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September 30, 2022

The Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St., S.W., seventh floor Washington, DC 20201

Re: Draft United States Core Data for Interoperability, Version 4

Dear Sir/Madam:

Benefits Data Trust (BDT) improves health and financial security by harnessing the power of data, technology, and policy to provide dignified and equitable access to assistance. Together with a national network of government agencies and partners, we efficiently connect people today to programs that pay for food, healthcare, and more while helping to modernize benefits access for tomorrow. A nonprofit since 2005, BDT has assisted people in submitting over one million public benefits applications and secured more than $9 billion in benefits for households across the country, helping to reduce hunger and poverty and build pathways to economic mobility.

BDT appreciates the opportunity to comment on the Office of the National Coordinator for Health Information Technology's (ONC's) draft United States Core Data for Interoperability, Version 4 (USCDI v4), and appreciates the most recent USCDI commitments by the White House Conference on Hunger, Nutrition and Health strategy.[1] BDT works closely with state governments, health insurance companies, health information exchanges (HIEs), and hospital systems to perform direct service and technical assistance to assist low-income patient populations to access public benefits for which they are likely eligible. Public benefit participation data (with the appropriate patient consent) has the potential to assist healthcare organizations with addressing the social drivers of health (SDOH) by helping them meet their social needs in a timely and proactive manner.[2] We would like to request that ONC consider adding data elements pertaining to participation status in the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Increasingly, there are clear use cases involving collecting and sharing information about benefits participation status in health information systems. Growing evidence links these programs to improved health outcomes and reduced costs. **Specifically, ONC could create new data elements (or adapt existing data elements) to capture an individual's participation status in public benefits like SNAP and WIC and incorporate those elements into the USCDI.**

BDT would welcome the opportunity to discuss how public benefit participation data elements could be incorporated into the USCDI.

The Rationale for Making Public Benefits Part of Whole-Person Clinical Care

We are glad to see that ONC and its partners are working on making social drivers of health needs and interventions part of a standardized and well-adopted part of health information systems, including electronic health records. We are also glad to see the Trusted Exchange Framework Common Agreement (TEFCA) includes government benefits determination as a use case for data exchange and look forward to its implementation and further opportunities to guide the process.

Public benefits access interventions, enabled by public benefit participation data, can contribute significantly to the healthcare system's increasing focus on SDOH and health equity, as part of the greater journey towards better health outcomes and reduced costs. There is evidence that access to public benefits improve health and reduces health care costs. Benefits can help people better manage chronic conditions, including high blood pressure and diabetes.[3,4] For specific populations, food assistance like SNAP can help reduce hospitalizations, reduce nursing facility utilization, and improve medication adherence.[5,6,7] Participation in SNAP is associated with $1,400 per person per year savings in adult Medicaid participants.[8] In studies among older adults, estimates of annual savings range from $2,100 to $2,360 per person.[9,10] Similarly WIC is associated reduced risk of preterm birth and infant mortality.[11] WIC is also associated with $2.48 in healthcare, labor, and education cost savings for each $1 invested in the benefit program.[12] Given this evidence, maximizing public benefits access is in the interest of those seeking to improve health outcomes and reduce healthcare costs.

Adding public benefit participation data (with the appropriate patient consent) to health information system standards is a natural extension of ONC's efforts to integrate SDOH and health equity data in USCDI, including the movement to include ICD-10 "Z-codes" on food insecurity and other forms of financial security. We also feel that public benefit participation data could potentially be an appropriate subcategory of SDOH intervention codes that exist in SNOMED, CPT ®, and LOINC vocabularies. We look forward to discussing these options.

BDT's Work in the Healthcare Space and Use Cases for Including Public Benefits Participation Data

BDT brings expertise in connecting patients to assistance. For example, BDT works with multiple Pennsylvania Medicaid Managed Care Organizations ("PA MCOs") to assist their members in accessing up to nineteen public benefits. A key piece of this work is that Pennsylvania Department of Human Services shares individual-level SNAP participation data with PA MCOs. In turn, our PA MCO partners identify which of their members are not currently participating in SNAP, which enables us to focus our outreach on people who are likely eligible and not accessing this critical public benefit. BDT also works with a number of health information exchanges (HIEs) to identify people likely eligible for public benefits based on proxy data. For example, in Maryland, BDT is working with a coalition of food-as-medicine organizations in partnership with health information exchange to deliver timely food security interventions to low-income patients.

With better data, healthcare organizations could reach more people to provide timely assistance. To our knowledge, public benefits participation status is not generally part of data exchanged through HIEs or captured in electronic health records (EHRs). As a result, workarounds using proxy data are required to engage in data-driven public benefits access interventions in the healthcare space. Such work could be better targeted if it were possible to have public benefits participation data capture. In turn, this would enable outreach efforts to reach people not already participating.

Beyond BDT's core work, we believe that making SNAP and WIC data available to healthcare teams would enrich their activities around screening and referring for SDOH services – especially given the continued prevalence of food insecurity and participation gaps in these benefits, and the promise of value-based care to address social drivers of health.[13] For example, if a patient is screened as food-insecure *and* is not currently enrolled in SNAP, then a healthcare team could assist them in completing an application or refer them to a community-based organization who could assist them in doing so. We recognize that establishing the data infrastructure is necessary but insufficient to lead to the clinical practice reforms to accelerate the uptake of screening, documenting, and referring relating to public benefits. Nonetheless, we believe this would be a key step to enabling clinical teams to have a fuller picture of all the medical and nonmedical interventions that the patient is receiving. In addition to the use cases for benefits participation data as part of care delivery, healthcare organizations could potentially use benefits participation data as an indicator within an SDOH dashboard for population health decisionmakers. In the same vein, structured and standardized benefits participation data within EHRs could enable higher quality cross-geographical evaluations of benefits access interventions that take place in the healthcare setting.

In the future, enabling connectivity and data sharing between the healthcare sector and government data systems (with patient consent) would be an exciting next direction. For example, Rhode Island's KIDSNET child health information system connects families, pediatric providers, and public health programs – with specific exchange of WIC participation status. This system enables pediatric providers to screen patients for WIC participation in the same place where they access state immunization data.[14,15] Examples like this point towards a future where healthcare providers can easily track and act upon public benefits participation data.

Next Steps

In conclusion, BDT would be excited to work with ONC to support efforts to facilitate successful interoperability and secure sharing of public benefits participation data to support better integration among the healthcare, government, and SDOH spaces. If you have any questions about these comments and recommendations, please do not hesitate to contact us.

Sincerely,

Rachel Gershon, JD, MPH (BDT Senior Policy Manager, rgershon@bdtrust.org)

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