BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

September 21, 2021

The Honorable Cheri Bustos
Co-Chair, Congressional Social Determinants of Health Caucus
1233 Longworth House Office Building
Washington, DC 20515

The Honorable Tom Cole
Co-Chair, Congressional Social Determinants of Health Caucus
2207 Rayburn House Office Building
Washington, DC 20515

The Honorable GK Butterfield
Co-Chair, Congressional Social Determinants of Health Caucus
2080 Rayburn House Office Building
Washington, DC 20515

The Honorable Markwayne Mullin
Co-Chair, Congressional Social Determinants of Health Caucus
2421 Rayburn House Office Building
Washington, DC 20515

RE: Request for Information (RFI) – Congressional Social Determinants of Health Caucus

Dear Representatives Bustos, Cole, Butterfield and Mullin:

The Blue Cross Blue Shield Association (BCBSA) is pleased to have the opportunity to share our input and insights in response to the call for public comment on the Request for Information (RFI) put out by the Congressional Social Determinants of Health (SDOH) Caucus to help advance health equity.

BCBSA is a national federation of 35 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide health care coverage for one in three Americans. For more than 90 years, BCBS companies have offered quality health care coverage in all markets across America — serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

As a health insurance provider to more than 111 million Americans, BCBSA believes that everyone should have access to high-quality health care regardless of race, ethnicity, national origin, sex, gender identity, sexual orientation, religion, education level, age, geography or disability. BCBS Plans across the country, including in Puerto Rico, have launched local

initiatives and are actively engaged in hundreds of initiatives to address health disparities and advance equity. Many BCBS Plan initiatives focus on addressing social determinants of health (SDOH) across crucial areas like food insecurity, housing and transportation. Other initiatives address health disparities within a specific health condition, including diabetes, heart disease, behavioral health and maternal health — areas known to adversely affect underserved communities in America.

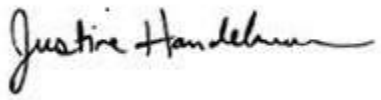
BCBSA is encouraged by the establishment of the new Congressional SDOH Caucus, as we believe that addressing social determinants of health is foundational to improving health outcomes for all Americans. Given our local presence in every state and zip code across the U.S., BCBSA and Plans bring a unique perspective to addressing local health care issues, including SDOH. We also have a wealth of expertise and data that can be tapped to assist the SDOH Caucus in tackling the existing challenges and barriers that impede efforts to address the social drivers of health, as well as leveraging the breadth of opportunities to make important strides in improving health outcomes.

Our detailed comments are focused on the challenges and opportunities for SDOH in the following areas:

- Technology-Driven Solutions
- Insurance Market Rules
- Aligning Efforts and Priorities

We appreciate your consideration of our comments and believe that our recommendations will help the Caucus in developing legislation to improve health outcomes and invest in addressing social determinants of health.

Sincerely,



Justine Handelman
Senior Vice President
Office of Policy and Representation

BCBSA Detailed Comments on the Challenges and Opportunities for Addressing Social Determinants of Health (SDOH)

Socially determined factors have profound and measurable impacts on health. They can affect health and quality of life outcomes long before individuals and families need medical care, and explain in part why some people — and groups of people — have better health outcomes than others. Conservative estimates show 60 percent of health outcomes are driven by social determinants of health, including housing, transportation, food security and environment, among other factors. Focusing on addressing these non-medical factors can improve health outcomes and general well-being, as well as move the needle on advancing health equity.

Across the country, BCBS Plans are leading efforts to address SDOH for both their members and the broader communities in which their members live. We include in the appendix to our comments a non-exhaustive list of BCBS Plan programs and initiatives aimed at addressing SDOH, highlighting the way the Blue System can leverage resources and provide much needed insight into best practices.

I. Barriers and Opportunities for Technology-Driven Solutions

In general, BCBSA believes technology should be leveraged to increase awareness and used to securely track utilization of solutions by population segments, including aging populations in underserved areas. Understanding whether and how populations engage with the technology platform builds evidence regarding the platform's effectiveness and overall impact. Currently, there are federal policies that hinder the healthcare industry's ability to deploy and scale such technology-driven solutions for the underserved**.** In order to foster technology-driven solutions, we suggest the following:

- **Congress should support multi-industry efforts to develop technical data standards and implementation guides to scale:** National industry standards and technical implementation guides are necessary to drive care management efficiency and leverage critical data to improve patient outcomes. To foster deployment of novel technologies to scale, BCBSA and BCBS Plans are actively engaged in industry-led efforts, such as the HL7 Gravity Project — a multi-industry effort to reduce current barriers to integration of social risk data into clinical decision making to improve health outcomes, while increasing safeguards and privacy protections to enhance the appropriate use of sensitive consumer information.

- **Congress should invest in interoperable and secure data infrastructure that connects with community-based organizations:**

    - Community-based organizations serve as critical links in the collection of standardized SDOH data. Historically, community-based organizations have been subject to requirements as business associates under the Health Insurance Portability and Accountability Act (HIPAA) rules in order to receive personal health information from a covered entity, which has posed a significant operational barrier to data exchange for care coordination to address consumers' social (i.e. non-medical) needs. Newly proposed HIPAA

regulations may provide more flexibility for data sharing with community-based organizations to reduce this as a barrier. We encourage Congress to work with agencies to look for opportunities to continue to provide greater flexibility and reduce burden, while aligning HIPAA protections for non-HIPAA covered entities. Further, we encourage Congress to explore opportunities to provide grants to communities to improve the interoperability of community-based data exchange infrastructures.

