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Good morning Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the Health Subcommittee. My name is Romilla Batra, MD., M.B.A, and I am the Chief Medical Officer at SCAN Health Plan and a primary care physician. Thank you for the opportunity to share how SCAN addresses Social Determinants of Health (SDOH). It is a great honor to be here today.

My remarks will briefly cover SCAN's background and history with SDOH, SCAN's approach to addressing SDOH, supplemental benefits, and recommendations. SCAN serves mainly older adults, so my comments will focus on this population.

I. SCAN Background/History with SDOH

SCAN Health Plan is one of the nation's largest not-for-profit Medicare Advantage (MA) plans, serving more than 220,000 Medicare beneficiaries in California. Since its founding in 1977, SCAN has been a mission-driven organization dedicated to keeping seniors healthy and independent. For the past four years, SCAN has received a 4.5 (out of 5-Star-Rating) from the Centers for Medicare & Medicaid Services.

SCAN, which stands for Senior Care Action Network, began in Long Beach, California by 12 angry seniors who wanted not only medical care, but also social services to help them remain living in the community. In 1985, SCAN received a national social health maintenance organization contract and participated in a congressionally mandated demonstration to provide home and community-based services to medically complex patients at risk of nursing home placement. SCAN remained in the demonstration until it ended in 2005 and transitioned into a Medicare Advantage Prescription Drug Plan (MA-PD). SCAN continues to specialize in serving frail, older adults. We offer a variety of Special Needs Plans (SNPs), including the only Fully Integrated Dual Eligible (FIDE) SNP in California.

SCAN also operates Independence at Home (IAH), a separate community-based organization that provides services to meet the social, functional, and medical needs of community dwelling older adults, regardless of their health plan membership. It also offers a multipurpose senior services program to nursing home eligible older adults, education programs, community funding, volunteer opportunities, and other community services throughout our California service area.

II. The Importance of Addressing SDOH

Addressing SDOH (e.g., food insecurity, housing, social support, caregiver support, isolation, transportation, community safety, etc.) is important to improve health outcomes as these factors represent 70 percent of the drivers affecting a person's overall health status.[1] A 2019 nationally representative survey found that 53 percent of the over 2,000 respondents reported being adversely affected by at least one unmet social need. Not surprisingly, individuals with unmet SDOH needs generally have higher medical utilization and poorer health outcomes.[2]

III. SCAN's Approach

SCAN's approach to addressing SDOH needs is systematic, person-centered, and grounded in serving diverse populations in an equitable manner. It includes the following steps:

- **Identify** social risk factors that affect health outcomes using multiple data sources from SCAN and provider group (if applicable);
- **Stratify** members/clients based on clinical risk and unmet social needs;
- **Serve** members/clients through one or more of SCAN's suite of SDOH programs or benefits;
- **Measure** impact of SDOH programs on members/clients' health outcomes through ongoing tracking and analysis and adjust accordingly;
- **Scale** programs/services to a broader population, as appropriate; ideally performed in a cost-effective manner; and
- **Engage and support** community resources and stakeholders and promote community partnerships to ensure that care and services address what matters most and reflects the needs of our members, clients, and the community.

The following provides additional background on the above steps:

- ***Identify.*** A key component of how SCAN identifies members' health needs is though our Health Risk Assessments (HRA). All SCAN members receive a HRA, which gathers data on: 1) Health Behavior and Status, 2) Demographics, and 3) Social Determinants of Health. It includes several questions on SDOH and basic needs, such as housing, language and literacy, medical needs, food, transportation, social connectedness, and isolation. Since 2018, approximately 80,000 of SCAN members have completed a HRA, which is about a 35 percent response rate. For our SNP members, the HRA completion rate is 80 percent.

  SCAN also uses other data sources to help identify members' health needs including population-level data, such as the social vulnerability index; medication data; lab data; and encounter data.

[1] 2012 Bipartisan Policy Center Report: Lots to Lose: How America's Health and Obesity Crisis Threatens our Economic Future

[2] McKinsey 2019 Consumer Social Determinants of Health Survey

- ***Stratify/Serve.*** After collecting members' SDOH data, SCAN stratifies the information based on clinical risk and unmet social needs. This allows us to direct people to appropriate programs for assistance.[3] The following are three examples:

    - Member-to-Member Program. Seniors (who are also SCAN Health Plan members) are trained in motivational interviewing, so that they can communicate peer-to-peer with individuals who are at high-risk for geriatric conditions and areas of concern, including incontinence, mental health issues, falls, and low physical activity. The goal of this outreach is to encourage individuals to be more engaged in their healthcare and open to discussing these topics with their physician. SCAN contacts about 10,000 members per year, and we have a 51 percent adoption rate (members who choose to participate).

