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Assistant Secretary for Planning and Evaluation
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted via electronic submission system to ASPEImpactStudy@hhs.gov

Re: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

The Association for Community Affiliated Plans (ACAP) greatly appreciates the opportunity to provide comments to Assistant Secretary for Planning and Evaluation (ASPE) on the IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors. ACAP is an association of 63 not-for-profit, community-based Safety Net Health Plans located in 29 states. Our member plans provide coverage to over twenty-one million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Advantage Dual-Eligible SNPs. Twenty-three of our member plans are D-SNPs, twenty-three operate Managed Long-Term Care Supports and Services (MLTSS) plans, 13 of our member plans participate in the Financial Alignment Demonstration, and our plans make up thirty-three percent of all Medicare-Medicaid plans' enrollment.

ACAP plans have developed several initiatives to address social risk factors prevalent in their communities by working with states and community-based organizations. These initiatives have improved beneficiaries' health outcomes and demonstrated long-term cost savings. The dual-eligible beneficiaries our plans serve are most at risk due to their socioeconomic status. Below includes details of our plans initiatives and our comments in response the questions posed in the RFI.

Identifying Medicare beneficiaries with social risk factors

ACAP-member D-SNPs and MMPs leverage multiple data sources to compile information on their Medicare members' social risk factors. Plans glean information on members' social risk factors through the annual member assessments and during the assessments that occur during care transitions or at the member's request. They also gather information on social risk factors from member touch points that occur through care management activities. Community-based partners are another data source for social risk factors. For example, UPMC works with their community partners to obtain information on housing instability for their Cultivating Health for Success program (more information on that program is available below).



However, plans do experience challenges with collecting information on social risk factors and integrating that information into their care management data systems. One challenge is educating providers on the need to assess beneficiaries for social risk factors and how they can document that information. For example, one ACAP-member works with their network providers to educate them that the providers can document homelessness using the ICD-10 Z59 code.¹ It can also be a challenge for plans to identify how best to synthesize social risk factor information from multiple sources, such as providers, community-based organizations, and care manager notes, and merge that information into plans' care management systems.

We are hopeful that through this study, ASPE is able to identify best practices for identifying and tracking social risk factors, and can share that information with plans and providers.

Addressing the needs of beneficiaries with social risk factors

ACAP-member D-SNPs and MMPs employ multiple strategies to address beneficiaries' social risk factors, including developing pilot programs and forming partnerships with community-based organizations. Some of the social risk factors that ACAP plans report to have the most affect on beneficiaries' health are lack of adequate and stable housing and inadequate nutrition. Below are details on how some ACAP-member plans address these social risk factors.

Commonwealth Care Alliance's Medically Tailored Meals Program

Commonwealth Care Alliance (CCA) provides home-delivered medically tailored meals to their dual-eligible Medicaid and Medicare beneficiaries through Community Servings, a Boston-based not-for-profit food and nutrition program. CCA's medically tailored meal program is designed for younger individuals with higher rates of disability that were at nutritional risk. These meals are approved by a registered dietitian and determined to be an appropriate medical diet per evidence-based practice guidelines for addressing nutrition-related health outcomes.² The program includes meals that vary across 15 medical diet tracks and can include up to three different dietary combinations.

Community Health Group's Homeless Program

Community Health Group of San Diego contracts with Project 25, a program that seeks to improve health outcomes and to reduce costs of care for homeless individuals. Project 25 helps to identify housing opportunities for a small, high-need subset of the plan's members, including dually eligible beneficiaries, and links them to preventive medical care, intensive care management, and round-the-clock case workers. Project 25, which began as a three-year pilot, has saved San Diego taxpayers more than \$2 million per year. The Medi-Cal managed care plans

¹ National Health Care for Homeless Council. "Ask & Code: Documenting Homelessness Throughout The Health Care System." October 2016. <https://www.nhchc.org/wp-content/uploads/2017/06/ask-code-documenting-homelessness-throughout-the-healthcare-system.pdf>.

² Community Servings. "The Impact of Medically Tailored Meals." 2018. https://www.servings.org/wp-content/uploads/2018/06/MTM_Community-Servings-Final_Web-Friendly.pdf



in San Diego cover up to 40 percent of service costs for Project 25 clients, and the program receives additional funding from the Substance Abuse and Mental Health Services Administration.³

Health Plan of San Mateo's Housing Program

The Health Plan of San Mateo developed the Community Care Settings Program to help members transition out of institutions to the community and avoid unnecessary institutionalizations. Members receive intense case management, housing assistance services, and medical care. The plan partnered with a care management agency and a housing agency to create the program, which also leverages the plan's relationships with other organizations in San Mateo County, including: affordable supportive housing providers; county agencies; hospital and nursing facility discharge planners and social workers; and a network of community Residential Care Facilities for the Elderly. Health Plan of San Mateo uses various funding sources to operate the program, including a Money Follows the Person grant, state waiver programs, and the health plan's own reserves.⁴

CalOptima and Inland Empire Health Plan Programs on Housing Instability

CalOptima and Inland Empire Health Plan recognized the need to develop a discharge plan that addresses housing instability and ongoing medical oversight for their high-need members. Both of these ACAP MMPs partnered with the Illumination Foundation, an organization that provides recuperative care (i.e., a combination of interim housing, integrated medical oversight, interdisciplinary case management, and targeted support to identify housing options) for homeless individuals in southern California. The Illumination Foundation found that providing recuperative care and connecting beneficiaries to housing has reduced hospital readmissions by 50 percent and lowered the daily cost of care by 90 percent for homeless members participating in the program.⁵