- Development and investment in an interoperable data infrastructure that engages culturally appropriate networks to allow opportunities to get the right information to address diverse communities' health risk factors. These community networks also play a critical role in recruiting and training lay community health workers (CHWs) who can help not only decipher the appropriate data points, but also introduce technology-based health improvement tools and strategies to underserved community members.

A. Examples of Health Promotion Using Technology-Driven Solutions

Novel technology-driven approaches can leverage diverse data sets to measure the impact of social and environmental conditions on health care resource utilization and outcomes. Such technology contributes to the ability to forecast the risk of individuals developing certain disease conditions given the SDOH present within communities, coupled with medical factors derived from claims data. These analyses also may incorporate access barriers, which have been exacerbated by the current COVID-19 pandemic. These technologies can lead to actionable insights on social and environmental determinants of health by providing clarity on barriers present within communities.

SDOH also was added to the core expectations of both the 2015-2020 and the current 2020-2025 Federal Health IT Strategic Plans. This development, combined with the inclusion of SDOH in the Healthy People 2030 objective, as well as the effort to capture SDOH data in electronic health records as discussed above, are examples of programs that will lead to better individualized patient treatment.

BCBS Plans are actively leveraging technology, where appropriate, to provide innovative solutions and services to members. Some examples include:

- **Neighborhood partnerships:** One such example is a neighborhood partnership co-founded by Horizon Blue Cross Blue Shield along with six other partners to help providers reach high-risk members and inform state health policies. The Horizon Neighborhood Program leverages community health workers and advanced analytics to ensure at-risk members' medical and social needs.

- **Online social resource tool:** Employers and employees can get help through Anthem's engagement with an online social resource tool powered by an outside vendor called Aunt Bertha, to assist members with urgent needs. The site includes a directory of community benefit organizations and other nearby resources that users can find by ZIP code. Members executed thousands of searches within the first five

months of the COVID-19 pandemic, with most searches focused on assistance with food, housing, and health and dental services.

- **Raise awareness of community resources:** Several other BCBS Plans are leveraging data and analytics to better understand and address health disparities. For example, several have developed educational programs for at-risk communities to help create awareness of available health services and community resources, as well as supporting local community health centers whose patients are from ethnic and racial minorities and who are disproportionately impacted by chronic conditions such as diabetes.

B. Public-Private Partnerships

Public-private partnerships are essential to addressing SDOH by leveraging the adoption of technology-driven solutions that can improve outcomes for at-risk populations. Government should lead the effort to establish a broad-based collaboration between the public and private sectors (comparable to ONC's FAST or HL7 Da Vinci) with a focus on key initiatives to accelerate the development, implementation and adoption of national SDOH standards to support screening, diagnosis, planning and interventions across critical domains of SDOH (as discussed above).

More specifically, Congress should invest in federal programs that create unique, multi-agency, multi-million dollar challenge grant programs with the health care industry, including a formal, supplemental challenge with providers and payers to offer a private sector "match" that would include participation by the local community-based organizations as a key element to reach the underserved. Such federal grant programs should be modeled after the existing 2020 HHS Administration for Community (ACL) Social Care Referrals Challenge for technology solutions to support partnership between health care and social services. The scope of this program should extend beyond the ACL challenge, be broader than referral for resources and include the following:

- Programs for community health workers
- Alignment of social data standards of the Gravity Project
- Involve broad coordination within the federal government
- Incentivize community partners with value-based care reimbursement models to drive adoption and utilization of technology while building community trust and addressing equity

Congress should also consider ways in which it can create incentives for public and private entities to work together to address social determinants of health. Such incentives could be tied to data sharing, performance on key prevention and health outcome measures, or establishment of innovative partnerships to meet health-related social needs.

II. Barriers and Opportunities with Insurance Market Rules

In one way or another, social determinants of health impact the lives of all Americans, regardless of age, socioeconomic status or type of health insurance. As such, it is imperative

that efforts to address SDOH be undertaken across Medicare, Medicaid and Commercial markets. As with the technology-driven solutions, barriers and opportunities exist within the current insurance market rules. As health plans across Medicare, Medicaid and Commercial markets explore innovative ways to remove barriers to care and improve members' health outcomes, there are numerous steps Congress can take to support these efforts. Below we provide a detailed assessment of the barriers and opportunities within each market segment for your consideration.

A. Medicare Advantage (MA)

Medicare Advantage (MA) plans are a crucial partner in Congress' work to address social determinants of health. The value-based payment framework in MA is designed to support innovative care that aims to use all available tools to improve outcomes. As a result, MA has been at the forefront of advances in care delivery that address social determinants of health, illustrated by the growth in non-emergency transportation benefits, nutrition and grocery benefits, and innovative programs that address issues ranging from loneliness to pest control to in-home supports.[1,2,3] Additionally, MA is a vital partner in efforts to address health disparities and improve care for low income individuals as the program increasingly cares for a more diverse and lower-income population of individuals with greater clinical complexity as compared to Traditional Fee-for-Service (FFS) Medicare.[4] In fact, if current trends continue, the majority of Black, Hispanic and dual enrollees will be in MA within the next five years (the majority of all beneficiaries are expected to be in MA within ten years).[5]

As we look toward ways to continue to improve care in MA, it is important to applaud the bipartisan, multi-stakeholder work that led to the Chronic Care Act and was passed in the Bipartisan Budget Act of 2018 (and clarified in subsequent regulation) that gave MA Plans more flexibility to target care. These changes expanded the definition of what was an allowable supplemental benefit (e.g., meal services, fall prevention devices), gave Plans more flexibility in how benefits could be adjusted without violating uniformity requirements, and also gave Plans the ability to target supplemental benefits to chronically ill members. In addition, the Value-Based Insurance Design (V-BID) demonstration at the Innovation Center has also resulted in learnings that inform future policy work and plan behavior. These flexibilities have led to the proliferation of supplemental benefits that aim to remove social barriers, such as lack of transportation or access to food, and spurred innovation and improved outcomes.

