



August 31, 2022

Submitted via regulations.gov

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

Re: Request for Information on the Medicare Advantage Program (CMS-4203-NC)

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to submit comments in response to the request for information (RFI) on the Medicare Advantage (MA) program.

[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, bipartisan 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 many of the 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 opportunities to address social determinants of health to advance health equity within the Medicare Advantage program.

Advance Health Equity

What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?

Effective Approaches for Screening for Social Needs

Screening for and collecting social needs and risk factor data has proven to be a continuous challenge. Comprehensively screening for both health and social needs will allow health care providers and Medicare Advantage Organizations 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 allow for data exchange with other health and social service providers.



Aligning for Health supports ongoing CMS efforts to promote screening for social needs within federal health programs, including through efforts to include standardized social needs screenings as part of Health Risk Assessments, as was finalized for Special Needs Plans (SNPs) in the Calendar Year (CY) 2023 MA and Part D Final Rule. These questions will help SNPs gather the necessary information to inform the development and implementation of each enrollee's comprehensive individualized plan of care.

We also support CMS' other steps to include new measure concepts in quality programs 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. However, 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.

Information from screenings should be used to connect beneficiaries to covered services or resources to help meet their needs, if consistent with the beneficiary's goals and preferences. Efforts to screen without ensuring availability and access to resources to support whole person care may unintentionally increase burden and risk patients' trust. Therefore, we encourage CMS to consider policies that would encourage both standardized screenings and referrals to address health-related social needs.

Gaps Due to SDOH and How They Might Be Addressed

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 and plans, 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.

Health care payers, including MA organizations, are increasingly looking to partner to better coordinate care and services. 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.

Enabling Health Care that is Informed by SDOH

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

Additionally, we encourage CMS to provide flexibility to Medicare Advantage organizations to leverage non-traditional health care providers, such as community health workers, eligibility support workers, Navigators, social workers and others as part of integrated care teams that can better reach underserved communities and assist with 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.

CMS can also work to improve the health of individuals by takings steps to improve screening for social needs and increase data sharing. We encourage CMS to take steps to share, with appropriate privacy and



consent safeguards in place, demographic data with providers and payers that CMS and its constituent departments may have access to in order to help improve care coordination and reduce the burden of duplicative data collection efforts.

What socioeconomic data do MA plans leverage to better understand their enrollees and to inform care delivery? What are the sources of this data? What challenges exist in obtaining, leveraging, or sharing such data?

Addressing social needs is a complex task; some needs are easily identified and tackled while others much less so. Access to structured data on social needs will help to better understand prevalence and complexities and provide insights into what interventions can be addressed at an individual level and what interventions, like affordable housing and transportation, may need to be addressed at a system-level.

Advancing equity will require better understanding of where inequities occur. However, data on race, ethnicity, language, sexual and gender identity, and social needs are not uniformly identified and captured. Comprehensively documenting social risk and social needs data 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 the disparities contributing to health inequities.

This documentation is the foundational first step toward care models that drive better alignment between health and social needs to improve patient outcomes. 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.

The challenge, however, is that social needs and risk factor data is not always routinely or systematically collected across the health care system. A lack of standardization around how data should be collected makes it difficult to integrate this data into health records and to share, as appropriate, across coordinated entities, or to use for purposes of risk adjustment.

Unfortunately, most data sets do not include the necessary patient information, some of which could be provided through Z codes, to identify the social factors impacting the patients' health. To minimize reporting burden, it is important to have these data elements become part of the claims data so that the analysis of quality performance adds minimal extra reporting burden to quality reporting systems. In 2021, CMS and Medicare contractors issued guidance on use of Z codes to capture SDOH. These updated coding guidelines are a significant step forward to supporting whole person care. The move formally recognizes how SDOH can contribute to moderate medical decision-making complexity when a social need or social risk significantly limits diagnosis or treatment. Social determinants are now listed under risk for complications and/or morbidity or mortality of patient management, noting SDOH as one of the components for moderate level of medical decision making.

However, a CMS [2021 report](#) on the utilization of Z codes for social determinants of health found that social needs data had only been collected and reported for 1.59 percent of Medicare beneficiaries, a fraction of the likely population with social needs. CMS should promote the use of these Z codes by providers, including through additional training, guidance, and incentives, to better and more consistently identify social needs in MA beneficiaries.

While updated SDOH coding guidance assists with enhancing the capture of structured data, limitations at the provider level persist. Even with the benefits of accurate billing and coding, including higher reimbursement rates, coding guidance, and education, physicians often continue to have an incomplete

understanding of medical billing and coding. Moreover, workforce shortages limit a provider organization's ability to educate, train and hire staff to ensure that proper documentation is occurring. SDOH data elements, when captured accurately and frequently in structured claims data, help health care managers, providers and policymakers gain the insights needed for strategic, quality-driven, and equitable health care planning.