    - Personal Assistance Line (PALS) Program. SCAN dual eligible members are assigned their own assistant or PAL. The PAL onboards the new member, conducts a health risk assessment to screen for health and SDOH needs, and connects the member to health plan benefits and community resources. Because approximately 40 percent of our duals population are Hispanic, all of our PALs are linguistically and culturally competent to serve our members.

    - Connecting Provider to Home (CP2H). The CP2H program assists our extremely high-risk members with complex social and medical issues. Members receive in-person intensive case management led by a social worker, community health worker, and a medical provider team. The CP2H team visit members to identify non-medical needs such as housing insecurity, social isolation and nutrition; assist them in obtaining needed resources; and provide insight to the medical care team during appointments. SCAN evaluated the CP2H program prior to the pandemic with a "control" and "intervention" population. Results showed reductions in hospitalizations and emergency room visits following CP2H interventions. In both cases, the results were statistically meaningful.

      CP2H - SCAN Member Story

      Mr. M lives alone in a mobile home and, at the time of his enrollment in the SCAN CP2H program, he was grieving the loss of his spouse. The CP2H team went to his home and completed a thorough review of his living situation, including his ability to afford food, shelter, as well as his health needs.

[3] SCAN/IAH also pilots programs based on older adults' health needs, such as the Insights program, which provides at home, no-fee, evidence-based mental health care in clients' primary languages (211 clients participated). Results showed significant improvements in depression, anxiety, quality of life, self-rated disability, and patient activation. https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.16088

- *Assessment.* Based on the assessment, the team concluded that Mr. M. had poor access to nutritious food and was struggling to pay for food and utilities. He had a history of falls and multiple serious chronic conditions, including chronic kidney disease (stage 4 and approaching dialysis), hypertension, congestive heart failure, and depression. He was also dealing with incontinence. Because of his financial situation, he had trouble adhering to medications. Although he had a primary care physician, Mr. M was not engaged in managing his health and other social issues.

- *Intervention.* The CP2H team identified the benefits Mr. M. could access to support his health. They also contacted his physician to identify a solution to support balance and prevent falls in his mobile home; equipped him with an ongoing delivery of incontinent supplies; and identified community resources for food and utility assistance and enrolled him in the programs.

- *Outcome.* Today, with the support of the CP2H program and team, Mr. M is able to afford nutritious foods, utilities, and medications. He is managing his incontinence, chronic conditions, and has not fallen. The CP2H team continues to check on Mr. M periodically.

- ***Measure/Scale*.** SCAN continually measures health outcomes and uses data to improve care when necessary. We also measure the adoption of newer benefits introduced to address social needs, such as caregiver respite programs. Two examples of developing new interventions based on the results of our data are our medication adherence and flu vaccination efforts.

  SCAN analyzed our members' medication adherence rates against our star ratings through a health equity lens (we have data on race and ethnicity for about 90 percent of our members) and discovered that our Black and Hispanic members scored lower than our White members did. We then developed a targeted medication adherence program for our Black and Hispanic members.

  In addition, SCAN developed a specific intervention for flu vaccination for Spanish-speaking populations, which has increased vaccination rates. SCAN's COVID-19 vaccination efforts also produced positive results, especially in the Black and Hispanic communities. SCAN helped close the health equity gap by reducing vaccination rates among our Black versus White members from 17 to 6 percent and from 11 to 4 percent for our Hispanic versus White members.

- ***Engage/Support.*** SCAN connects our members with community resources and strengthens community capacity by providing grants to local organizations in areas that

serve SCAN members. During COVID-19, SCAN's IAH program gave $1.8 million to community-based organizations to help them respond to the increased demand for their services. SCAN also has Community Based Organization Advisory Committee, which fosters connections and builds strong partnerships with community organizations.

IV. Supplemental Benefits

Another important tool for addressing SDOH is MA plans' ability to offer supplemental benefits. Over the years, SCAN has offered many supplemental benefits to our members that have greatly improved their quality of life. These include hearing aids, eye exams and glasses, dental care, fitness, meals, transportation, in-home support, bathroom safety, telemonitoring, and caregiver support.