In order to build on these successes, BCBSA recommends that Congress pass H.R. 4074, the *Addressing Social Determinants in Medicare Advantage Act of 2021*, which would allow plans to

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[1] Providing Non-Medical Supplemental Benefits in Medicare Advantage: A Roadmap for Plans and Providers. 2021. Long Term Quality Alliance (LTQA) and ATI Advisory. Link.
[2] Anthem Addresses Senior Loneliness through the Power of Human Connection. September 2021. Link.
[3] Independence Blue Cross and United by Blue Deliver Locally-Sourced Grocery Boxes to Medicare Advantage Members during COVID-19. April 2021. Link.
[4] Data Brief: Medicare Advantage Offers High Quality Care And Cost Protections To Racially And Ethnically Diverse Beneficiaries. Better Medicare Alliance. June 17, 2021. https://bettermedicarealliance.org/publication/data-brief-medicare-advantage-offers-high-quality-care-and-cost-protections-to-racially-and-ethnically-diverse-beneficiaries/.
[5] Medicare Advantage Offers High Quality Care And Cost Protections To Racially And Ethnically Diverse Beneficiaries. June 2021. ATI Advisory Analysis.

not only target supplemental benefits based on chronic disease but also based on low-income status and other criterion for social and socioeconomic risk.

BCBSA also supports efforts that address other key areas of disparities in Medicare, including but not limited to:

- Improving the care of individuals with end-stage renal disease (ESRD), including providing more dialysis treatment options, including supporting the growth of in-home dialysis;
- Addressing disparities in access to recommended screenings and routine care through access to home lab kits, home provider visits and other approaches;
- Addressing cost barriers and improving adherence to vital prescription medications, such as insulin; and
- Better support for seniors aging in place, such as more in-home care support and A/C units, especially in areas impacted by extreme heat.

BCBSA aims to be a partner in analyzing how all aspects of the MA system — including the benchmark methodology, risk adjustment system, Star quality ratings, Special Needs Plan requirements, dual eligible coordination efforts and others — could help to address health disparities, remove social barriers and better coordinate care. We encourage the Centers for Medicare & Medicaid Services (CMS) to leverage their access to Medicare data to shine light on the areas where plans and provider partners should focus. BCBSA is eager to be an ongoing partner with Congress and the Congressional SDOH Caucus.

B. Medicaid

Blue Plans have seen the tremendous impact that all social determinants of health — including, but not limited to, nutrition, housing, personal safety and social connection — can have on members' health and wellbeing, particularly in the Medicaid space, where many members face significant economic and social challenges. While there are many publicly and privately funded programs to meet unmet resource needs, these programs often address a single need (e.g. housing, nutrition), making it difficult to determine the program(s) that are responsible for addressing intersectional needs. Additionally, some members may not realize that there are non-medical social services that can assist in disease management, and support overall health and wellbeing. Other times, existing services are insufficient to meet a person or population's needs. For example, SNAP-eligible individuals who live in rural areas or food deserts may have difficulty accessing a grocery store in order to purchase healthy food, and many states restrict access to SNAP and/or TANF benefits for individuals convicted of drug-related felonies upon their release from prison, making it challenging for these individuals to find nutritional support.

In scenarios where these gaps and barriers exist, Medicaid managed care plans are well positioned to help bridge the gaps. Using existing touchpoints with patients, Plans can ensure individuals are screened for any unmet health-related resource needs, referred to programs and community providers that can address those needs, and connected to wraparound services that will help promote health and wellbeing. In the Medicaid market, care management and care coordination services — hallmarks of the Medicaid managed care model — can help identify unmet social needs that are impacting an individual's health, facilitate referrals and conduct

follow-up as needed. Blue Plans have leveraged their role to address SDOH in a number of ways, such as:

- Using validated SDOH assessments during care management or provider visits to identify unmet SDOH needs
- Developing networks of community health workers (CHWs) to visit members' homes and, when necessary, search homeless camps to find members and identify and help address their health-related social needs
- Cultivating partnerships with local food resources, and connecting food-insecure members to these resources
- Working with community partners to fund and establish resources to address SDOH, such as food banks, in communities where these resources do not exist or are severely limited
- Offering housing-related and wrap-around services to Medicaid members with serious behavioral health conditions who are experiencing or are likely to experience homelessness
- Hiring housing coordinators to work with care management staff and provide referrals to services and collaborate with state housing agencies
- Launching ride share programs to help individuals get to/from medical appointments and the pharmacy

While plan-led and state-led models have found innovative pathways for addressing social determinants of health, there are still significant hurdles that both states and plans must overcome to provide comprehensive social determinants of health support to the Medicaid population. Congress and federal agencies can help reduce these barriers and better enable plans to address SDOH in Medicaid in several ways.