Additionally, data sets do not always include all patient information, which can be a challenge in getting the full picture and knowing which individual is receiving which services. Finding ways for SNAP, WIC, housing-related programs, and other federal programs to become part of the claims data system would be helpful in connecting these dots.

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 workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, how have the compensation arrangements been structured? In the case of community-based organizations, do MA plans and providers tend to contract with individual organizations or networks of multiple organizations? Please provide examples of how MA plans and providers have leveraged particular MA supplemental benefits for or within such arrangements as well as any outcomes from these partnerships.

Examples of Successful Partnerships

There are several examples of successful partnerships between MA organizations and local community-based organizations (CBOs) and support services workers aimed at addressing social determinants of health within the communities they serve:

- To address food insecurity as part of the whole-person health approach for its members, **Blue Cross and Blue Shield of North Carolina** [partnered](#) with Benefits Data Trust, Manna Food Bank, Food Bank of Central & Eastern North Carolina, and Second Harvest Food Bank of Northwest NC to increase enrollment in Food and Nutrition Services (FNS) and SNAP. The health plan also partnered with Eat Well to provide members with a monthly stipend to purchase fresh, frozen, or canned fruits and vegetables.
- **Unite Us** [partners](#) with several Medicare Advantage plans, providing plans with the platform to make referrals and directly track beneficiary interactions with CBOs to track service delivery and outcomes. Unite Us has partnered with MA plans to develop evaluations and strategies for how to combine data sets to better tell the story behind what happens when beneficiaries are connected to and receive social services.
- Since 2020, more than 65 MA plans have [partnered](#) with **Papa**, a curated platform of companionship and support for older adults, to address the social needs of their members. The Papa Pals program provides companion care services and support for everyday needs like housework, as well as to counter social isolation and loneliness, to MA beneficiaries to improve overall health and wellbeing.

Data Sharing to Support Successful Partnerships Across Sectors

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.

We recommended that CMS consider the following ways to address data sharing within the MA program:

- 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 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 help to close gaps in care and focus on more upstream challenges – improving outcomes.

How are MA plans currently using MA rebate dollars to advance health equity and to address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?

Congress and CMS have expanded policies around supplemental benefits for MA plans in recent years to allow MA plans more flexibility in designing and targeting supplemental benefit offerings to address both medical and social needs. Through the Bipartisan Budget Act of 2018, Congress began allowing MA plans to offer Special Supplemental Benefits for the Chronically Ill (SSCBI) that are not primarily health related. Beginning in 2019, CMS expanded the definition of primary-health related benefits to include non-medical services, such as broader use of transportation or meal delivery services, in order to better address the needs of enrollees. The growth in supplemental benefit offerings by MA plans has shown demonstrated interest in addressing SDOH and improving wellbeing.

The number of MA plans offering certain non-medical benefits doubled between 2018 and 2020 as a result of these policy changes, with 57 percent of plans [indicating](#) they would offer non-medical benefits in 2021. This trend has continued with more MA plans offering non-medical benefits to their members – according to a recent [Health Affairs](#) article, the number of plans offering non-medical benefits has tripled over the past three years (from 626 to 1,851). Additionally, [34 percent](#) of Medicare plans offer at least one non-medical benefit. This is especially true for MA Special Needs Plans (SNPs) – in 2022, 42 percent of SNPs offered Special Supplemental Benefits for the Chronically Ill. Non-medical benefits offered included meals, transportation supports, social isolation solutions and home modifications.

According to a recent Better Medicare Alliance [report](#) on the state of Medicare Advantage, MA plans have continued to enhance coverage options through non-medical supplemental benefits that address beneficiary social needs. Between 2021 and 2022: post-acute meal benefit offerings increased 32 percent; food and produce benefit offerings increased 120 percent; transportation for non-medical needs benefit offerings increased 106 percent; medical nutrition therapy benefit offerings increased 172 percent; nutritional and dietary benefit offerings increased 327 percent; and pest control offerings increased 56 percent.



