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**Humana**

November 16, 2018

Brenda Destro, Deputy Assistant Secretary for Planning and Evaluation (ASPE)  
United States Department of Health and Human Services (HHS)  
7500 Security Boulevard, Baltimore, MD 21244-1850  
Submitted electronically to ASPEImpactStudy@hhs.gov

RE: Request for Information: IMPACT Act Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Dear Deputy Assistant Secretary Destro:

This letter is in response to the Request for Information: IMPACT Act Research Study. Humana thanks ASPE for the opportunity to provide our comments on the importance of improving care for Medicare beneficiaries with social risk factors.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. As one of the nation's top contractors for Medicare Advantage (MA) with approximately 3.1 million members we are distinguished by an over 30-year, long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend on the Medicare Advantage program as their safety net and many in underserved areas – receive integrated, coordinated, quality, and affordable care through our plans.

Addressing social risk factors, including food insecurity and social isolation, is a growing priority for many health plans. Humana has been working for many years on addressing the social determinants that are impacting the health of our members and their communities through our Bold Goal initiative. Through this initiative we are continuing to learn about the impact social risk factors have on the health of our Medicare beneficiaries and about best practices for addressing them. Humana is encouraged by HHS's focus on this issue and we look forward to working together to better address the needs of all Medicare beneficiaries.

As always, we value this opportunity to provide comments and are pleased to answer any questions you may have with respect to the comments below. We hope that you consider our comments as constructive feedback aimed at ensuring that together we continue to advance

our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to Medicare beneficiaries, focused on improving their total health care experience.

Sincerely,

A handwritten signature in blue ink, appearing to read "Mark A. Newsom".

Mark A. Newsom  
Vice President, Public Policy  
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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?*

Many factors contributing to an individual's overall health cannot be directly linked to medical services or treatments and it is estimated that approximately half of factors influencing health are attributable to social and environmental factors.<sup>1</sup> For many years, Humana has been working to address the social determinants that are impacting the health of our members and their communities. Humana launched its Bold Goal initiative in 2015, with the objective of improving the health of the communities we serve by 20 percent. Through this initiative, Humana partners with nonprofits, businesses, and local governments as well as physicians and other medical providers within communities to develop innovative programs designed to improve the clinical health outcomes of individuals by addressing social needs. Humana's Bold Goal has chosen to address loneliness and social isolation as well as food insecurity as top priorities given the research demonstrating that these are two of the biggest social factors negatively impacting the health of older Americans. Recent studies have found that socially isolated adults have a 29% increased likelihood of mortality than those who are more socially connected and older adults experiencing loneliness are 3.4 times more likely to suffer from depression.<sup>2,3</sup> Loneliness in older adults is also associated with an increased risk of late-life dementia.<sup>4</sup> Research on the impact of food insecurity on older adults has found that it is as strong of a predictor of later declines in health as heart disease, cancer, stroke, diabetes, or pulmonary disease.<sup>5</sup> Food insecure seniors have also been found to be 78% more likely to experience depression, 55% more likely to experience asthma, 40% more likely to experience chest pain, 21% more likely to have limitations in activity, and are 10% more likely to experience high blood pressure.<sup>6</sup> Because of the Bold Goal pursuit, Humana has gained a deeper understanding of the need for addressing social determinants of health (SDOH) to improve clinical health, has gained experience in implementing programs and partnerships to do this, and has a greater appreciation for the importance of this work.<sup>7</sup>

### *How plans and providers serving Medicare beneficiaries:*

- *Identify beneficiaries with social risk factors*

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<sup>1</sup> McGinnis JM, Williams-Russo P, Knickman JR. The Case for More Active Policy Attention to Health Promotion. *Health Affairs*. 2002 Mar-Apr; 21(2): 78-93.

<sup>2</sup> Holt-Lunstad, Julianne, Timothy B. Smith, Mark Baker, Tyler Harris, and David Stephenson. Loneliness and Social Isolation as Risk Factors in Mortality: A Meta-Analytic Review. *Perspectives on Psychological Science*. 2015, Vol. 10(2) 227–237

<sup>3</sup> See [https://www.socialfinance.org.uk/sites/default/files/publications/investing\\_to\\_tackle\\_loneliness.pdf](https://www.socialfinance.org.uk/sites/default/files/publications/investing_to_tackle_loneliness.pdf)

<sup>4</sup> Wilson RS, Krueger KR, Arnold SE, et al. Loneliness and Risk of Alzheimer Disease. *Arch Gen Psychiatry*. 2007;64(2):234–240. doi:10.1001/archpsyc.64.2.234

<sup>5</sup> Alley, Dawn E et al. "Material resources and population health: disadvantages in health care, housing, and food among adults over 50 years of age" *American journal of public health* vol. 99 Suppl 3, (2009): S693-701.

<sup>6</sup> See <https://www.feedingamerica.org/sites/default/files/research/senior-hunger-research/senior-hunger-infographic.pdf>

<sup>7</sup> See [http://populationhealth.humana.com/wp-content/uploads/2017/03/Humana\\_BoldGoal\\_2017\\_ProgressReport-v2.pdf](http://populationhealth.humana.com/wp-content/uploads/2017/03/Humana_BoldGoal_2017_ProgressReport-v2.pdf)

- *Disentangle beneficiaries' social and medical risks and address each*

Humana has employed a number of methods to identify beneficiaries with social risk factors, focusing particularly on food insecurity and loneliness and social isolation. First, we have worked to integrate SDOH screening and referral protocols for social and community services in primary care clinics. In a pilot program undertaken by Humana in partnership with Feeding America and Feeding South Florida, a food insecurity screening and a health-related quality of life (HRQOL) survey were administered to patients at primary care clinics in south Florida, with those screening positive for food insecurity being provided food resources onsite and receiving referrals to additional community resources. The program used the Centers for Disease Control (CDC)-developed Healthy Days measure to examine HRQOL and The Hunger Vital Sign™ food insecurity screening tool.<sup>8</sup> In other clinics, Humana has partnered with providers to screen patients for loneliness using the UCLA Loneliness Scale.<sup>9</sup> In both cases, Humana has provided toolkits, resource guides, and technical support for how to conduct screenings and refer to community and public resources to address needs.

We are also working to integrate SDOH screening and referral into Humana clinical programming, with the goal of treating social needs as clinical gaps in care. Screenings have been incorporated into the workflow of several care teams who work directly with our members. Humana's chronic care management nurses screen members for a variety of social risks as they complete clinical assessments and create care plans to help members reach their health goals. This is a component of their National Committee for Quality Assurance (NCQA) care management accreditation. Humana Pharmacy case management teams have also begun screening members for food insecurity to help address root causes of non-adherence to medications.

Additionally, we have developed SDOH predictive models in order to proactively identify members with the highest risk in order to develop care plans to support their needs. In screening thousands of beneficiaries for social risks, Humana has learned a great deal about the association of loneliness and social isolation with worsening HRQOL, increased mortality, and other poor health outcomes.<sup>10,11,12</sup> With these insights, in addition to claims and laboratory data, electronic medical records, and consumer information, we have developed a predictive analytic model to predict loneliness in individuals enrolled in a MA health plan. Identifying individuals at risk for loneliness and related outcomes allows us to estimate their healthcare needs and establish appropriate preventive strategies to support their health and wellbeing. We are currently undertaking a similar process for predicting food insecurity.

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<sup>8</sup> McGrath E, Renda A, Eaker E, Glasheen WP, Cordier T, Dobbins J, Prendergast K, Vatske S, Hernandez Y, Connolly C. Measuring food insecurity and Healthy Days in a primary care setting. Poster presentation at: 2017 Art & Science of Health Promotion Conference. March 27-31, 2017. Colorado Springs, CO.

<sup>9</sup> [UCLA Loneliness Scale](#)

<sup>10</sup> Hawkley L, Cacioppo J. Loneliness matters: A theoretical and empirical review of consequences and mechanisms. *Annals of Behavioral Medicine*. 2010; 40: 218–227.

<sup>11</sup> Segrin C, Passalacqua S. Functions of loneliness, social support, health behaviors, and stress in association with poor health. *Health Communication*. 2010; 25(4): 312-322.

<sup>12</sup> Luo Y, Hawkley L, Waite L, Cacioppo J. Loneliness, health, and mortality in old age: A national longitudinal study. *Social Science & Medicine*. 2012; 74(6): 907-914.

In addition to predictive modeling to identify Humana members with SDOH in need of addressing, Humana identifies low-income MA members who may benefit from dual enrollment in Medicare and Medicaid and acts as an authorized representative to assist them in applying to the appropriate state Medicaid agency. Humana's predictive modeling begins with identifying those that are the most likely to be eligible for but not enrolled in Medicaid. Humana then conducts direct outreach to those likely Medicaid-eligible members and assists them in applying to their Medicaid agency. Through internal surveys, Humana has found high levels of satisfaction with this initiative.

Humana believes that the analytic powers of predictive modeling offer promising opportunities for both data collection and the tailoring of services. As CMS continues its efforts to improve the care of Medicare beneficiaries with social risk factors, efforts such as CMS's Blue Button 2.0 and other data sharing projects that could provide MA plans with critical data should remain a priority. Data sharing opportunities allowing MA plans access to data about beneficiaries from before they become plan members – prior claims data or even clinical, social need, or health risk assessments completed by previous providers – would allow us to run our SDOH predictive model for members sooner. Rather than having to wait for new claims, Humana could quickly and preemptively implement an individualized care plan for a member, potentially preventing future health issues and costs.

Finally, Humana understands that a person's physical and social environment play a strong role in their health. That is why Humana has built [zoom in™](https://zoomin.humana.com) (zoomin.humana.com), a data visualization tool that identifies population health risks at a local level by aggregating public health data with key SDOH to provide a more comprehensive view of patient and community social health needs. This tool is intended to enable a place-based, collaborative approach to care by Humana's clinicians, community nonprofit organizations, other health care professionals and local government leaders. Piloted in San Antonio, Texas and Broward County, Florida, two of our Bold Goal communities, Humana is expanding zoom in™ to communities nationwide in 2019.

- *Approaches plans and providers have used to address the needs of beneficiaries with social risk factors*
- *What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?*

Humana has designed our MA supplemental benefit offerings to directly address the needs of beneficiaries with social risk factors, to the extent allowed, including: non-emergency medical transportation, respite care, post-hospital discharge meals, and companionship. Despite the innovative work in this area by Humana and others, MA regulations and guidance have historically stipulated that plan sponsors can only offer narrowly defined supplemental benefits that are primarily health services related in the traditional medical model. In the 2019 MA Call Letter and in subsequent guidance, CMS reinterprets the definition of "primarily health related"

to include additional services but the agency's guidance explicitly prohibits coverage of items or services primarily intended to address SDOH.<sup>13</sup>

Humana has urged and will continue to encourage CMS to consider extending benefit and cost sharing flexibility to supplemental benefits targeted at addressing SDOH. The literature clearly demonstrates that health is influenced by more than just medical-specific factors.<sup>14</sup> Allowing Medicare Advantage Organizations (MAOs) to expand supplemental benefits will have positive impacts on social and environmental deterrents and ensures a holistic approach is taken to enhance health outcomes for the Medicare population. Specifically, Humana has prioritized addressing food insecurity and social isolation because an analysis of our MA population demonstrated that these are the key SDOH impacting the lives and health of older adults.

While we know food insecurity is correlated with a number of chronic conditions, such as diabetes, hypertension and cardiovascular disease,<sup>15</sup> regulations generally prohibit social factors, on their own, from qualifying an MA enrollee for meal services.<sup>16</sup> Humana has urged CMS to work with MAOs to design policies allowing plans to address food insecurity and recommended targeted modifications of the Medicare Managed Care Manual. For enrollees eligible for Supplemental Nutrition Assistance Program (SNAP), MAOs should be able to coordinate and include meal services as a benefit to ensure that members have enough nutritious food to last throughout each month.

One of the biggest risk factors for social isolation is lack of access to transportation. Seniors without access to transportation or who have retired from driving are often unable to participate in community activities and therefore to connect in-person with others. Humana has recommended to CMS that transportation should be an eligible supplemental benefit to be offered to MA members who are socially isolated to the point where that isolation is a root cause for clinical depression or other behavioral health issues. Lack of transportation may also exacerbate food insecurity, as vulnerable seniors may be unable to travel to grocery stores with healthier foods, and instead may have to rely on more easily accessible fast food options located closer to their homes. As such, CMS should allow MAOs the flexibility to provide non-

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<sup>13</sup> See [CMS April 27, 2018 HPMS memo](#).

<sup>14</sup> Alley, D. E., Asomugha, C. N., Conway, P. H., & Sanghavi, D. M. (2016). Accountable health communities—addressing social needs through Medicare and Medicaid. *N Engl J Med*, 374(1), 8-11; Adler, Nancy E., et al. *Addressing Social Determinants of Health and Health Disparities*. Discussion Paper, Vital Directions for Health and Health Care Series. National Academy of Medicine, Washington, DC. <https://nam.edu/wp-content/uploads/2016/09/addressing-social-determinantsof-health-and-health-disparities>; Braveman, Paula, and Laura Gottlieb. "The social determinants of health: it's time to consider the causes of the causes." *Public Health Reports* 129.1\_suppl2 (2014): 19-31; and Meddings, Jennifer, et al. "The impact of disability and social determinants of health on condition-specific readmissions beyond Medicare risk adjustments: A cohort study." *Journal of general internal medicine* 32.1 (2017): 71-80.

<sup>15</sup> Berkowitz, S. e. (2017). Food Insecurity and Health Care Expenditure in the United States, 2011-2013. Health Services Research, 10.1111/1475-6773.12730

<sup>16</sup> Chapter 4, Medicare Managed Care Manual, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>

medical transportation services as a supplemental benefit if transportation is deemed a barrier to accessing healthy food.

Collaboration with community partners is imperative to helping address the social risks facing our members and is key to our Bold Goal initiative. After identifying at-risk members, we connect them to community resources in a variety of ways. For our food insecurity interventions in the clinical setting, we have a formal partnership with Feeding America and Feeding South Florida to provide food resources onsite and referral to appropriate community resources. We have also developed a loneliness tool kit that can be provided directly to a member or to a patient by their physician that both describes the health risks associated with loneliness and social isolation and suggests resources in their community to help, including community centers, volunteer opportunities, and Humana in Your Neighborhood locations that offer programs and activities such as Silver Sneakers, designed to connect members with others in their communities. Humana care managers also connect members to community-based organizations that can help address health related social needs by leveraging an internally developed and maintained community resource directory.

We believe that providers are key to address the needs of beneficiaries with social risk factors. They know their patients intimately and care for all their traditional health-related needs. That is why so many of our interventions are located in the physician's office and why we have developed numerous tools to make it as easy as possible for the care team to identify and address social risks. We have created a Continuing Education Unit for physicians, nurses, pharmacists, and social workers on the SDOH and HRQOL. This not only provides Humana's clinicians with an opportunity to build their skills in this area, but we are also sponsoring trainings for clinicians in the community for a broader impact.

- *Evidence regarding the impact of these approaches on quality outcomes and the total cost of care*

While we do not yet have causal evidence that the interventions we have implemented to address social risks have an impact on quality outcomes and the total cost of care, we have seen correlations in the literature and our own studies. For instance, a recent study found that food insecure seniors are 65 percent more likely to be diabetic, twice as likely to report fair or poor health, 19 percent more likely to have high blood pressure, 57 percent more likely to have congestive heart failure, 66 percent more likely to have experienced a heart attack, and 2.3 times more likely to suffer from depression.<sup>17</sup> Two peer-reviewed studies of 54,000 Maryland residents on both Medicare and Medicaid found that SNAP participation reduced their odds of nursing home admission by 23 percent and of hospitalization by 14 percent. Based on this

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<sup>17</sup> Gundersen C, Ziliak J. The Health Consequences of Senior Hunger in the United States. 2014.

research, it is estimated that enrolling eligible people ages 65 and older in SNAP could reduce annual healthcare costs by \$2,120 per person.<sup>18,19</sup>

We also know that social isolation, loneliness, and the availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities can play an important role in patient health.<sup>20</sup> According to research from the AARP Foundation, 17 percent of adults age 65 and older are isolated, leading to a 26 percent increased risk of death due to the subjective feeling of loneliness.<sup>21</sup>

Humana measures Healthy Days, a HRQOL measure developed and validated by the CDC, to measure the population health of the communities we serve and as a leading indicator for the impact of social risk interventions on an individual's health and well-being. Because Healthy Days captures broad dimensions of health from the individual's perspective, it is a simple way to holistically measure the health and well-being of a population and its trend over time, and there is a strong evidence base correlating Healthy Days to chronic disease conditions.<sup>22</sup> Results from Humana's pilot screening for food insecurity in primary care clinics found that food insecure individuals had nearly twice as many physically unhealthy days per month as food secure individuals (13.68 days versus 7.44) as well as more than twice as many mentally unhealthy days per month (12.91 days versus 6.10).<sup>23</sup> Knowing this, Humana believes we can significantly improve a beneficiary's HRQOL by addressing their food insecurity. We have a randomized control test underway to measure food insecurity's impact on quality outcomes and the total cost of care. The outcomes of this study will require a longer timeframe to measure and results will be available in 2019.

In addition, Humana's Bold Goal work has shown improvement in the number of Healthy Days in our targeted Bold Goal communities. For example, in 2017, San Antonio, TX experienced an overall 3.5% improvement in Health Days and a 5.1% improvement for members living with diabetes. In Knoxville, TN, Healthy Days increased by 5.4% overall and there was an improvement of 9.7% for seniors living with diabetes. The senior populations of Baton Rouge and New Orleans, LA experienced an improvement in Healthy Days of 4.1% and 3.9%, respectively in 2017.<sup>24</sup> These positive outcomes in improved Healthy Days lead not only to better health outcomes for members but also to lower costs, as a recent study found increased

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<sup>18</sup> Zielinskie G, Samuel L, Szanton S, Betley C, Cahill R. Access to Public Benefits among Dual Eligible Seniors Reduces Risk of Nursing Home and Hospital Admission and Cuts Costs. July 2018.

<sup>19</sup> Samuel L, Szanton S, Cahill R, Wolff J, Ong P, Zielinskie G, Betley C. Does the Supplemental Nutrition Assistance Program Affect Hospital Utilization Among Older Adults? The Case of Maryland. *Population Health Management*. Apr 2018; 21(2): 88:95.

<sup>20</sup> HHS, "Healthy People 2020 and Social Determinants of Health," available at <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

<sup>21</sup> See <https://connect2affect.org/>

<sup>22</sup> Slabaugh S, Shah M, Zack M, Happe L, Cordier T, Havens E, Davidson E, Miao M, Prewitt T, Jia H. Leveraging Health-Related Quality of Life in Population Health Management: The Case for Healthy Days. *Population Health Management*. 2017 Feb; 20(1):13-22.

<sup>23</sup> See <http://apps.humana.com/marketing/documents.asp?file=3105791>

<sup>24</sup> See [http://populationhealth.humana.com/documents/Humana\\_BoldGoal\\_2018\\_ProgressReport.pdf](http://populationhealth.humana.com/documents/Humana_BoldGoal_2018_ProgressReport.pdf)



medical costs of \$15.64 per person per month associated with just one additional Unhealthy Day.<sup>25</sup>

- *Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?*
- *Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?*
- *What are barriers to collecting data about social risk? How can these barriers be overcome?*
- *What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?*

Beginning in 2015, Humana has measured the Healthy Days, a HRQOL measure developed and validated by the CDC, of our members. We conduct an annual survey of a representative sample of members to measure the population health of the communities we serve, including by line of business (i.e. Medicare Advantage and Medicaid) and market (i.e. San Antonio, TX and Knoxville, TN), as well as by certain population segments such as members with disabilities or diabetes. Because Healthy Days captures broad dimensions of health from the individual's perspective, it is a simple way to holistically measure the health and well-being of a population and its trend over time. By segmenting the population, we are able to identify groups who may need more attention or where specific interventions may be having an impact. We also use Healthy Days as a leading indicator for the impact of social risk interventions since other outcomes, such as utilization and lab values take longer to realize. Humana has also incorporated Healthy Days and other HRQOL questions into our Humana at Home and clinical care management screening tools. In fact, Humana at Home telephonic and in-home care management teams screen for Health Days every 90 days while a member is in managed status.

One barrier to collecting social risk data is restrictions on contacting members imposed by the Telephone Consumer Protection Act (TCPA). Due to the complex nature of these regulations, the challenge of collecting and tracking Do Not Call information, and the high cost of violations, considerable effort and expense goes into collecting this information. However, Humana believes this data to be so valuable that we continue with its collection despite these challenges. Insights from our annual Healthy Days survey has, for example, helped us highlight the critical role of providers in value-based relationships to improving HRQOL and the need for special attention to members with disabilities, who experience a substantially higher number of unhealthy days each month.

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<sup>25</sup> Cordier, Tristan, MPH; S. Lane Slabaugh, PharmD; Eric Havens, MA; Jonathan Pena, MS; Gil Haugh, MS; Vipin Gopal, PhD; Andrew Renda, MD; Mona Shah, PhD; and Matthew Zack, MD. A Health Plan's Investigation of Healthy Days and Chronic Conditions. *Am J Manag Care*. 2017;23(10):e323-e330

Data interoperability is key to achieving continuity of care for beneficiaries as they interact with plans, health providers, and community service organizations and as beneficiaries switch between plans or are covered by both Medicare and Medicaid. Interoperability is also critical to enable patients to receive truly individualized care, as it could allow for all providers to access and share the same information without requiring the patient to repeatedly provide social risk information, some of which may be uncomfortable to discuss. Humana applauds the efforts CMS has taken to achieve the goal of interoperability, such as its Blue Button 2.0 initiative and the adoption of the Fast Healthcare Interoperability Resources (FHIR) standard and encourage continued focus in this area.

Time is often identified by providers as a barrier to collecting data about social risks. That is why Humana is undergoing a methods study to assess the time it takes to screen patients in a clinical setting using both face-to-face and tablet methods. We will also evaluate the validity of assessment based on each modality. We hope to publish the outcomes of this study in 2019 to contribute to the discussion around the best practices of collecting data on and addressing social risks.