs/publications/104656/err-309.pdf.
[8] Food Insecurity in the Rural United States: An Examination of Struggles and Coping Mechanisms to Feed a Family among Households with a Low-Income: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9785039/.

Without an insurer as the coordinating entity for HRSN services, providing access to these same benefits through FFS presents some challenges. But with the commitment we have observed from health care providers and social service agencies, we believe it is worth the Committee's time to develop options for payment of these benefits through Medicare FFS.

SDOH-Related Billing Codes

The white paper also notes "CMS has finalized several PFS policy changes aimed at increasing the level and scope of Medicare payment for certain services intended to support the clinical management of chronic disease, focused largely on primary care…[including the] addition of new billing codes related to care navigation, social determinants of health, and community health integration." NASDOH supported adding these codes for Community Health Integration (CHI), SDOH Risk Assessments, and Principal Illness Navigation (PIN) services to accurately reflect the resources involved in obtaining information from patients about health-related social needs and risks. NASDOH also supported the addition the new standalone G code, GXXX5, to the Medicare Telehealth Services List to accommodate a scenario in which the practitioner (or their auxiliary personnel incident to the practitioner's services) completes the risk assessment in an interview format, if appropriate.

Since these codes just went into effect in Calendar Year 2024, it is too early to assess their impact yet. Therefore, we recommend that the Committee request information from CMS about uptake and use of these codes by providers to see whether they are working as intended. This data will be helpful to the Committee in assessing the need for future legislative action to potentially codify or modify these codes.

Quality Measures

Quality measures are an important tool for advancing the use of social needs screenings and connecting people to services that support improved health outcomes. NASDOH has supported the work of CMS in developing and implementing quality measures related to social needs screening and connection to social services, including the addition of SDOH-related quality measures in the Merit-based Incentive Payment System (MIPS) and MIPS Value Pathways (MVPs). Over the past five years, screening for health-related social needs (HRSNs) within physician offices and hospitals has increased, in part due to these federal programs promoting expanded screening. NASDOH created a resource on the existing quality measures which can be found on NASDOH's website.[9]

In December 2023, NASDOH convened multiple stakeholders, representative of payers, providers, community-based organizations, social service providers, public health, and technology resources across the country. At this convening, stakeholders discussed the various social needs related screening measures and how quality measures and quality programs can best meet patient needs and policymakers' objectives. Participants also discussed the goals and outcomes of screening, variability of tools and processes for screening, incorporating data from social needs screening into clinical care and decision making, funding needs for screening and addressing HRSNs, including building community capacity, and supporting multi-sector involvement. The result of the convening was ten principles for adoption, updating, and implementing quality measures related to social needs. As the Senate Finance Committee considers changes to MIPs and quality

[9] SDOH Quality Measures: https://nasdoh.org/wp-content/uploads/2024/03/NASDOH-SDOH-Quality-Measures-Table-Revised-2024.02.29.pdf.

programs, NASDOH encourages the Committee to consider these principles in furthering SDOH-related policies within quality reporting and payment programs.

1) Improving Outcomes—Quality measures are an important tool for advancing the use of culturally sensitive social needs screenings, connecting people to services that improve outcomes, and advancing health equity.
2) Meeting Patient's Needs—SDOH-related quality measures should be designed and implemented primarily to advance the health and well-being of individuals, including through the delivery of social services and supports. SDOH-related measures should prioritize holistic improvement in the patient's health and well-being rather than focusing on reducing the number of social needs.
3) Screening Intervals and Duplication—Implementation of quality measures should consider how patients engage with the health care system and avoid unnecessary duplication of screenings. While repetition of screenings at appropriate intervals can support the identification of emerging or changing needs, duplication of screenings may lead to mistrust.
4) Strengths-Based Approach—SDOH-related quality measures should be designed to highlight assets and support strengths-based solutions rather than focusing on deficits and imposing specific interventions to address individual HRSNs.
5) Incorporate Feedback—Feedback from patients on their experiences of SDOH-related screenings should be used to inform updates to quality measures.
6) Harmonized Measures—A core set of measures harmonized across quality and payment programs would support adoption and reduce the administrative burden for patients, providers, payers, social workers, community health workers, and others involved. Determinants of health that impact health equity should be a part of measures used, including integrated healthcare, community resiliency, physical environment, socioeconomics, and community trauma.
7) Using Existing Data—Collection of data to inform SDOH measures should, whenever possible, draw from existing data sources to minimize additional data collection burden on all involved.
8) Screening Tools and Administration—Quality measures should allow for the use of a variety of validated screening tools and entities that are screening should have flexibility to determine how screenings are conducted.
9) Shared Responsibility and Commitment—Identifying and addressing HRSNs is a shared responsibility. Therefore, quality measures should be driven and informed by engagement with patients and impacted communities and should encourage meaningful collaboration between health care, public health, and social service, and other sectors to screen and connect patients to the resources they need. Additionally, each sector must be committed, supported, and empowered to address patient needs, improve outcomes of individuals and communities they serve and hold each sector accountable for performance.
10) Data Justice—Screening data should be shared with the communities it originates from to advance community-level efforts to address SDOH. The data should be useful and updated regularly, consistently, and accurately.

NASDOH has supported quality measures that promote screening and connecting to services across five domains: food insecurity, housing instability, transportation problems, utility needs,

and interpersonal safety. NASDOH recommends the Senate Finance Committee focus on services across these domains to improve chronic care in Medicare FFS.

While screening is being conducted across these five domains, it is critical that we move beyond SDOH screening to what is done with this information. Information about an individual's social risk and needs has been shown to be sensitive, and individuals are often hesitant to disclose this information for fear of bias, misuse, or discrimination. It is important to offer services to address health-related social needs identified during a screening, and benefit-related policies supporting these services can increase access to these services and improve health outcomes for patients.

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We appreciate your focus on improving Medicare physician payment. Please consider NASDOH a resource on SDOH issues. Should you have any questions or wish to discuss our comments further, please contact Sara Singleton at Sara.Singleton@LeavittPartners.com.

Sincerely,

Sara Singleton

Sara Singleton
Principal, Leavitt Partners and Advisor to NASDOH