Aligning for Health member organizations are leveraging supplemental benefit flexibilities in unique ways to address the health and social needs of Medicare Advantage beneficiaries:

- **Signify Health** recently [partnered](#) 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 that are part of AACN 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 to improve health outcomes for people who need help with non-medical services.
- **Blue Shield of California**, a health plan of the Blue Cross Blue Shield Association (BCBSA), [added](#) a range of supplemental benefits for its MA beneficiaries for 2022 coverage options, including a new grocery benefit and expanded home meal delivery benefit for eligible SSBCI members through a program called Healthy Grocery. This program provides a \$25 monthly allowance to purchase healthy and nutritious foods and produce. An additional benefit for such members includes home meal delivery service upon discharge from an inpatient hospital or skilled nursing facility stay, for up to 22 meals and 10 snacks per discharge.

While progress has been made, there are some barriers that exist in leveraging supplemental benefits to address social needs. A recent [report](#) published in the *American Journal of Managed Care*, for example, highlighted opportunities and challenges that MA plans face in making decisions related to the supplemental benefits they offer to address the social needs of beneficiaries. Data collection, generation and analysis was cited as one major barrier in better informing interventions to address social risk factors, highlighting the need to ensure interoperability of new and existing data sources and address gaps in evidence on certain social care interventions to help inform future supplemental benefit offerings.

Risk adjustment methodologies that are clinical and categorical provide a baseline for improving accuracy and efficacy within care management, resource utilization, and analysis of social risk factors so programs and benefit design is tailored to meet the needs of a population. For example, avoidable events that are risk adjusted using a clinical categorical risk model can be effectively used as Key Performance Indicators (KPIs), providing rate-based efficiency measures by health plan, provider, or geographic area to improve population health management and focus on social needs.

Performing analyses on avoidable events, such as admissions, readmissions, complications, and Emergency Department (ED) visits allow for a rate-based analysis of system performance, while simultaneously identifying performance variation at a granular level for meaningful intervention.

Variation in the utilization of preventable services, such as higher than average utilization of ED services, reflects on the efficacy of provider performance as it relates to patient care management, particularly with chronically ill individuals. Sicker individuals with one or more SDOH conditions have even greater barriers to preventive, outpatient care due to potential issues with transportation, frailty, or health literacy concerns. These issues may inhibit access to preventive care, leading to worsening conditions and the overutilization of potentially avoidable and expensive services. Identifying utilization variation allows providers and MA plans to understand areas of opportunity for patient management optimization such as tailored interventions and allocation of practice resources specific to an individual’s social and clinical needs. For example, if transportation to regular outpatient care is an issue for an individual’s overutilizing

the ED, the provider may explore ways to help coordinate for transportation services or for them to receive telehealth services and ensure they have the appropriate access and knowhow for a particular digital modality, and/or empower synergies with CBOs. Additionally, analyzing rates of preventable services enables plans and policymakers to better understand where enhancements need to be in benefit design, specific to the needs of a population.

Drive Innovation to Promote Person-Centered Care

What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?

Program administration often exists in siloes – funding, eligibility, outcome measures, reporting, and data systems all tend to be program specific. Therefore, efforts to better coordinate care and services provided across health and human service programs, or to reduce burden on individuals applying for or receiving services, are often difficult to accomplish. 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.

An example of a current demonstration project that CMS should leverage learnings from is the [MA Value-Based Insurance Design \(VBID\) Model](#). This model, which is discussed further below, allows MA plans to offer non-primarily health-related supplemental benefits to target enrollees based on their chronic health conditions or socioeconomic status. CMS should catalyze on lessons learned and best practices obtained from this model to inform future policies within the MA program to effectively address the social needs of beneficiaries.

Breaking down the siloes and incentivizing coordination between programs and systems will also help to ensure that they are most effective in improving health and wellbeing. CMS should continue to leverage the CMS Innovation Center (CMMI) to pilot, evaluate, and expand models that address social needs, and encourage efforts to develop value-based arrangements and demonstrations through MA programs. Future CMMI models should be focused on specific changes that could be evaluated and implemented as permanent changes to the Medicare and Medicaid programs.

Community information exchange (CIEs) or health information exchanges (HIEs) can be leveraged to connect different types of organizations for data sharing purposes. CMMI could consider how to best leverage or develop connective infrastructure in states to capture different data sources across federal and other disparate programs. Additionally, CMMI should work with other federal agencies, including the Office of the National Coordinator for Health IT (ONC) and Administration for Community Living (ACL), on their ongoing work to advance social determinants of health data use/sharing and interoperability to foster better connections between the health and social services sectors.

CMMI could also promote and catalyze additional efforts to develop interoperable and integrated networks that have the infrastructure necessary to exchange data. CMMI could take lessons learned from the [Accountable Health Communities \(AHC\) Model](#), which worked to address the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services. According to a recent [blog](#) by CMMI officials, as of June 2022, CMS data showed that more than 137,000 patients accepted navigator help connecting to resources to address their health-related social needs through the model, and patients reported that over 92,000 of their health-related social needs were resolved through the model. However, one remaining barrier cited was around tracking navigation and resolution outcomes to understand if patient needs have been resolved.