First, we encourage Congress to enact legislation that would permit CMS to identify specific medically-related social services that states can include as state plan services. Although the 1115 waiver process currently provides states with a pathway for addressing social determinants in Medicaid, the time and resources involved in designing a waiver demonstration, drafting a waiver, and conducting waiver negotiations may be prohibitive for some states. This burden has been exacerbated during the COVID-19 pandemic, with many state agencies spread thin as they attempt to navigate and address the evolving public health emergency. In states that do not pursue 1115 waivers to address social determinants of health, Medicaid enrollees have limited access to important medically-related social services. Legislation permitting states to include certain medically-related social services in their state plans could expand access to these services beyond those states with social determinants-related 1115 waiver demonstrations, and encourage more states to address SDOH in Medicaid.

In addition, CMS' standardized risk scoring and risk adjustment methodologies should better incorporate social risk factors, to better ensure that capitation rates enable issuers to meet the needs of members with health-related social risks. In Medicaid, the MassHealth "neighborhood stress score" or Minnesota Integrated Health Partnerships social risk adjustment methodology, which adjusts for homelessness, past incarceration and deep poverty (or parental poverty, for children), could serve as a model for risk adjustment informed by social factors. Additionally, while Medicaid MCOs are allowed to cover interventions that address SDOH as value-added services (which are included in the numerator when calculating MLR), they are not able to cover

SDOH-related interventions as a covered service. Plans also face issues around "premium slide" — if a Plan invests in efforts to address members' SDOH needs and in doing so successfully reduces members' health care costs, the plan may receive lower capitation rates in the future, thereby limiting the resources available to the plan to make future investments in medically-related social services. Identifying benefit categories of medically-related social services that states may adopt as part of the State plan for medical assistance could formalize the range of medically-related social services available, and assist state Medicaid agencies in setting up their managed care organizations to convene resources to provide medically-related social services.

Strengthening coordination across safety net programs and providing additional guidance on how Federal programs, such as Medicaid, CHIP, SNAP, WIC, etc., can align to effectively address social determinants in a holistic way could also better enable both states and Managed care plans to address social risk factors for the Medicaid population. Guidance that clarifies when Medicaid should serve as the primary payer for an unmet health-related need, and when Medicaid can/should serve as the payer of last resort for these needs would help Medicaid agencies and MCOs better understand when and how they should address their members' SDOH needs. Additionally, aligning and simplifying eligibility and enrollment processes across these programs could better enable Medicaid plans, providers and care managers to determine when a Medicaid-enrolled individual may be able to receive medically-related social services through another federal or state safety net program.

Finally, given Medicaid's critical role in providing health coverage for mothers and children, BCBSA encourages Congress to explore opportunities for addressing social determinants and promoting health equity through medically-related maternal and infant health services, such as home visiting programs and doula services. Home visiting programs have a track record of success in improving health and social outcomes for new parents and infants.[6] By visiting families in their homes, nurses and other trained home visitors can not only provide accessible maternal and infant care but also identify health-related social needs and connect families to resources to address those needs Congress should continue to develop and invest in programs such as the Health Resources & Services Administration's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program to increase access to the Nurse-Family Partnership and other evidence-based home visiting programs. Doulas can also help promote healthy birth outcomes for mothers and children by providing a range of non-medical services during pregnancy, birth and the postpartum period. Research shows that mothers receiving doula care are four times less likely to have a low birth weight baby, and two times less likely to experience birth complications.[7] Increasing coverage of doula services in Medicaid would allow more mothers to access these important non-medical services, and promote health outcomes for both mothers and babies. Finally, we encourage Congress and federal agencies to explore and invest in programs that address the needs of children and the adults in their lives together, rather than focusing on children and adults separately. The Aspen Institute's "2Gen" model provides a helpful framework for developing programs that help both children and their caregivers thrive.

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[6] Nurse-Family Partnership. Overview. August, 2021 | link

[7] Gruber, Kenneth J et al. "Impact of Doulas on Healthy Birth Outcomes." The Journal of Perinatal Education vol. 22, 1 (2013): 49-58. doi:10.1891/1058-1243.22.1.49 | link

C. Commercial Markets

The Affordable Care Act's current Medical Loss Ratio (MLR) requirements were enacted before the impact that social determinants of health (SDOH) have on health outcomes was fully recognized. The statutory language (42 U.S. Code § 300gg–18) classifies health plan expenditures into three buckets: "reimbursement for clinical services," quality improvement activities, and "all other non-claim costs" (excluding state and federal taxes, licensing and regulatory fees).

Social determinants of health are, by definition, factors that are not in themselves health care services, but that have a direct impact on health. These include barriers that prevent individuals from accessing needed health care services or "non-medical" goods and services that improve health outcomes. Health plans are exploring innovative new ways to remove barriers to care and improve our enrollees' health outcomes by addressing the various social determinants of health. It is critical that the MLR formula does not discourage these efforts by treating plan spending on social determinants of health as "administrative overhead."

BCBSA recommends that the MLR formula be modified to support efforts to provide benefits that address SDOH. MLR requirements are intended to ensure that health plans use premiums prudently to benefit the health enrollees. Spending for benefits related to social determinants should be included in the numerator of the MLR formula for all markets along with spending on clinical services. This treatment would be consistent with the definition of "incurred claims" used to calculate Medicare Advantage and Part D MLRs.

BCBSA also recommends that tax rules, including reporting requirements, be reviewed to ensure that they do not present unnecessary barriers to addressing SDOH. Low income individuals will be hesitant to take advantage of assistance with SDOH if that assistance is treated as taxable income that may threaten their eligibility to other support programs they may depend on.

III. Opportunities for Aligning Efforts and Priorities

In order to foster meaningful solutions to address SDOH and advance health equity across all health care markets, BCBSA believes there are many opportunities for all stakeholders to align efforts and priorities. Specifically, we recommend the following:

Congressional Assistance. Across healthcare markets, Congress can facilitate coordination for effective SDOH interventions by:

- Pursuing legislation to build community organizations' capacity to receive and interpret SDOH-related information from plans, providers etc. The Social Determinants Accelerator Act 2021 (H.R. 2503), sponsored by Representative Bustos, creates an opportunity for "accelerators" to (among other things) develop plans for accessing and linking relevant data to coordinate benefits and services. Best practices from these accelerators could help inform future legislation around linking data to address SDOH.

- Encouraging CMS to continue dialogue between different federal agencies that address social determinants of health, and continue to develop a vision for what it will look like for agencies to work in tandem to address whole-person health and wellbeing.
- Encouraging HHS to continue exploring best practices for social determinants of health screening tools.
- Pooling and blending funding sources can prevent gaps in services that span multiple social/health need domains (e.g. housing related modifications that would impact a person's health), by reducing questions around where one system or program's responsibility ends and another system or program's responsibility begins. Instead, blending funding creates a clearer pathway for all programs/systems implicated to work together in addressing a health-related social need. When encouraging pooled or blended funding approaches, federal agencies should provide clear guidance on eligibility for services financed using blended funds.
- Supporting research to demonstrate the return on investment of programs to address social determinants of health.
- Federal agencies can also provide additional guidance on delineating funding responsibility, particularly in scenarios where eligibility criteria may limit how services are provided and paid for.

Alternative Payment Model Opportunities: Alternative payment models help to measure health care based on its outcomes.

- **Bundled Payments.** Given the lack of validated, standardized measures for evaluating SDOH outcomes, bundled payments that incorporate SDOH may be a better pathway for developing SDOH-related VBP models in the near term. In particular, asthma and diabetes, conditions around which several payers have already developed bundled payments (e.g. Arkansas Episodes of Care Initiative) could be well suited to incorporate SDOH. Asthma bundles could include health-promoting services provisions like allergen-proof bedding, screening homes for air quality and mold removal. Diabetes management bundles could include provision of medically tailored meals, and/or education on healthy food preparation.
- **Value Based Partnerships**. Some Blue Plans have also established value-based partnerships with CityBlock Health, a network of providers who deliver both medical care and behavioral health care, and address member's health-related social needs.
- **Medicaid.** When exploring new value-based models and demonstrations, CMMI should consider ways in which to include Medicaid in demonstrations that can provide high-value care and address the SDOH needs for the underserved.

Rural, tribal and other traditionally underserved areas can see improvement in health outcomes by having:

- **Broadband Access.** While important for many communities and populations, broadband access is of particular importance for rural and tribal communities, as it can increase their access to medical specialists via telehealth and allow for remote referrals to organizations that can address social determinants of health.
- **Community health workers (CHWs)**. They can also play a critical role in reaching individuals in rural, tribal and underserved areas and helping address their SDOH needs.

Several Blue Plans have found success in developing networks of CHWs (who often come from the communities they serve), and leveraging the CHWs to meet with members in their homes and communities to understand their resource needs and address SDOH barriers.

- **Managed Care Plan Partnerships**. Many managed care plans have already begun implementing processes to screen members for unmet social needs, and have cultivated strong connections with community resources that can help address social needs. In developing legislation, BCBSA encourages Congress to consider how managed care plans can continue to serve as a partner in addressing social determinants of health and ensure they have the resources needed to do so.

APPENDIX: Examples of BCBS Plan Programs Aimed at Addressing Social Determinants of Health (SDOH)

Housing

- In a targeted effort to address some of the most basic health inequities for Rhode Islanders, Blue Cross & Blue Shield of Rhode Island has, for the second year now, directed the focus of its BlueAngel Community Health Grant program toward improving access to safe and affordable housing. Building on an initial grant of $500,000 in 2020, BCBSRI has now awarded an additional $500,000 to nine local organizations aimed at closing the gap for Rhode Islanders whose health outcomes are directly tied to housing quality.
- Guided by the knowledge that inadequate housing or homelessness is a social driver of health, Anthem Blue Cross Blue Shield has invested nearly $90 million in affordable housing across the state of Indiana. The funding will provide 1,139 affordable housing apartment units, townhomes and single-family homes in Avon, Bloomington, Columbia City, Culver, Fort Wayne, Gary, Kokomo, Lawrenceburg, New Castle, Spencer and Vincennes.

Transportation

- Blue Cross Blue Shield of Massachusetts, the Massachusetts League of Community Health Centers and Lyft will begin offering access to transportation to and from COVID-19 vaccination sites across the state as part of their joint effort to help provide equitable access to vaccinations. Blue Cross and the League last month announced their plans to address barriers to COVID vaccine access, with a focus on low- and middle-income populations served by community health centers. A $1 million contribution from BCBSMA is expected to fund thousands of free rides to vaccine appointments in underserved communities, including communities of color.

Food Security

- In Minnesota, Blue Cross and Blue Shield of Minnesota is offering mothers and families in need clinically tailored meals and food boxes as well as nutritional coaching. Members can start as early as 20 weeks into their pregnancy and continue through the second month after birth. The program is a partnership with Project Well and Second Harvest Heartland, which will deliver the food and the coaching. Members will also be connected to food programs and solutions to meet other social needs through case management.
- In New York, Excellus BlueCross BlueShield is working with FoodLink, a local food bank, to pilot a nutrition program designed to identify at-risk moms and connect them to nutritional education and resources. Experts from Excellus BCBS say providing boxes of food is only one step in addressing food insecurity. Empowering mothers with culturally competent nutrition education can do even more to keep moms and their children healthy.
- Blue Cross and Blue Shield of Kansas City works with local food banks and food distributions centers to help members who are pregnant or new moms. Mothers who continue to experience food insecurity are connected with a state food assistance program. The health plan trains front line providers to screen women for food insecurity. Then Blue Cross and Blue Shield of Kansas City community health workers connect those members to resources to meet their social needs and follow up with providers.

- Blue Cross Blue Shield of Massachusetts' DotRx program addresses social determinants of health like poverty, ethnicity and socioeconomic status that are having an outsized impact on the community of Dorchester, near Boston. The health plan brought together local nonprofits, including the Codman Square Health Center, to encourage doctors to write prescriptions for healthy food, activity and nutritional coaching through specially trained peer coaches.
- Nearly 12% of people in Connecticut experience food insecurity, which includes 16% of children in Connecticut, and these numbers are likely on the rise given the impact of challenges COVID-19 has introduced. In light of Hunger Action Month this September, Anthem Blue Cross and Blue Shield in Connecticut and its philanthropic arm, the Anthem Blue Cross and Blue Shield Foundation, are committing volunteer hours and donating nearly $90,000 to address hunger in local Connecticut communities. These activities are part of a $1.4 million total commitment Anthem has made in Connecticut so far this year.
- To help address urgent needs for food relief in the region, Florida Blue donated or prepared nearly 1.5 million meals through partner agencies such as Second Harvest Food Bank. At the beginning of the pandemic, a creative partnership developed to handle a new influx of food donations to Feeding Northeast Florida. The nonprofit teamed with Florida Blue, using the skill and expertise of its kitchen staff and the current availability of its campus cafeteria to turn perishable food donations into nearly 3,000 meals daily.
- BlueCross BlueShield of Tennessee Foundation is donating $3.25 million to six regional food banks, which can often purchase supplies at much lower costs than individuals—stretching to provide as many as four meals for each dollar they receive in cash donations.
- Ending childhood hunger is the goal of the Wyoming Hunger Initiative. Blue Cross Blue Shield of Wyoming has donated $100,000 to support this effort, making sure Wyoming families don't go hungry during the unstable job market brought on by the COVID-19 pandemic. This donation supports the Wyoming Hunger Initiative and its work with the Wyoming Department of Education and anti-hunger organizations statewide to solve food insecurity, which plays a significant role in overall health.
- Capital BlueCross, serving 21 counties in Pennsylvania, is increasing funding to food banks and other organizations, as well as providing meals to seniors, healthcare workers and others in need. Grants have helped to feed nearly 4,800 home-bound seniors and provide food access throughout their community. The Healthy You Café, located in the Capital Blue health and wellness center, is also preparing and delivering meals across Capital BC's counties. Recipients include families without transportation, seniors, underserved students and women's shelter residents.
- Blue Cross and Blue Shield of North Carolina has provided $5.6 million to address food access and other critical community needs in the wake of the coronavirus. This money has helped distribute millions of meals across the state, deliver local farmers' produce to students, food-insecure communities and out-of-work restaurant and hospitality workers, and more.
- In a state full of nutrition deserts, Blue Cross and Blue Shield of New Mexico is providing food to families and seniors through Roadrunner Food Bank's mobile food pantries at nine Albuquerque Public Schools and two senior centers. This mobile distribution is replacing standard food pickup processes to reduce potential exposure to COVID-19.

BCBS NM has also donated 2,000 reusable bags to APS for food distribution while students are out of school.

- Blue Cross Blue Shield of Michigan serves both urban and rural nutrition deserts. In response to the COVID-19 pandemic and statewide school closures, the health plan increased support to its long-time community partners by providing $500,000 toward their efforts across Michigan, providing meals to vulnerable kids, protecting seniors and supporting other populations in need.
- Blue Cross and Blue Shield of Minnesota is committing $750,000 to Second Harvest Heartland's COVID-19 response plan, providing emergency food boxes for families. The funding will directly support food boxes for families facing hunger due to missed work so those impacted can access needed meals while also reducing their risk of exposure.
- North Dakota's only food bank, the Great Plains Food Bank, serves more than 100,000 clients a year in normal times. But when the COVID-19 pandemic began, these numbers increased by 30 - 50%. Much needed support came from Blue Cross and Blue Shield of North Dakota at just the right time, including initial emergency funding and further support to buy a truckload of food.
- Highmark Blue Cross Blue Shield donated nearly $600,000 to regional food banks to alleviate food insecurity during the pandemic.
- BlueCross BlueShield of Tennessee donated more than $5 million to foodbanks across the state.

