March 7, 2022

Submitted via regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comment on the proposal for Improving Experiences for Dually Eligible Individuals: Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments (§ 422.101) within the Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs.

Aligning for Health is an advocacy organization that brings together a broad coalition of members focused on improving health and wellbeing through efforts to address both health and social needs.[1] We support the many steps that the Biden-Harris Administration has taken to prioritize equity for all, including through initiatives and efforts to address social determinants of health (SDOH).

There is a significant body of academic work showing that economic and social conditions have a powerful impact on individual and population health outcomes as well as health care costs. The conditions or environments that we inhabit - including our communities, our homes, and our access to healthy foods, education, employment and transportation - all impact our health outcomes. In particular, as CMS notes, dually eligible individuals often face homelessness, food insecurity, lack of access to transportation, and low levels of health literacy.

Such social risk factors and social needs increase the risk of, and exacerbate existing, chronic conditions and lead to poorer health outcomes.[2] Additionally, surveys have found that respondents who self-report poor health and higher health care utilization, and who experience high inpatient or ER utilization, are more likely to report multiple unmet social needs.[3]

However, screening for and collecting social needs and risk factor data has proven to be a continuous challenge. Such data is not always routinely or systematically collected across the health care system and often is not collected in a standardized way, making it difficult to integrate into health records, to share, as appropriate, across coordinated entities. For instance, CMS' 2021 report found that social needs data had only been collected and reported for 1.59 percent of Medicare beneficiaries, a fraction of the likely

[1] https://aligningforhealth.org
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/
[3] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/insights-from-the-mckinsey-2019-consumer-social-determinants-of-health-survey

population with social needs.[4] This information is the foundational first step toward cross-sector and more integrated care models that drive better alignment between health and social needs to improve patient outcomes.

Comprehensively documenting social risk and social needs data in a standardized way and increasing appropriate exchange of such data will ensure payers and providers delivering health and non-health care to individuals have a more comprehensive view of the factors affecting an individuals' wellbeing, as well as overarching disparities contributing to health inequities. We believe that the outcome-focused care delivery systems of the future must rest on a data foundation that provides meaningful information about both health and social risks, and documenting social risk and social needs data is the foundational first step in driving better alignment toward this goal.

Therefore, we support CMS' proposal to require Special Needs Plans (SNPs) to include one or more standardized questions on the topics of housing stability, food insecurity, and access to transportation as part of Health Risk Assessments. We believe that these questions will help SNPs gather the necessary information to inform the development and implementation of each enrollee's comprehensive individualized plan of care. Further, information from social needs screenings should be used to connect enrollees to covered services or resources to help meet their needs, if consistent with the enrollee's goals and preferences.

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Thank you again for the opportunity to provide comments on this important issue. Please do not hesitate to let us know if you have any questions. I can be reached at mquick@aligningforhealth.org.

Sincerely,

Melissa Quick

Melissa Quick
Co-Chair, Aligning for Health

[4] https://www.cms.gov/files/document/z-codes-data-highlight.pdf