A similar approach to the AHC Model Health-Related Social Needs Screening Tool was recently finalized in the [CY2023 MA and Part D final rule](#) which, as stated above, would require MA 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. Aligning for Health was [supportive](#) of this proposal, as these questions will help SNPs gather the necessary information to inform the development and implementation of each enrollee’s comprehensive individualized plan of care. 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.

CMMI could also consider lessons learned from Medicaid managed care organization (MCO) practices, such as provisions in MCO contracts requiring plans to incorporate community-based organizations into moderate and high-risk value-based arrangements or requirements to screen for social needs, or establishing pilots to test and evaluate the impact of providing select evidence-based non-medical interventions to test within MA.

Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBID Model that would test how to address social determinants of health and advance health equity?

As stated above, the [MA Value-Based Insurance Design \(VBID\) Model](#) allows MA plans to offer non-primarily health-related supplemental benefits to target enrollees based on their chronic health conditions or socioeconomic status, testing whether various model components improve health outcomes and lower costs for MA enrollees.

CMS currently [permits](#) a range of non-primarily health related supplemental benefits to be offered under the model, such as food and produce, meals, non-medical transportation, pest control, and more. Additional considerations CMS could look to test through this model to address health and wellbeing could include additional housing benefits or supports for beneficiaries at risk of homelessness, tools to address language barriers that impede access to care, or “companion” benefits to address social isolation, which has been exacerbated particularly among older adults by the COVID-19 pandemic.

Some plan participants have [cited](#) the model’s temporary status as a demonstration program under CMMI as a reason uptake of the program has grown at a slower rate. VBID benefits are contingent on the demonstration model, which creates uncertainty about the future of the program. This could impact plans in their strategy for the types of interventions or investments they choose to implement, as efforts that require multi-year planning to be effective may require more certainty. CMS could consider permanently authorizing this model to promote innovation and provide MA plans with more certainty to make long-term investments that address beneficiary social needs.

Support Affordability and Sustainability

What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?

Care delivery innovations to achieve higher quality, equitable, and more person-centered care start with a clinical categorical risk adjustment methodology that considers burden of illness, functional status, and social determinants. This method is patient-centric, accounting for co-morbidities and measuring the health status and burden of illness of an individual over time, rather than focusing on specific diseases, as seen with the CMS Hierarchical Condition Categories (CMS-HCC) risk adjustment model. The benefit of a clinical categorical model is that it enhances efficiency, which drives sustainability and improves health equity by ensuring risk adjustment is accurate for managing the entirety of the MA health care ecosystem.



Specifically, clinical categorical risk adjustment is extremely flexible, enabling stakeholders to segment populations both at a summary level (i.e., population reporting for strategy, rate-setting, and benchmarking), or granular (i.e., patient specific at point of care). This can be a powerful tool for targeting patients for care management, tracking patients over time, profiling providers, and enhancing the quality of the care delivered. This model places less significance on time-limited acute diseases, while still accounting for their impact on health status and cost of care, while also clearly representing how chronic disease affects post-acute resource use. This allows providers and health care managers to be more efficient, especially with resource constraints.

For example, clinical severity within a diabetic population can vary greatly, therefore it is not equitable, efficient, or accurate to assign the same resource expenditure intensity for all MA diabetic individuals. Clinical categorical risk adjustment considers disease progression and comorbidities when assigning diabetic severity. This allows for alignment of clinical precision with resource intensity needs, such as implementation of care measures and interventions, health plan and provider resources based on accurate cost estimation and administrative needs, and workforce burnout.

Interoperability and patient centered care principals are optimized with risk adjustment that accounts for the total picture of health of individuals in a population, as seen with clinical categorical risk adjustment, which accounts for SDOH in severity leveling. Clinical and social risks should be viewed together for a complete patient picture, as understanding social factors provides invaluable insight for improving a person's health status and predicting negative outcomes. [Studies show](#) medical care accounts for approximately 20 percent of health outcomes variation, but SDOH is tied to 50-80 percent. Overlaying clinical and social risks helps to identify high risk individuals to facilitate prevention and care management to better manage and avoid catastrophic health events. It also allows for an effective communication between payers and providers to describe and understand individuals' burden of illness and expected resource needs.

Consideration of social risks alongside clinical conditions allows for a way to monitor effectiveness of care provision, identify instances of poor care delivery, and surface areas for collaboration with community-based organizations. 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. CMS should 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.

Thank you 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