Maternal Health

- Blue Cross of Idaho offers a comprehensive program to help pregnant women with acute or chronic health conditions have a safe and healthy pregnancy and childbirth. A Maternity Coordinator conducts a risk assessment with a member which includes questions about physical and behavioral health. After identifying concerns, the member connects with a case manager to craft a personalized care plan in tandem with the member's provider. The team is able to address social determinants of health which may be driving some of the health risks.
- Blue Cross and Blue Shield of Illinois is working to improve birth outcomes in Chicago's South and West Side neighborhoods with funding for community-based organizations. The organizations use doulas, midwives and telemedicine to provide education, labor care, breastfeeding help and postpartum support within a culturally appropriate lens.
- CareFirst provided seed money for and is actively involved in a program called B'more for Healthy Babies that has helped Baltimore cut its infant mortality by nearly 30%. Thanks in part to a centralized intake system, B'more for Healthy Babies ensures that no pregnant woman in the city falls through the cracks. This means program outreach workers can visit new mothers to provide education on safe sleep for babies. It also means that providers can help connect women with food, mental health services, domestic violence services, insurance, health care and more.
- Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York have created a high-risk maternity home visiting case management program, partnering with local agencies to deliver services in a mother's home. Home visitors can address the social determinants of health that might affect a woman's pregnancy, child birth or postpartum health, including housing and transportation issues. Home visiting for pregnant mothers is an evidence-based practice shown to help women have healthier, safer pregnancies. For women of color, who are at

greater risk of dying from pregnancy-related causes or experience pregnancy complications, a home visiting program can help address some of the risk factors, including support in managing chronic conditions like hypertension or diabetes.

- Blue Cross Blue Shield of Arizona has partnered with Arizona's tribal nations to support native mothers and newborns through culturally appropriate interventions. In part, that means investing in programs and organizations that already serve American Indian communities throughout the state and expanding their capacity.

Rural Healthcare

- Blue Cross of Idaho and the Blue Cross of Idaho Foundation for Health have a history of expanding health equity in rural Idaho. Projects include:
    - A $500,000 scholarship fund to the University of Washington School of Medicine's WWAMI program to support 10 scholarships over the next five years. These scholarships are for Idaho residents who wish to practice medicine in rural Idaho upon becoming physicians.
    - A $50,000 grant to Mariman Health, owned and operated by the Coeur d'Alene Tribe, to support the evaluation of a new state-of-the-art community center designed to be a holistic healing center for all tribal members. Mariman Health is a prevention center that will continue to bring positive changes to the rural reservation community, and a safe place for youth to play, learn, for families to heal and be well, and where the community can connect with one another and its Native heritage.
    - $30,000 to launch a telehealth pilot program in two rural Idaho counties in partnership with the Idaho Commission for Libraries and two libraries in Orofino and Weippe.
    - $5,000-$10,000 per school in technical assistance grants to help implement the Healthy Minds Partnership, an on campus behavioral health program.
- To bolster access to care in rural Alabama, where local hospitals have closed at an alarming rate over the past decade, Blue Cross and Blue Shield of Alabama has implemented a new program called Enhanced Patient Care. It gives rural hospitals the opportunity to do more for patients and get paid for it. At rural Bibb Medical Center, the hospital identified patients who didn't have a primary care doctor and connected them to that preventive care. The hospital was also able to use the health plan's support to open an urgent care clinic. The efforts keep residents healthier, keep ER visits down and provide rural residents more options for care so that they don't have to drive long distances.
- Rural residents may face barriers, such as access to primary care doctors, to keeping up with recommended colorectal cancer screenings. Premera Blue Cross mailed 4000 at-home colorectal cancer screening kits to customers in Alaska and Washington who appeared to be overdue for screening. 25% of recipients returned a sample. A Premera nurse reached out to the approximately 5% with positive test results to schedule follow up screening, potentially catching early-stage cancers.

Using SDOH Data and Predictive Analytics

- At Blue Shield of California's two clinics in Southern California, the health plan is piloting a new model to capture social determinants of health data. Patients are formally screened, not just for physical or mental health conditions such as diabetes or depression, but also for other factors that might affect their health, such as a lack of

transportation or food insecurity. SDOH data are embedded in a patient's electronic medical record. Recent studies estimate that these kinds of social determinants of health, which can also include a lack of basic resources, low income, and a lack of knowledge about the healthcare system can be responsible for up to 80% of health outcomes.

- To better understand how social determinants of health impact high-risk maternity patients, Independence BC is building predictive models into its existing maternal care program: Baby Blueprints. Available to all expectant members, the program supports women before, during and after birth. This work includes behavioral health screenings and social need assessments for factors including transportation, food security and financial wellbeing. By incorporating predictive capabilities into this program, Independence hopes to better understand the potential needs of high-risk members early in a person's pregnancy journey.
- Horizon Blue Cross and Blue Shield of New Jersey analyzed four Newark ZIP codes with a high percentage of members who were at much higher risk for serious health problems than residents in other parts of the city. Those problems stemmed in large part from social determinants of health, such as demographics, poverty and education levels, and neighborhood characteristics, like access to healthy food or doctors. The health plan and Robert Wood Johnson Barnabas Health System partnered on a ZIP code-based pilot to embed community health workers, a social worker, chronic disease care coordinator, and a Horizon personal health assistant who could help members navigate their benefits right in the neighborhoods. Outreach included visits to members after an emergency room visit, direct outreach, and engagement at a new community health center. Community health workers and the team have been able to break down barriers to better health and keep members out of the emergency room with better management of chronic disease.

