

September 16, 2020

Amy Katzen  
Executive Office of Health and Human Services  
3 West Road  
Cranston, RI, 02920

Re: Comments on [Health System Transformation Project Social Determinants of Health Investment Strategy](#)

Dear Ms. Katzen,

Tufts Health Public Plans (THPP) appreciates the opportunity to provide comments on the Health System Transformation Project (HSTP) efforts to address social determinants of health and the five strategies defined by the Executive Office of Health and Human Services (EOHHS). We agree with the stated vision that, in order to achieve accountability for quality and total cost of care, significant actions must be taken to address the social determinants of health (SDoH). We also recognize the importance of addressing systemic barriers, disproportionately impacting underrepresented racial minorities, highly impacted by the novel COVID-19 pandemic, and most exposed to SDoH issues such as food and housing insecurity.

The proposed HSTP investments provide a sound platform to accomplish the stated objectives for robust coordination between health care providers and community-based organizations, through community-led engagement to address upstream SDoH and health inequities. Initiatives such as Rhode to Equity, Community Health Teams, and Health Equity Zones are promising efforts that should be leveraged and scaled for meaningful impact.

We also recognize the importance of infrastructure to achieve sustainable SDoH results with demonstrated positive impact to quality and total cost of care for the AE program. Infrastructure investments in IT systems to screen for SDoH and maintain social services resource information through a referral platform are crucial. We appreciate the “participatory budget” of \$3.5 million made available from HTSP to seed the significant incremental investments needed for AEs, CBOs, and MCOs to build robust infrastructure.

While we commend EOHHS for establishing a solid vision, strategies and seed infrastructure to advance SDoH solutions, we believe that such efforts should be closely aligned with future-state enhancements to the AE program.

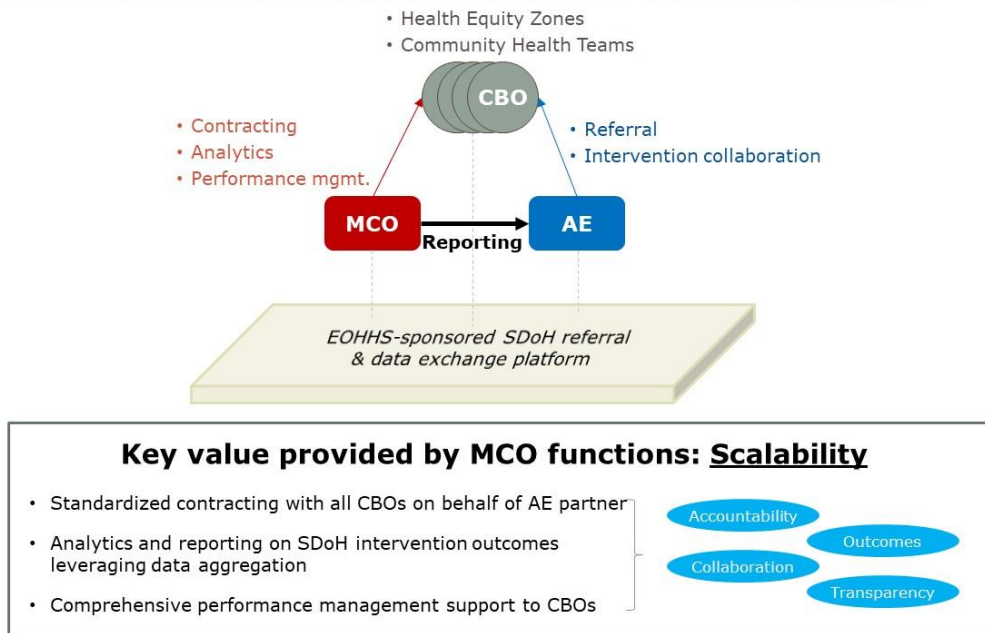
A key enhancement to the program is to support greater alignment and partnerships between AEs and MCOs of choice to enable SDoH investment. Such partnerships may achieve the necessary scale with member assignment support from EOHHS to allow attributed patients to remain with their PCP and avoid continuity of care disruption. Higher scale of attributed patients to a single AE/MCO relationship provides a platform for SDoH investments that can be sustained beyond the HSTP seed infrastructure (“participatory budget”).

Scalable investments by AEs and MCOs, in collaboration with CBOs will enable several capabilities, depicted in Exhibit 1, and described below:

1. Shared **standards and best practices** for the collection of SDoH data. In order to leverage SDoH data across the care delivery system, standards should be established for the collection of SDoH data. Additionally, effective collection requires a high degree of cultural/ linguistic competence and empathy as patients are often reluctant to share such sensitive information, particularly due to a sense of fear or humiliation when seeking social services. Such fears are particularly pronounced within immigrant communities who have been most impacted by the recently-enacted Federal administration’s “public charge” rule.
2. Contractual and **service level agreements** should be established with community-based organizations rendering SDoH services and resources. MCOs play an important role, and bring the know-how to establish such agreements, leveraging similar structure in place provider networks. Agreements may include reimbursement terms, turnaround times for completing SDoH referrals, and data exchange, among other terms.
3. An interoperable SDoH data and referral **platform**, or Community Information and Referral Platform (CIRP) as referred to by EOHHS, is a foundational infrastructure to maintain information about CBO services and capacity. Such platform should be integrated with population health management systems in place by AEs/ MCOs. We support EOHHS’ efforts to procure a common CIRP platform, understanding that there may need to be flexibility in the early and exploratory stage of SDoH infrastructure development if the market has existing disparate solutions in place.
4. A set of **performance metrics** should be established to monitor SDoH processes and outcomes across AE program participants. Such metrics may include, but limited to:
  - Subpopulation analysis across major SDoH markers (e.g., % of members screening for food insecurity) and corresponding TCOC to measure overall impact cost through SDoH interventions
  - Referral analysis to determine subpopulation with a referral in place
  - Case status to determine referral effectiveness

- Health disparity dashboards by AE to determine quality metrics by race/ethnicity, in order to inform culturally-oriented population health interventions
5. With partnerships of scale, AEs and MCOs can define SDoH priorities for **focused investment**. Food and housing insecurity are two of the most prevalent challenges facing low-income communities, particularly in the aftermath of the COVID-19 pandemic.

### Exhibit 1: SDoH Infrastructure and MCO Functions



In closing, we believe that MCOs play a crucial role in supporting the AE program achieve SDoH scale and sustainability. MCOs have expertise and resources to establish standardized SDoH contracts with CBOs, on behalf of AE partners. Additionally, MCOs can deploy robust population health analytics and reporting on SDoH intervention outcomes, leveraging data aggregation. Lastly, MCOs can provide comprehensive performance management support to CBOs, to complement the potential resource and infrastructure gaps.

Sincerely,



Juan Lopera  
 VP, Marketing & RI Medicaid, Public Plans  
 Corporate Business Diversity Officer