L.A. Care's Intensive Case Management Services for Homeless Members

In a new pilot program, L.A. Care Health Plan awarded a grant to the Corporation for Supportive Housing to provide intensive case management services to its highest-need, highest-cost homeless members and link them to a large network of housing and social service resources to reduce readmission rates. This program meets a significant need: in Los Angeles County, the top

³ Center for Health Care Strategies, Inc. "ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons." June 2016. <http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Medicare-Medicaid%20Plans%20and%20the%20Financial%20Alignment%20Demonstrations.pdf>

⁴ Center for Health Care Strategies, Inc. "ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons." June 2016. <http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Medicare-Medicaid%20Plans%20and%20the%20Financial%20Alignment%20Demonstrations.pdf>

⁵ Center for Health Care Strategies, Inc. "ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons." June 2016. <http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Medicare-Medicaid%20Plans%20and%20the%20Financial%20Alignment%20Demonstrations.pdf>



10 percent of highest-need homeless individuals account for 72 percent of homeless health care spending. L.A. Care hopes that the two-year pilot program can be replicated to target its approximately 20,000 homeless Medi-Cal members.⁶

UPMC's Housing Initiative

Since 2010, UPMC *for You*, located in Pennsylvania, has partnered with Community Human Services, a local contractor with the U.S. Department of Housing and Urban Development (HUD), to create the Cultivating Health for Success (CHFS) program. This program provides permanent housing, a patient-centered medical home, and case management and care coordination to their homeless beneficiaries, which are estimated to be approximately 40 to 50 of their Medicaid and Special Needs Plan members. Coordination of care was problematic prior to this program due to lengthy housing waiting list and access to quality resources. To qualify for the program, beneficiaries must be defined as homeless by HUD, have a medical disability, enrolled in the plan's Medicaid or SNP program, and have at least one year of health care expenditures. Beneficiaries of the program receive a secure living environment with social supports, coordinated medical care, in-home assistance with daily living activities, medical monitoring, and basic life skills training.

Evidence on quality outcomes and the total cost of care

ACAP-member plans have found that services for social risk factors improve quality and reduce the cost of care. As stated above, CCA developed a program on medically tailored meals. CCA was also able to conduct an evaluation of the program. In collaboration with Massachusetts General Hospital, CCA evaluated the impact of the medically tailored meals on emergency department visits and hospital admissions. The analysis showed that beneficiaries receiving the medically tailored meals had approximately 1.5 fewer emergency department visits, 0.3 fewer inpatient admissions, and 1.14 fewer uses of emergency transportation.⁷

UPMC has also found positive outcomes from their housing initiative (described above). The program reduced cost and resolved several housing issues for their beneficiaries. Within the first five years of establishment, 51 to 60 members were securely housed, and the stable housing and coordinate case management saved \$6,384 for each housed member. CHFS had fewer unplanned claims compared to members within the U.S. Department of Housing and Urban Development (HUD).⁸ Savings also increased for members after being stably housed for ten months. Visits to primary care providers and specialists also increased and results suggest that medication adherence improved. Due to the success of the program, UPMC is planning to expand their program in order to provide these services to housing insecure beneficiaries that

⁶ Center for Health Care Strategies, Inc. "ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons." June 2016. <http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Medicare-Medicaid%20Plans%20and%20the%20Financial%20Alignment%20Demonstrations.pdf>

⁷ American Journal of Managed Care. "Home-Delivered Meals Keep Medicare, Medicaid Population Out of ED, Lower Costs." April 2018. www.ajmc.com/newsroom/homedelivered-meals-keep-medicare-medicicaid-population-out-of-ed-lower-costs.

⁸ UPMC Health Plan. Department of Health Economics HUD Initiative Analysis. May 2017.



do not meet HUD's definition of homeless (i.e., beneficiaries living on friend's couch). Although different funding would be required, the infrastructure of the program would remain the same.

Disentangling beneficiaries' social and medical risks and address each

ACAP-member plans have found that, for the dual-eligible population, the social and medical risks can be inseparable. Plans assess for both social and medical needs during assessments and when care managers are working with beneficiaries on their plan of care. In some instances, beneficiaries prioritize their social needs over their medical needs and want to work with care managers on their social needs first.

Social risks – such as inadequate housing, food insecurity, and social isolation – often have a direct impact on beneficiaries' medical risks. When necessary, plans address beneficiaries' social needs first and then work with beneficiaries on their medical risks after their social risks are addressed. Sometimes, addressing a social risk has a direct, positive impact on a beneficiary's medical risk. For example, diabetes can be better controlled when a beneficiary has access to adequate and stable housing, healthy food, a refrigerator, and electricity. Working with beneficiaries on their social needs first also helps to establish trust between the beneficiary and the health plan. Plans have found that establishing trust and a relationship with beneficiaries is particularly important for the dual-eligible population that tends to have experienced poor and fragmented care prior to joining the health plan.

Conclusion

ACAP is prepared to assist with additional information, if needed. If you have any questions, please do not hesitate to contact Christine Aguiar Lynch at (202) 204-7519 or clynch@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer