MEDICAL HOME NETWORK

November 16, 2018

Assistant Secretary for Planning and Evaluation, Room 415F
ASPE IMPACT Study Team
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Thank you for the opportunity to respond to your Request for Information (RFI) regarding approaches for improving care for Medicare beneficiaries with social risk factors.

Medical Home Network (MHN) is a not-for-profit collaborative that has fundamentally changed how care is delivered. Our proven model of care unites provider communities and diverse healthcare entities around a common goal: to redesign healthcare delivery and transform the way care is managed at the practice level. The result is stronger patient relationships with their primary care team, and the realization of value in the safety net through technology-enabled population health management at the practice level.

It starts with providers and patients working together to improve health. Care teams drive engagement by developing relationships with patients that extend beyond the four walls of the primary care practice. We provide the tools and processes to help care teams engage patients and help them become an accountable member of the team. Research shows that patients who are involved in making their healthcare decisions tend to be healthier and have better outcomes. By connecting providers and delivering real-time information, we enable coordinated care management, improve transitions of care, and promote timely follow-up. But the most important change is that patients receive better care where and when they need it.

The MHN Accountable Care Organization (ACO) MHN ACO, LLC is provider-owned and provider-driven, consisting of 2400 providers in 12 organizations, serving about 118,000 patients in the Chicagoland area. We operate as equal partners, which means shared-decision making and true collaboration among our members. We are transforming health care delivery by offering coordinated, patient-centered care for Medicaid patients. We have an innovative technology platform that enables virtual delivery system integration and is the foundation of our patient-centered, team-based model. We are committed to improving care while reducing costs, and we are achieving results.

Our responses to the following questions are shaped by our lessons learned while operating our patient-centered, practice-level care management model on behalf of Medicaid beneficiaries in Illinois. We appreciate your consideration and welcome any opportunity to further collaborate.

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

Medical Home Network Accountable Care Organizations do not serve Medicare beneficiaries within the framework of the ACO, but many of our lessons learned with the Medicaid Managed Care population in IL are relevant across payor type. In particular, our model of collecting a Health Risk Assessment for every patient aligns with the Annual Wellness Visit model in Medicare.

Our research has shown that although many managed care networks do not systematically collect social and behavioral risk factors in a medical setting, social risk factors are associated with an increase in healthcare costs. Healthcare costs were $65 Per Member Per Month higher for beneficiaries who had trouble securing food, clothing, or housing (95% Confidence Interval [CI], $10 to $119; P=0.02). The presence of 1-3 addressable risk factors is associated with $132 higher Per Member Per Month spending, even when both groups reported infrequent hospitalizations (95% Confidence Interval [CI], $77 to $188; P<0.001). (Jones A, Lemak CH, Lulias C, Burkard T, Mc Dowell B, et al. (2017) Predictive Value of Screening for Addressable Social Risk Factors. J Community Med Public Health Care 4: 030.)

2a. Are social risk data being used to target service or provide outreach? If so, how? How are beneficiaries with social risk factors identified?

- MHN ACO member organizations conduct a health risk assessment (HRA) with each of their members within 60 days of enrollment. Our rate of HRA completion is currently 81%. As part of this HRA we collect the following social risk factors: Gender, Primary Language, whether a responsible adult is available at home to care for this member, whether the member lives in permanent or temporary (shelter, homeless, transitional) housing, whether the member feels safe at home, whether the member needs help obtaining the essentials (food, clothing, housing), whether the member has difficulty paying for medication.
- This data, along with clinical information, is used to stratify patients into four categories of risk: High, Medium, Low, and Low with Social Risk. We have found through research that our members categorized as Low with Social Risk have the same utilization rate as a member with Medium overall risk. We use these categories to guide the care manager in determining how often they should engage with the patient, ranging from daily for our highest risk members to quarterly for members with low risk. Care management caseload is managed based on members risk level.

2b. Are there especially promising strategies for improving care for patients with social risk?

Many of the medical homes in the ACO have programs that address social risks. They also have strong relationships with community-based organizations serving the needs of their specific populations. The MHN ACO has connected our medical homes to the majority of area hospitals through technology, capturing approximately 75% of patient activity in real-time, and is in the process of connecting with key community-based-organizations in the area. Integrating care management at the provider level means that a multidisciplinary care team is able to work with patients to holistically meet their needs and to refer patients to community partners. Sharing a common understanding of our members/patients and being able to communicate securely about these patients has led to improved workflows and outcomes for our patients.

2c. How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management and to provide additional services? What is the ROI in improved outcomes or reduced healthcare costs?

