FEHB Program Carrier Letter
All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter Number 2023 - 14

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Fee-for-service [12] Experience-rated HMO [12] Community-rated HMO [13]

Subject: Taking Action on Social Determinants of Health for FEHB Members

Background

Carrier Letter 2022-03 explicitly focuses on health equity and the role social determinants of health (SDOH) play in advancing health equity and influencing health outcomes. Two of President Biden's Executive Orders, Executive Order 13985, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, and Executive Order 14035, Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce, instruct agencies to assess, and work to redress, inequities in agency policies and programs that serve as barriers to equal opportunities. In many instances, removal of these barriers can only be done by addressing SDOH.

SDOH are non-medical factors that impact health status and outcomes. These factors are defined by the World Health Organization as "the conditions in which people are born, grow, live, work and age." SDOH are sometimes also referred to as Social **Drivers** of Health to underscore the reality that these factors can be modified by policies and interventions.

Longstanding health literature suggests that social and economic factors such as income and education are the primary drivers of health status, accounting for about 40 percent of the impact on premature mortality. These are followed by health behaviors, which account for about 30 percent

of the impact. Only about 20 percent of the impact on premature mortality is attributed to medical care.[1]

Among commercially insured populations, individuals negatively impacted by SDOH are more likely to ration or delay care, engage in unhealthy behaviors, and experience diminished physical health and behavioral health, including higher rates of chronic disease.[2] Individuals with employer-sponsored group health insurance, individual market coverage, and Medicare and Medicaid coverage all report having unmet social needs; more than 35 percent of individuals regardless of coverage type reported experiencing at least one unmet social need.[3] Living in an unhealthy or dangerous environment or eating unhealthy foods can directly contribute to increased medical costs that are ultimately borne by FEHB Carriers.

Health insurance companies are tackling these issues through specific actions that address food insecurity, poor housing, lack of transportation, and other factors that can impact health.[4] The ongoing shift towards value-based payment that incentivizes prevention and improved health outcomes for persons and populations rather than service delivery alone has also made it important to consider broader approaches to addressing non-medical health-related factors that may be outside the clinical encounter.

Actions for Carriers

We recognize that our FEHB Carriers are taking action to address SDOH by adding benefits in areas such as nutritional supports, transportation, and case management services with strengthened ties to social services. We are pleased with the reported uptake of the Hear Her Campaign for our pregnant population. FEHB Carriers are also working in community partnerships that support local initiatives and efforts to improve living conditions that impact health. Both actions (establishing benefits and community partnerships to

[1] Magnan, S. 2017. Social Determinants of Health 101 for Health Care: Five Plus Five. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC.
[2] Pera MF, Cain MM, Emerick A, Katz S, Hirsch NA, Sherman BW, Bravata DM. 2021. Social Determinants of Health Challenges Are Prevalent Among Commercially Insured Populations. J Prim Care Community Health.
[3] Understanding the impact of unmet social needs on consumer health and healthcare
[4] Major payers act on Social Determinants of Health

address SDOH) require an understanding of local conditions that impact health and knowledge of the resources available Two strategies can be employed to gain this knowledge and understanding: expanding the types of healthcare personnel that can assist in SDOH collection and coding and using community based organizations to connect people to resources.

Diagnostic Codes

ICD-10 Z Codes 55-65 list individual SDOH that can affect lives.[5] These codes are infrequently recorded by providers[6] but could identify non-medical challenges individuals encounter that may negatively impact their health. As Carriers seek to offer benefits that address SDOH, Carriers should work simultaneously with their providers to educate and encourage more frequent use of these codes. Carriers can encourage and incentivize provider practice models where any member of the patient's care team (e.g. physicians, nonphysician providers, nurses, social workers, community health workers, case managers, and patient navigators) can be empowered to collect SDOH data during any patient encounter. Coders can also translate SDOH information in the patient's chart into Z codes which can then be analyzed to identify patient needs, connect them to appropriate resources, or create resources to assist with these needs (food pantries, medical transportation, housing, etc.). For example, if food insecurity is identified as problematic, the Z codeZ59.41) for food insecurity would be annotated and addressed through social supports.[7] For 2023, Z Codes within the ICD-10-CM codes for the social determinants of health were revised and expanded (see pages 103-104 of ICD-10-CM Official Guidelines for Coding and Reporting FY 2023). Carriers can also support increased provider uptake of SDoH screening by providing and incentivizing provider training via platforms such as the American Medical Association's STEPSforward[8] or the American Academy of Family Physicians' EveryONE Tool.[9]

[5] CMS Infographic on Z Codes
[6] Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019
[7] Social Determinants of Health: Food Insecurity in the United States
[8] American Medical Association's STEPSforward
[9] American Academy of Family Physicians' The EveryONE Toolkit

Using Community Service Organizations (CSOs) to Connect People to Resources

Identifying social risks or needs is only the first step for Carriers' SDOH programs; referral networks are essential to closing care gaps that affect health outcomes. Referral networks can include the engagement of Community Service Organizations (CSOs), typically non-profit organizations that focus on providing needed social services to help individuals with life and non-medical challenges. These social services often lie outside the medical model and are found operating at the local, state, and national levels. Raising awareness of the local availability of these social services, to include Federal Agency Employee Assistance Programs (EAP), and strengthening the social services-medical services referral network should be viewed as important elements of a connected approach to SDOH. National directories of CSOs can be accessed through electronic databases. Some states have also created their own databases of CSOs and describe the services they provide, such as North Carolina's NCCare360. Several of these databases have detailed filtering capabilities (e.g., distance from the member's home), are HIPAA compliant, and can integrate into most electronic health records.

Carriers with a limited geographic focus can establish these connections on their own and provide individual provider practices (whether large or small) with the information necessary to utilize social services. Carriers can establish referral protocols for individuals with unmet SDOH needs to available resource support, including community-based options such as findhelp.org (formerly Aunt Bertha), which is a free online social services search engine, and the 211 network, which provides callers with information about and referral to available social services in their geographical location. The 211 network is currently available in portions of all 50 states, the District of Columbia, and Puerto Rico.[10] The availability and use of these databases is a great example of the additive power of social services and medical services working together to address SDOH.[11]

[10] 211 Helpline Center
[11] Innovative Policy Supports For Integrated Health And Social Care Programs In High-Income Countries

Conclusion

Many FEHB members have health-related social needs that directly impact their ability to access healthcare services, follow medical advice, and to be healthy. In the 2021 Automated Data Collection (ADC), OPM asked Carriers to respond to a baseline inquiry of their SDOH practices. That 2021 ADC found that several Carriers have begun to implement programs to link members to social services via flexible benefits or social work personnel.

OPM will expect Carriers to report more extensively on their SDOH activities in upcoming plan years considering emerging accreditation standards for Carriers such as:

- NCQA's Social Need Screening and Intervention measure (SNS-E) with a corresponding focus on intervention with one month of need identification,
- CMS's SDOH 2023 Medicare Hospital Inpatient Prospective Payment System that requires hospitals to report what portion of their population is screened and tests positive for various SDOH categories, and
- national public collaboratives (Gravity Project) that are developing consensus-based data standards involving SDOH for Carriers.

FEHB Carriers should take a broader view of health care coverage with health equity in mind, begin to assess how SDOH affects the health of their members, and actively engage in efforts to address these issues. OPM believes that doing so will ultimately lead to a healthier population and lower health care costs.

Sincerely,

Laurie Bodenheimer
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