



August 18, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Request for Information on Medicare Advantage

Dear Administrator Brooks-LaSure:

FinThrive appreciates the opportunity to offer comments in response to the August 1, 2022 Request for Information (RFI) seeking input from the public regarding various aspects of the Medicare Advantage program. FinThrive is committed to transforming the healthcare economy, driving inefficiencies out of healthcare, and eliminating the friction that has long plagued the healthcare system. FinThrive is advancing the healthcare economy ensuring every transaction and patient experience is addressed holistically.

We applaud CMS for its focus on advancing health equity, expanding access, driving innovation, supporting affordability, and engaging partners in Medicare Advantage (MA). Further, there are several data furnishers uniquely positioned in this respect to help enrich care and enact meaningful change among the communities served through providing timely data that accurately identifies social needs. **FinThrive recommends that third party datasets be evaluated and required for risk stratification and population-based interventions for providers, health plans, and other stakeholders.**

FinThrive's comments in response to specific questions included in the RFI can be found below.

Advancing Health Equity

What steps should CMS take to better ensure that all MA enrollees receive the care they need?

One of the primary health equity goals for CMS is closing gaps in healthcare access, quality, and outcomes for underserved populations. Specifically, the Strategic Plan outlines a focus on “expanding and standardizing the collection and use of data.” The steps CMS takes to ensure that MA enrollees receive the care they need should hinge on data-driven decision making. The World Health Organization has stated, “Social determinants of health are non-medical factors that account for up to 55 percent of an individual’s health outcomes.” The National Opinion Research Center (NORC) at the University of Chicago further found a “dramatic increase in plan activity to address social needs’ within Medicare Advantage—particularly in the areas of social isolation, transportation, housing, and food—buoyed by recent flexibilities allowing Medicare Advantage to offer expanded supplemental benefits for non-primarily health-related services and targeted to the chronically ill.”¹ Separate research “cited in the report shows that 845 separate Medicare Advantage plans participated in Special Supplemental Benefits for the Chronically Ill (SSBCI) in 2021, compared to 245 the year prior.”² This report outlined ways to promote identification of social needs by health providers and encourage the use of ICD-10 Z codes. The report also outlined the need for “CMS [to] strengthen guidance and [to] add standards for collecting SDOH information in Medicare” and stated that “several health plans indicated that it would be helpful to receive currently unavailable information about beneficiaries who qualify for certain government assistance programs.”

Several data furnisher entities exist that could accomplish this directive through:

- Reducing screening burdens at the point of patient interaction
- Enhancing predictive analytics and risk stratification for more targeted clinical interventions
- Driving more informed referrals to appropriate community-based social needs organizations.

¹ “Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries,” NORC at the University of Chicago, <https://bettermedicarealliance.org/wp-content/uploads/2021/08/Innovative-Approaches-to-Addressing-SDOH-for-MA-Beneficiaries-FINAL.pdf>.

² “Report Shows Dramatic Increase in Medicare Advantage Activity to Address Social Determinants of Health, But Barriers Remain,” Better Medicare Alliance, August 5, 2021, <https://bettermedicarealliance.org/news/report-shows-dramatic-increase-in-medicare-advantage-activity-to-address-social-determinants-of-health-but-barriers-remain/>.

Addressing individual and community needs that extend beyond traditional healthcare—such as housing, transportation, employment, food insecurity and social isolation—can enhance prevention and treatment strategies, improve wellness, and mitigate risk. By combining socioeconomic data with clinical and claims information to determine a patient’s utilization risk, providers can better identify and address health disparities with more effective interventions.

CMS can also benefit through establishing API-based data exchange standards that include key social determinants of health (SDOH) data elements (such as the efforts ONC implemented through FHIR Project Gravity SDOH data sets within the scope of USCDI). CMS should update payer interoperability requirements to include SDOH data sets—specifically FHIR-based Project Gravity data sets. In addition, CMS can task the Center for Medicare and Medicaid Innovation (CMMI) with piloting value-based care (VBC) programs that would specifically reward performance based on health equity goals and publish the results. Finally, an industry workgroup should be established to develop common standard risk models that CMS would adopt for alignment on SDOH risk across populations with industry stakeholders.

What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

Innovations that advance health equity must be driven by data and insights on disparities in care. By combining socioeconomic data with clinical and claims information to determine a patient’s utilization risk, providers can better identify and close the gap on health disparities with more effective interventions. Although this concept is not new, adoption and utilization within Medicare Advantage has had its challenges, specifically with technology limitations surrounding the “inability to identify social needs due to a lack of timely data.”

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?

Gaps in health outcomes, quality, or access to healthcare providers and services have existed for years, and a primary source of these gaps stem from risk factors related to SDOH. As the NORC study identified: “Medicare beneficiaries experience many of the same social needs as the general population, but certain social risk factors are more pronounced in the program’s more elderly and disabled membership. Screening and survey data has frequently identified food, housing, and transportation as leading social risks, and all health plans and provider organizations interviewed for this report confirmed that they are working to address these issues in their beneficiary and patient populations.” The importance of using consistent, rich, varied datasets—based on specific SDOH risk attributes—to fuel more holistic, informed healthcare decisions for patients and members is highlighted by several research organizations.

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?

The NORC study stated, “To obtain more accurate individual-level information about potential beneficiary social needs, some health plans purchase consumer datasets that provide information about beneficiary demographics and lifestyle that can flag potential SDOH risks.” The report added: “Health plans face challenges in receiving SDOH data from other organizations, particularly those outside the traditional health care industry providing services to address beneficiary social needs. Some new technology vendors are offering software solutions to help bridge the data gap between health care and social services....” Data sources typically are derived from business, public records, and proprietary consumer data at the individual and community level. The importance of using consistent, rich, varied datasets—based on specific SDOH risk attributes—to fuel more holistic, informed healthcare decisions for patients and members is highlighted by several research organizations.

