August 1, 2022

Submitted electronically to OASHPrimaryHealthCare@hhs.gov

The Honorable Admiral Rachel L. Levine, MD
Assistant Secretary for Health
Office of the Assistant Secretary for Health
Department of Health and Human Services
Hubert H. Humphrey Building, Room 716-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Request for Information: HHS Initiative To Strengthen Primary Health Care

Dear Assistant Secretary Levine,

Thank you for the opportunity to submit comments in response to the request for information (RFI) on the HHS Initiative to Strengthen Primary Health Care, and for your leadership on this initiative to improve primary health care and address health equity.

Aligning for Health is an advocacy organization that brings together a broad coalition of members focused on improving health and wellbeing through interventions related to better aligning health and social needs. We are supported by an Advisory Board of individuals representing public health, mental health, housing, community development, human services, and many other sectors. As a coalition, we work to develop and promote actionable policies that create opportunities - and remove challenges - for states and local governments, health care organizations, and non-health care organizations to work together to develop cross-sector, coordinated solutions to address both health and social needs.

We support the many steps that the Biden-Harris Administration has taken to prioritize equity for all, including through initiatives to address social determinants of health (SDOH). Below, we provide comments in response to the specific questions posed in the RFI as it pertains to the intersection of primary health care and SDOH in improving overall health and wellbeing.

Successful Models or Innovations that Help Achieve the Goal State for Primary Health Care

Aligning for Health is a coalition focused on improving health and wellbeing through interventions related to better aligning health care and social needs. Our members are leaders in developing innovative cross-sector partnerships and advancing whole health. Our members represent and serve diverse populations who often face varying challenges when it comes to having their social needs met, and have worked on innovative initiatives to address social determinants of health in the populations they serve.

For example, **UPMC's** Cultivating Health for Success program is a Pay for Success program that works with community service partners through the Pennsylvania Department of Housing and Urban Development to provide stable housing and care management to members experiencing homelessness. The program blends US Department of Housing and Urban Development (HUD) Continuum of Care (CoC) program and voucher dollars with UPMC funding to support these members in need, through providing an opportunity to have regular visits with a primary care doctor for preventive care and resources to help find stable, permanent housing or other supports. The program has resulted in 85 percent of participating enrolled members finding stable housing and a 42 percent decrease in unplanned medical care.

As another example, **Signify Health** has a partnership with Humana and the Alamo Area Community Network (AACN) to support Medicare Advantage members in San Antonio by connecting individuals in need with health-related social services and community resources. AACN uses Signify Health's technology platform to ensure the entities can connect individuals to social services and close the loop on referrals between AACN

participants, helping to ensure the needs of individuals in the area are being met and better track and understand clinical outcomes over time. The partnership also leverages Social Care Coordinators that help conduct outreach to address unmet needs and improve health and wellbeing. Signify Health has also partnered with Independence Blue Cross in Philadelphia on a similar program.

3M Health Information System's Clinical Risk Grouper (CRG) Methodologies are being used by state Medicaid Agencies, such as Ohio, to perform risk adjustment for value-based care programs for primary care practices. CRGs incorporate Z codes 55-65, which describe SDOH listed in the electronic medical record provided they make it into the claims data that goes to the payer, in this case Medicaid. The Ohio Department of Medicaid's PCP payment innovation model, Comprehensive Primary Care, covered 1.7 million lives, including 920,000 children, in 2021. They group patients into three risk tiers based upon complexity of their clinical conditions, as determined by 3M CRGs using all payer claims data, as the basis of capitated payment rates to participating practices. One goal of this program is to address SDOH and care coordination at the level of the primary care practices. The model has led to better care and outcomes - total cost of care declined by nine percent. Total admissions, ambulatory care sensitive condition (ACSC) admissions, emergency department (ED) visits, and specialist visits declined 33 percent, 45 percent, 17 percent, and 24 percent, respectively. This effect was widespread among practices, with more than 90 percent of them demonstrating substantial improvement.

Healthy Alliance IPA is a network of social care providers with multiple clinical affiliates in upstate New York that bridges the gap between medical care and social care by connecting community members (patients) to the social care services that they need. Since 2018, Healthy Alliance has served over 22,000 community members with over 38,000 connection requests. Earlier this year, Healthy Alliance partnered with Hixny, the regional health information exchange, to create an easier way for clinical providers to connect community members with social needs to organizations who can help – without having to leave their electronic health record (EHR). Early results confirm that clinical providers need an easy way to access a referral tool and network of social and behavioral services that doesn't require them to navigate yet another technology application, but allows them to focus on providing great medical care and better support for their patients.

Barriers to Implementing Successful Models or Innovations

While there has been great momentum in addressing social determinants of health at the federal level, many barriers still exist. Today's health and social services systems and services are largely siloed, despite clear evidence that social needs can have an impact on overall health and wellbeing. Investments to better align and coordinate between health care providers, including those delivering primary care services, and social services providers will yield better, more efficient health interventions, reduce preventable health costs, and keep the most vulnerable populations from falling through the cracks. Reducing these siloes is the best way to make these programs more effective, particularly in rural, Tribal, and underserved areas.

States, local governments, health care providers, payers, social services providers, community-based organizations (CBOs), and others are increasingly seeking to partner to better coordinate care and services. Meanwhile, many states are more deeply integrating social determinants of health strategies within their Medicaid programs, with help from CMS.

However, one of the greatest challenges to high-impact interventions is the difficulty in navigating and coordinating fragmented and complex programs aimed at addressing health care needs, food insecurity, housing instability, workforce supports, and transportation reliability, among others. In particular, the siloed funding, data systems, and administration of many of these programs at the state and local, and nongovernmental, levels create barriers to effective coordination and partnership.