Below are two examples of how supplemental benefits are helping SCAN members.

- **Fitness Benefit.** A Kaiser Health News article featured an 87-year old male SCAN member who is using our fitness benefit.[4] Below is a description of his progress.

  When we first talked, his AFib had slowed him down so much he could not walk a block without getting winded. He wanted to do more so we started out with baby steps. He agreed to get a FitBit, try to walk two blocks, get up every hour to walk around the house, and go to silversneakers.com to find easy sitting and standing exercises.

  [Now] he is averaging 5000 steps/day and his personal best so far is just over 8000 steps. His goal is to reach 10,000 steps. He now takes his dog for a walk 3-4 times a week. When his nearby Silver Sneakers gym reopens, he and his friends are planning on returning.

- **Transportation.** When we asked our members, as part of the HRA, if they would use the transportation benefit, all cohorts (members divided from low to very high need) responded they would use it. The transportation benefit was especially relevant to our most frail members with complex health conditions.

SCAN is grateful to Congress for allowing greater flexibility to offer supplemental benefits to people with chronic conditions.[5] Since 2019, SCAN has been able offer additional targeted benefits to help our members. Examples of SCAN's new supplemental benefits include:

- **Returning to Home** provides personal in-home care (40 hours total per year) to help members after a hospitalization with activities of daily living such as bathing, dressing,

[4] https://khn.org/news/article/as-pandemic-eases-many-seniors-have-lost-strength-may-need-rehabilitative-services/

[5] Providing additional supplemental benefits for chronic care conditions were included in the Bipartisan Budget Act of 2018. Beginning in 2020, MA plans could target non-medical health-related services to members who have chronic care conditions.

laundry, bed linen changing, light housekeeping, caregiver relief, etc. It also provides telephone coordination aid in scheduling follow-up care and up to four weeks of meals delivered to the home;

- **Home Advantage** provides a licensed Occupational Therapist who conducts an initial in-home assessment, identifies risk for falls/injury, and recommends safety measures to keep people safe at home. A SCAN Care Navigator conducts a follow-up home visit to help facilitate the home safety plan;
- **Non-Medical Transportation** allows members to use a portion of their routine transportation rides to go to the senior center, grocery store, and fitness center.
- **Respite Care** provides up to 40 hours of respite care to relieve full-time informal caregivers.
- **Chronic Condition Meals** provide nutritious meals to eligible members who have one or more chronic conditions. Members receive three packaged meals per day that support the special dietary needs of their condition, for up to 28 days.
- **HEALTHtech** provides a technology support line that helps members use a computer, tablet, or smartphone to access healthcare and health-related information and services.
- **BrainHQ** provides online exercises at no cost to enhance memory, brain speed, and other functions to boost brain health.
- **Telehealth** offers zero copays for virtual physician visits.

We are still evaluating the outcomes of our latest supplemental benefits, but are already seeing promising results. Based on the small surveys we conducted, there is a reduction in utilization following the Returning to Home benefit and the Home Advantage program.

V. Recommendations

As a nonprofit MA plan with a long history of serving older adults and vulnerable populations, we know first-hand how supplemental benefits improve the lives of our members. We respectfully ask Congress to continue allowing MA plans to offer flexible benefits and consider extending them to additional populations in the future, such as people who are experiencing homelessness.[6]

We also recommend that Congress include SDOH, such as food insecurity, to the criteria for supplemental benefits more broadly than only for specific chronic conditions. This would help to mitigate some social inequities and allow health plans to expand services to more members in need.

Finally, we recommend that you consider supporting, *H.R. 2166, Ensuring Parity in MA/PACE for Audio Only-Telehealth Act*. This bill would create parity between the audio/video platforms for risk adjustment purposes. We discovered during the pandemic that many older adults do not

[6] In July 2019, SCAN launched a Housing and Homelessness Care Management Initiative that focuses on collaborating with providers and community-based organizations to provide long-term complex case management to homeless or at risk members. This program provides social supports to the members with a special focus on getting the member housed or helping the member keep their current housing.

have access to video technology because they cannot afford it or do not have broadband service. There is also a Senate companion bill*, S. 150, Ensuring Parity in MA for Audio Only-Telehealth Act.*

On behalf of SCAN, thank you for your ongoing commitment to improving healthcare for older Americans. We would welcome the opportunity to be a resource to members of this committee if we can be of service. Thank you again for the honor to speak before this distinguished committee. I look forward to your questions.