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November 16, 2018

Alex Azar
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

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

Dear Secretary Azar:

On behalf of over 39,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on a request for information (RFI) that seeks input on how health care providers and health plans are working to improve care for Medicare patients with social risk factors. As emergency physicians, we see patients from all social statuses, and both by law and by oath, we treat all patients that come through our doors. We intersect with many different type of providers across the health care sector, including primary care clinicians, behavioral health specialists, hospitalists and other specialists, social workers, and community workers—and routinely consult with these colleagues for the sake of our patients. Given the unique role we play as the healthcare system's safety net, we believe that we can be active partners in any policy effort that your Department engages in related to improving care for patients with social risk factors.

Before responding to your specific comments, we would like to note that we have long supported accounting for social risk factors in Medicare payment programs. Emergency department (ED) patients in rural parts of the country, as well as those in urban, medically underserved areas, often have many more social risk factors than those in geographic areas that are better served, with less access to the many resources and community services needed to ensure better health outcomes. Inadequate risk adjustments that do not account for these factors could result in unfair penalties for providers that care for the highest acuity low-income patients, creating a perverse incentive that could result in these patients over the long term being further underserved and having their access to care threatened.

As a College, ACEP is committed to improving the quality of care that is delivered to all our patients, and we are cognizant of the specific challenges facing patients that do not have access to adequate social support services. With this value and understanding in mind, we offer the following responses to the Department's major questions posed in the RFI.

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How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

In recent years, providers and health plans have begun to recognize the importance of social determinants of health to a patient's overall health. Many interventions help identify barriers to health such as transportation and access to food and housing. One such tool that ACEP supports to help manage care for patients with complex needs is the Collective Medical Technologies' (CMT) Edie™ (a.k.a. PreManage ED) software. Edie™ is an information exchange that provides critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their drug history, other providers who are involved with the patients, and finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It also lowers health care costs through a reduction in redundant tests and through better case management that reduces hospital readmissions. Through an alliance with CMT, ACEP has seen this system mature in approximately 17 states. Washington state, in the first year alone, experienced a 24 percent decrease in opioid prescriptions written from emergency departments, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than $32 million.[1]

Some EDs across the country are attempting to create care coordination and case management programs that help improve follow up appointment scheduling from the ED and target social interventions and primary medical care to high ED utilizers. One such program in Maryland applies mobile technology to use paramedics in a community health worker role to follow up on discharged patients at risk for readmission.[2] Many of these patients are Medicare beneficiaries. Another program in the East Bay, California has a help desk for health-related social needs with four integrated medical-legal partnerships, called Health Advocates, to help patients navigate housing and transportation challenges, immigration challenges, and benefit eligibility.[3]

ACEP is continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients, including through participation in alternative payment models. We have developed a physician-focused payment model (PFPM) called the Acute Unscheduled Care Model (AUCM), which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recently recommended to the HHS Secretary for full implementation. The AUCM provides incentives to participants to safely discharge Medicare beneficiaries from the ED by facilitating and rewarding post discharge care coordination. Under the model, a Medicare beneficiary who presents to the ED will undergo a safe discharge assessment (SDA) concurrent to receiving clinical care to identify socio-economic factors and potential barriers to safe discharge back to the home or community, needs related to care coordination, and additional assistance that may be necessary. If the participating emergency physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA will be used to generate unique patient discharge instructions including identifying symptoms that would require rapid reassessment and return to the ED. After the initial ED visit, the patient will receive appropriate follow-up care from the ED physician, his or her primary care physician, and other specialists as needed. ACEP is excited about the infinite possibility this model has in terms of improving care for Medicare beneficiaries, and is eager to work with HHS on implementation.

How do plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors?

Understanding the full significance that specific social determinants of health have on a patient requires comprehensive screening by trained professionals. While screening can be burdensome, it can help highlight those patients who may need additional services (such as nurse follow up calls, peer counseling, or a visiting

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[1] https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/

[2] For more information on the Maryland Mobile Integrated Health Care Programs, please go to https://www.miemss.org/home/LinkClick.aspx?fileticket=w-K7gG-8teo%3D&tabid=56&portalid=0&mid=1964

[3] For more information on the Health Advocates Program, please go to http://www.levittcenter.org/ed-social-welfare-in-collabor/.

dietitian) to prevent the next acute care episode. There are many screening techniques and tools that exist, and while ACEP supports the concept of screening, we have not endorsed a particular approach.

Beyond screening, another way to identify Medicare beneficiaries with social risk factors is to simply look at utilization, particularly in acute care settings such as emergency departments. Edie™, which is described above, can help identify individuals that have gone to the ED frequently. Once these beneficiaries are identified, ACEP believes that it is important to create targeted care coordination plans that can help get the appropriate care to each individual patient.

What approaches have plans and providers used to address the needs of beneficiaries with social risk factors?

ACEP believes that the approaches that are most effective include:

- Direct patient engagement in the community;
- Broad community resource engagement;
- Customized patient care plans;
- IT System that allows for common information exchange across all community electronic health records (such as CMT's EDIE/PreManage platform described above)
- Use of care managers and coordinators, social workers, and health educators,
- Transportation services after discharge;
- Peer and support groups; and
- Services that address needs such as housing and food insecurity, especially for the highest utilizers of acute care services.

What evidence is there regarding the impact of these approaches on quality outcomes and the total cost of care?

There are numerous articles that try to address the financial impact of care coordination and case management on patients with social risk factors. However, some of these studies are limited in generalizability, and randomized controlled trials are rare.

ACEP has convened a group of emergency physicians who are interested in examining how social factors impact emergency care. This group has identified the following resources that may be helpful to HHS as the Department continues examining this issue:

Resources

Patient Activation Changes as a Potential Signal for Changes in Health Care Costs: Cohort Study of US High-Cost Patients. J Gen Intern Med. 2018 Oct 5. doi: 10.1007/s11606-018-4657-6.

Evaluation of The Behavioral Health Integration and Complex Care Initiative In Medi-Cal. Health Aff (Millwood). 2018 Sep;37(9):1442-1449.

Community Health Workers as an Extension of Care Coordination in Primary Care: A Community-Based Cosupervisory Model. J Ambul Care Manage. 2018 Oct/Dec;41(4):333-340.

Cost-Effectiveness Analysis of a Capitated Patient Navigation Program for Medicare Beneficiaries with Lung Cancer. Health Serv Res. 2016 Apr;51(2):746-67.

Low-cost Transitional Care with Nurse Managers Making Mostly Phone Contact with Patients Cut Rehospitalization at a VA Hospital. Health Aff (Millwood). 2012 Dec;31(12):2659-68.

Cost-effective: Emergency Department Care Coordination with a Regional hospital information system. J Emerg Med. 2014 Aug;47(2):223-31.

Evaluation of Housing for Health Permanent Supportive Housing Program, Hunter SB, Harvey M, Briscombe B, Cefalu M.. Santa Monica, CA: RAND Corporation. Available at https://www. rand. org/pubs/research reports/RR1694. html. 2017.

What are ways in which plans and providers disentangle beneficiaries' social and medical risks and address each?

ACEP believes that rather than focusing on disentangling these social and medical risks, we have to recognize that the two are intrinsically connected. Chronic medical illness may predispose a patient to have depression or decompensated mental illness. Homelessness impacts the ability of a patient with diabetes to have access to the insulin they may need. Patients with liver disease and encephalopathy may forget their follow up appointments and have poor adherence. Substance use disorder makes it less likely that a patient will follow a complicated medication regimen properly. The examples go on and on. In all, we think that a more prudent approach to treating patients is to address their social and medical risks together, not separately.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,

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ACEP President