Several of these challenges are ripe for HHS leadership and we believe should be considered as part of the HHS Initiative to Strengthen Primary Health Care. Specifically:

- Program administration often exists in siloes – funding, eligibility, outcome measures, reporting, and data systems all tend to be program specific. Demonstration projects that waive certain requirements, allow for braided or blended funding to more efficiently use federal dollars, or shared incentives and outcome metrics can help to break down some of these barriers.
- Comprehensively screening for both health and social needs will allow primary care providers and other clinicians to gain a better understanding of individuals' full stories and the barriers that may impact their health and wellbeing. However, social needs screening and referrals have not traditionally been a part of health screenings, and such data is often not collected in a standardized way. Capturing and reporting such data through electronic health records or other systems of record would also allow for data exchange with other health and social service providers.
- Social needs data can potentially be leveraged alongside health care data to risk adjustment payments or quality in order to provide additional resources to providers working to provide care to more vulnerable and higher risk populations. Moreover, not accounting for these social drivers may deepen access gaps for more socially complex patients by discouraging practices from caring for them, or make it more difficult for practices to attain quality benchmarks if they lack the requisite care management resources for the social complexity of their population. Addressing some of these barriers would ensure efficiency in addressing social determinants through federal programs and ensure that efforts can better address the health and social needs of individuals.
- While providers may want to address their patients' social needs, they do not always have the tools, capacity, or resources to do so. According to a survey by the Physicians Foundation, nine in 10 physicians want to address patients' social drivers of health, but six in 10 lack the time and ability to do so. It is not enough to just screen for social needs, but to provide incentives and ensure supports are in place to encourage referrals and steps to address identified social needs.
- Comprehensive, standardized, and timely data is a key component to successful care coordination and to connect individuals to needed services to address their health and social needs. But data sharing also requires that CBOs and other entities have the technical capability and capacity to seamlessly share data with the health care system or health care organizations. Over the past few years, CMS and HHS have taken steps to promote and require interoperability and exchange of health data. However, social services organizations and CBOs have not benefitted from the same level of infrastructure and systems funding, and often experience difficulty in connecting with and sharing information with health care organizations. Many CBOs do not have the capacity to invest in the tools and functionality required to connect with individual primary care providers or other entities that would allow for seamless closed loop referrals and data exchange.
- Organizations and health care providers alike do not always have the ability to see if someone has been referred or successfully connected to social services or government benefit programs, which is a huge disconnect and gap for ensuring individuals have the resources they need.

Proposed HHS Actions

Improving coordination of federal programs and services is critical to removing certain barriers faced by individuals in accessing needed benefits and services. We encourage HHS to consider advancing policies and strategies that would help to coordinate eligibility and enrollment processes for cross-sector programs. Examples could include:

- Provide flexibility and/or additional funding to states to cross-train and leverage non-traditional health care providers, such as community health workers, eligibility support workers, Navigators, social workers and others, to support primary health care, better reach underserved communities, and assist with eligibility and enrollment processes, referrals, and other supports and services. Doing so will help to reach more individuals, and help individuals to be able to support applicants in understanding, applying for, and enrolling in multiple benefit programs, or to help provide referrals to other non-governmental support.

- Provide guidance to states on integrating and aligning eligibility and enrollment processes for benefit programs. This could include use of an integrated application and eligibility system, or expansion of express lane eligibility initiatives to include additional populations, and allowing individuals to jointly apply for and enroll in programs such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Medicaid, among others.
- Streamline applications for federal programs and enable data sharing across programs that serve the same populations.

HHS can also work to improve the health of individuals by takings steps to address screening for social needs within primary health care visits and increase data sharing through the following measures:

- Take steps to enable comprehensive screening for both health and social needs, and provide training, education, incentives and resources for providers and payers to make social needs referrals.
- Support ongoing CMS efforts to promote screening for social needs within federal health programs, including through efforts to include new measure concepts that feasibly and accurately assess whether a beneficiary has had their health-related social needs assessed using a standardized screening tool and to assess screenings and referrals to interventions for unmet social needs. Encourage HHS to take steps to share, with appropriate privacy and consent safeguards in place, demographic data with providers and payers that HHS and its constituent departments may have access to.
- Continue to explore opportunities to incorporate social risk information into risk adjustment calculations; clinical and social risks should be viewed together to get a complete patient picture.
- Provide sustainable funding for the technological infrastructure and human intervention needed to connect the health and social services sectors together and ensure that funding can flow where the referrals are going. These investments to connect primary health care entities and social services organizations can help to reimburse CBOs, track capacity, and understand the true cost of and where such organizations are successful in addressing basic needs. Funding should be woven into the reimbursement methodology through value-based payment or other alternative payment methods to ensure that social care services are reimbursed for all members.
- Bolster CBO capacity, including by providing CBOs with support and assistance in navigating health care partnerships and in addressing data sharing exchange. Partnerships between CBOs and trusted community partners such as community health workers or other health care supports close gaps in care and focus on more upstream challenges – improving outcomes.
- Continue to pursue cross-agency coordination activities with other agencies working to improve health outcomes and address drivers of health. Such activities provide insight for federal officials about innovative work being done at the state and local level that impact consumers across HHS programs. This also helps to shed light on common barriers or challenges that stakeholders experience at the local level in addressing social determinants of health.
- HHS should consider providing guidance to states on how to better integrate data sources across federal and other disparate programs. For instance, federal programs do not necessarily have access to data to inform whether the individual is also eligible for or enrolled in other federal assistance programs. Finding ways for SNAP, WIC, housing-related programs, and other federal programs to coordinate and share data as appropriate would help to improve outcomes for all.

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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
Co-Chair, Aligning for Health