MHN has found that for our ACA Medicaid population, risk adjusted utilization was 15% lower for ER and 24% lower for inpatient admits compared to patients who were not part of the MHN Care management model.

2d. What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

MHN is currently partnering with NCQA to evaluate the effect that connecting medical homes and community-based organizations has on patient's social risk. Upon completion of this evaluation project, MHN and NCQA hope to contribute to best practices related to referring beneficiaries to social service organizations.

2e. What lessons have been learned about providing care for patients with social risk factors?

Building trusting relationships is the cornerstone to being able to successfully address social risk factors. MHN has embedded care managers in the medical homes and this has been demonstrated to be most effective at mitigating social risk. All of our care managers are employed by the medical home where they work, and whose patients they serve, and are part of a multidisciplinary, integrated care team.

2f. What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?

One challenge is the frequency with which some of our members move, change their telephone number, or present at a new location for care or services. By connecting all parts of the healthcare system, we're able to share information about the patient wherever they arrive and continue to connect them back to their medical home. There are also limitations to resources for stable housing and to psychiatric care.

There is also more opportunity to coordinate care across settings and to leverage technologies that encourage communication and collaboration and integration between medical, behavioral, and social service providers.

3a. Which social risk factors are most important to capture?

As part of our Health Risk Assessment for each patient we focus on a set of addressable social risk factors including whether the member lives in permanent or temporary (shelter, homeless, transitional) housing, whether the member feels safe at home, whether the member needs help obtaining the essentials (food, clothing, housing), whether the member has difficulty paying for medication or is in need of transportation to obtain medical care.

In a recent publication we showed that for our population the most statistically significant factors identified in the HRA in predicting future cost and utilization were: needing help obtaining the essentials, self-reported health rating, and lack of transportation. (Jones A, Lemak CH, Lulias C, Burkard T, Mc Dowell B, et al. (2017) Predictive Value of Screening for Addressable Social Risk Factors. J Community Med Public Health Care 4: 030.)

3b. 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? What are the burdens of this data collection on plans, providers and beneficiaries?

MHN ACO member organizations aim to complete an Health Risk Assessment (HRA) for each member within 60 days of enrollment, and 81% of members have an HRA completed.

Anyone on the care team can collect the HRA information, but most often it is an unlicensed Care Coordinator. The preferred workflow is to collect the information in person at the office, but some HRAs are also done telephonically. The HRA is collected once but then updated as appropriate by the Care Manager, as risk levels do shift over time. The HRA takes about 5 minutes to complete for an average patient.

3c. Would standardized data elements for EHRs help you collect social risk data? If so, how could these data elements be standardized?

MHN believes it would be useful to have standardized elements in the EHR that would be able to be interfaced into and out of our care management system, to further aid in the sharing of information across the healthcare ecosystem.

3d. What are barriers to collecting data about social risk? How can these barriers be overcome?

Prohibitions against sharing information from programs regulated under 42 C.F.R. Part 2 (the "Part 2 Regulations") create enormous real and perceived obstacles to sharing substance use disorder information. Although the Part 2 Regulations do not apply as broadly as is often believed, ambiguity in the regulations leads to widespread over-suppression of highly relevant data that could be leveraged to support continuity of care, reduction in duplication of services, and strengthen supportive services.

Additionally, every patient is different and has unique needs. Resolving those needs relies on the granularity of data that so often can be lost if unique cultural, social, and environmental factors that impact the populations served aren't taken into account when designing and delivering the social risk assessment. For example, assessing housing insecurity can be done using several different questions – a patient could screen positive on some but negative on others, and the resolution may be different depending on which are true. Providing a framework for assessment but allowing for cultural competence and individual care team judgement for each member is key to attaining optimal outcomes.

3e. What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

We believe that programs that are truly subject to the Part 2 Regulations could and should be identified with tags or flags on the applicable NPI number. Tagging and segregating true Part 2 programs would free up the use of the vast amount of substance use disorder information that is currently inappropriately suppressed and can derail efforts to meaningfully engage and coordinate care for patients in unique moments of vulnerability.

Having patients become more easily involved in providing data is an opportunity for the future. Many of our patients have smart phone technology and we are interested in connecting with them more through modalities that they prefer and that help to engage them in their own care.

Thank you again for the opportunity to participate in the Public Meeting and submit this written statement. We welcome the opportunity to discuss these ideas in greater depth. To coordinate, please Cheryl Lulias, President and CEO, at 312- 274-0126 or clulias@mhnchicago.org.

Sincerely,

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