Expanding Access

How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?

A KFF Tracking Poll found 45% of U.S. adults reported that their mental health has been negatively impacted due to worry and stress about COVID-19. Research has found those who suffer from behavioral health conditions are associated with an increased risk of dementia (64%), stroke (32%), coronary artery disease (29%) and early mortality (26%). And given one-third of adults 45 years and older report feeling lonely, according to an AARP Foundation survey, there’s a strong need for providers and payers to find innovative ways to better serve these individuals and communities. Per Health Affairs, the case is only made stronger when factoring in more than \$6.7 billion in healthcare expenses among Medicare recipients that can be attributed to social isolation.³ Addressing loneliness through interventions can improve care and reduce costs. Combining socioeconomic household and demographic information can highlight those most at risk. Having information such as household occupancy, age, and changes in employment status and income, can enable organizations to design and deliver targeted interventions and support services. Organizations can identify behavioral health needs to establish or modify community programming to strengthen social support. These efforts may improve community health outcomes and help address behavioral and overall health needs.

³ Julianne Holt-Lunstad, “The Double Pandemic Of Social Isolation And COVID-19: Cross-Sector Policy Must Address Both,” Health Affairs, June 22, 2020, <https://www.healthaffairs.org/doi/10.1377/forefront.20200609.53823/>.

Driving Innovation

How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?

JD Power recently performed a Medicare Advantage study and stated: “Effective communication drives satisfaction and trust: Clear, helpful, proactive communication provided by Medicare Advantage plans to members is a key driver of overall customer satisfaction and consumer perception of trust ... just 15% of Medicare Advantage plans deliver all three information and communication performance indicators. This gap has been amplified during the COVID-19 pandemic as consumers are 3.3 times more likely to receive a helpful communication from their bank than from their health plan...”⁴ Shortfalls in contact demographics with members often are a root cause of member disengagement. Latent phone or email contact information results in inefficient business operations and added expense. This can lead to poor outcomes and experience from the health plan. Care coordination efforts, coverage and payment inquiries, and other issues can manifest if demographic information is out of date. Organizations need to enhance their ability to reach the right member, at the right time, with the right information. Advanced analytic models exist to link critical contact information for health plans so they can ensure they are engaging members efficiently. Applying sound analytical strategies to member outreach and contact information can increase the speed at which MA plans’ wellness and cost containment initiatives reach populations, greatly improving odds of adoption and improved ROI. When member identification information is accurate, engagement programs can be developed and implemented. Data-driven strategies for member engagement may include efforts to:

- Identify the best and most efficient outreach pathways
- Better serve the health needs of your members and populations
- Improve risk prediction and knowledge of market viability
- Build innovative and highly customized plan offerings
- Attract members through targeted marketing efforts

⁴ “Medicare Advantage Plans Struggle to Communicate Effectively with Members, J.D. Power Finds,” J.D. Power, June 18, 2020, <https://www.jdpower.com/sites/default/files/file/2020-06/2020068%20U.S.%20Medicare%20Advantage%20Study.pdf>.

These engagement efforts are essential to help improve member wellness and satisfaction, reduce attrition, and drive growth and revenue for MA plans. Having a comprehensive view of potential members can better stratify risk, evaluate new market opportunities, and further develop buyer personas. It also allows MA plans to present information to potential and existing members at the right time through the right medium. This layer of personalization can improve member engagement, satisfaction, and response rates.

CMS should evaluate and bring forward standards for requiring third party data validation of member contact information to ensure plan objectives are obtained efficiently.

Supporting Affordability

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?

Accuracy in risk adjustments and driving improvements in health equity can be enhanced using third-party datasets. The NORC report stated: “There are numerous technological and policy barriers preventing health plans and their partners from identifying beneficiary social needs and taking even basic steps to address those needs. Technology limitations include an inability to identify social needs due to a lack of timely data....” The report adds that an opportunity exists in “identifying reliable sources for data on beneficiary social needs....” Data furnishers in this area consolidate information from thousands of data sources, delivering advanced analytics that quantify social risk and impact. Socioeconomic data can be used as one of a few sources to determine what level of risk a patient/member is for high utilization—low risk, moderate risk, rising risk, high risk, etc. In addition to using clinical and claims data, adding socioeconomic data provided by a third party can enhance risk scores built in-house. By combining socioeconomic data with clinical and claims information, healthcare organizations have been able to identify potential high-risk groups/individuals and determine which socio-clinical interventions to deploy. Aggregated data sets are being leveraged to identify which specific neighborhoods would benefit most from SDOH interventions. For example, hospitals in areas with high numbers of homelessness have provided patients facing housing instability with a safe and supportive place to heal after hospital discharge. As a result, organizations can build comprehensive models to segment populations and better manage health outcomes. In addition, healthcare stakeholders can better understand the barriers to healthcare in their community and target social interventions.

Engaging Partners

What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA? More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program?

MA enrollee risk could be identified using third-party datasets. These insights could drive educational efforts targeted at specific populations where engagement is lacking, or socioeconomic barriers exist.

What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?

Gaps in access, services and outcomes in health care systems could be identified using third-party datasets. This analysis could reveal where the MA program has opportunities for improvement in plan design, delivery, coverage, and costs.

FinThrive appreciates the opportunity to comment on this RFI and support CMS's efforts with respect to Medicare Advantage.

Please contact us if you have any questions (720.503.1186 / jonathan.wiik@finthrive.com).

Sincerely,



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Advancing the healthcare economy