COVID-19 Vaccine Access and Education

- Blue Cross and Blue Shield of Louisiana partnered with 100 Black Men in Baton Rouge and New Orleans to reach out to and provide resources to minority communities that lacked access to or education about the vaccines. Their efforts aim to make everyone, especially those at a higher risk for COVID-19, feel safe, prepared and comfortable getting the vaccine. This video highlights one of the key architects behind BCBSLA's partnership.
- Blue Cross Blue Shield of Alabama launched extensive educational campaigns addressing vaccine safety and efficacy and made outreach calls to high-risk members encouraging vaccination.
- Blue Cross and Blue Shield of Arizona partnered with the Arizona Department of Health Services to set up and staff two of the three state-run vaccination sites. The insurer rallied over 300 clinical and non-clinical volunteers for this effort each day, amassing 491,000 vaccines—about 15% of the 3.7 million vaccine doses in the state (as of April 5, 2021).
- Blue Shield of California served as the Third-Party Administrator of California's vaccine network. More than 44 million doses of vaccine have been administered in the state and over 60% of eligible Californians are fully vaccinated.
- Blue Cross of Idaho has been working to ensure vaccines and vaccine education are readily available to all Idahoans. Their statewide efforts include funding the purchase of

a van to expand mobile vaccine clinics in the most vulnerable and underserved communities; helping members schedule vaccine appointments; and running extensive vaccine campaigns to educate the public.

- Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma and Texas all use mobile vans to bring vaccines to vulnerable populations. They repurposed many customer service staff to help make vaccination appointments and deployed over 3,000 clinical workers to volunteer on the front lines. They were also able to provide data and analytics expertise to local and state departments of health to facilitate triage of patients for vaccine administration.
- Through our Better Together Campaign, CareFirst has invested $1.2M in culturally competent vaccination education, outreach, and delivery across our region. Investing in organizations that serve those hardest hit by the pandemic, these funds will minimize transportation barriers, deploy health navigators, stand up vaccination sites and build a new clinic to increase vaccine adoption.
- Blue Cross Blue Shield of Massachusetts committed $1 million to help provide equitable access to vaccinations, including a partnership with Massachusetts League of Community Health Centers and other local organizations. The health plan also provided financial support to Health Care for All's Help Line, the only statewide multilingual phone service — answering an average of 20,000 calls annually in English, Spanish and Portuguese — that helps Massachusetts residents at all income levels. To promote vaccine confidence, BCBSMA funded over 200 hours of community canvassing provided by three bilingual community ambassadors in East Boston.
- Blue Cross and Blue Shield of Michigan made outreach calls to more than 400,000 vulnerable members to alert them to the availability of the COVID-19 vaccine and help them get access. The health plan launched extensive, statewide education campaigns on vaccine safety and availability, and hosted eight vaccination events in high-need communities.
- In addition to extensive public education campaigns, Blue Cross and Blue Shield of Kansas City has been supporting frontline efforts to vaccinate and protect the community. They have partnered with the United Way of Greater Kansas City to provide rides to and from vaccination sites and are supporting state and local public health efforts.
- Horizon Blue Cross Blue Shield of New Jersey, in partnership with Rite Aid and faith-based organizations, is working in communities with high COVID-19 mortality rates to schedule appointments for their members while the churches schedule appointments for parishioners.
- Capital Blue Cross identified underserved areas with low vaccination rates and organized vaccine clinics in partnership with other community organizations. They also supported local nonprofits in bringing virtual care to those who were uninsured or underinsured, and provided bus passes for homeless populations at shelter vaccination sites.
- Independence Blue Cross provided space and support for many community COVID-19 initiatives, including the All Faiths Vaccine Campaign promoting equitable access to vaccines in Black and Brown communities. Independence BC also stepped forward as one of the region's first and strongest supporters of the Black Doctors COVID-19 Consortium, which has vaccinated tens of thousands of people in the region.

- Highmark Blue Cross Blue Shield partnered with Latino Connections to vaccinate 600 farm workers across Pennsylvania. They are also partnering with historically black churches, senior living centers, and mobile vans to administer the vaccine in urban and underserved areas.

Federal Employee Program (FEP) Initiatives:

Data Leadership

FEP is actively working to source and integrate various health equity related data sources such as race/ethnicity, social determinants of health (SDOH), social Vulnerability Index (SVI), and severe Maternal Morbidity (SMM), into their Plan-facing analytic environments to allow for insight around health disparities and targeted outreach by our Plans. A few examples include; the availability of SDOH data at a zip code level in the Community Health Management (CHM) hub, the integration of reports for members with SDOH related z-codes from claims within the Care Coordination Portal (CCP), and self-reported race/ethnicity data from members who completed the Blue Health Assessment in the Analytics 2.0 platform.

Vaccines

The FEP Directors Office (FEPDO) remains focused on lessening the COVID-19 burden for members in vulnerable areas. As such, they identified 400,000 members at higher risk for hospitalization or death due to COVID-19 infection by census track using the Social Vulnerability Index (SVI). Member-level reports were made available to Plans for Care Management outreach and assistance with vaccination scheduling. In the future, these reports will be integrated within the Analytics 2.0 platform for use by all Plans and updated regularly.

Maternal Health

In our efforts to reduce maternal health disparities, FEP has identified over 1,000 deliveries with Severe Maternal Morbidity (SMM) indicators. Using this data, FEP is creating a robust “Maternal Health Profile” within the Analytics 2.0 platform, which will allow our Plans to identify and provide outreach to members who are currently pregnant by race/ethnicity background, members with a history of deliveries and an SMM indicator, and members with high-risk pregnancies.