NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

June 17, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: CMS-1771-P, FY 2023 Hospital Inpatient Prospective Payment Systems and the Long-Term Care Hospitals Prospective Payments Systems Proposed Rule

Dear Administrator Brooks-LaSure,

On behalf of the National Alliance to Impact Social Determinants of Health (NASDOH), we thank you for the opportunity to provide comments on the fiscal year (FY) 2023 Hospital Inpatient Prospective Payment Systems (IPPS) and Long-Term Care Hospitals (LTCH) Prospective Payment Systems (PPS) proposed rule. NASDOH is a group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement. NASDOH brings together health care, public health and social services expertise, local community experience, community-convening competence, business and financial insight, technology innovation, data and analytics competencies, and policy and advocacy acumen to assess and address current regulatory frameworks, funding environments and opportunities, and practical challenges to implementing and sustaining efforts to address social determinants of health (SDOH).

NASDOH continues to be extremely appreciative of CMS's commitment to ensuring that social risks and needs are being identified and considered for Medicare enrollees across its programs and appropriately documented and accounted for given the impact they can have on individual's health overall. Similarly, we support CMS efforts to develop a comprehensive approach to measure and analyze disparities across its programs and policies. NASDOH recommends the following in response to the request for comments in the Hospital IPPS and the LTCH PPS Proposed Rule proposed rule:

Request for Information on Social Determinants of Health Diagnosis Codes

*CMS solicited public comments on how the reporting of 96 SDOH diagnosis codes in ICD-10 categories Z55-Z65 may improve the ability to recognize severity of illness, complexity of illness, and/or utilization of resources under the MS-DRGs, and how CMS might foster documentation and reporting of diagnosis codes describing social and economic circumstances. Specifically, CMS asked whether it should consider requiring more robust documentation and claims data reporting of these ICD-10 codes to inform the impact SDOH have on resource use and for the purpose of deciding whether to incorporate SDOH ICD-10 Z codes into the IPPS MS-DRG classification system in future years.*

Given the impact that social risks can have on health outcomes, we applaud CMS' efforts to encourage documentation and appropriate use of SDOH focused codes across medical settings. Identification of individual's social risks and needs will better enable all providers, including those in the inpatient setting, to provide social care and deliver effective health care. We offer the following input on CMS's specific questions with regard to this proposal.

- *CMS asked whether it should consider requiring more robust documentation and claims data reporting to inform the impact on resource use these determinants have on caring for patients affected by these circumstances in an inpatient setting and inform CMS's decision-making in a future year in determining the most appropriate inclusion of each SDOH Z codes in its IPPS MS-DRG model.*

  NASDOH believes there is value in claims data reporting particularly for determining the most appropriate SDOH Z codes to include in the Medicare program. That said, NASDOH encourages CMS to consider only requiring reporting that will lead to relevant and actionable change. In addition, NASDOH strongly believes that the use of this information should only occur if there are robust systems in place to protect and handle patients' information and privacy carefully and appropriately.

- *CMS sought public comments on developing protocols to standardize the screening for SDOH for all patients, and then consistently document and report such codes and on whether such protocols should vary based on certain factors, such as hospital size and type.*

  Should CMS require documentation and reporting, NASDOH strongly encourages CMS to include guidance on standardized screening for SDOH for all patients, and we recommend that CMS coordinate with other HHS agencies to align protocols and screening across programs. We also request that CMS coordinate with states, which are often requiring their own assessments to identify social risk and needs, to reduce burden. NASDOH members note that providers, who are most often responsible for collecting this information, are managing multiple and often competing programmatic requirements. This burden can be disruptive to effective and efficient operations. Importantly, this can also impact enrollees, who are then asked to share their social risks and needs, data which we know is sensitive, multiple times to meet provider programmatic requirements.

  We supported the approach proposed in the 2023 MA and Part D proposed rule to include screening questions and protocols in sub-regulatory guidance. However, we noted that it is important that there continues to be flexibility for providers to pursue more in-depth screening in the clinical setting as they deem appropriate. NASDOH believes these considerations are important again for inpatient and LTC hospitals. There are clinical reasons for tailoring questions or conducting more in-depth screening; for example, screening that is tailored to a pediatric or adult population, and the ability to conduct a more in-depth screening once need is identified to inform interventions or care plans.

- *CMS asked whether factors such as hospital size and type should be considered when developing protocols for screening and reporting.*

  NASDOH notes that in many hospitals, of all sizes and types, staff are not trained nor comfortable conducting social risk screening and instead delegate screening to community-based organizations (CBOs). This should be permitted and encouraged and allowed to be paid for; in some cases, CBOs and other organizations or community health workers are better positioned and equipped to collect accurate social risk and need information from beneficiaries.

- *CMS requested comment on which specific SDOH Z codes are most likely to influence (that is, increase) hospital resource utilization related to inpatient care, including any supporting information that correlates inpatient hospital resource use to specific SDOH Z code.*

  NASDOH recommends that CMS consider food security, housing security, transportation access and reliability, interpersonal violence, and social isolation to stratify performance by social risk. Existing social risk screening tools assess for these factors commonly, their impact on health outcomes are well documented, and they are factors that many healthcare organizations and providers are equipped to or are already confronting.

  We urge CMS to consider not only what codes influence hospital resource utilization but how this data can be used in meaningful ways to address beneficiaries' unmet social needs, and what guidance and resources CMS can provide hospitals on meeting social needs in line with the beneficiary's preference. While this information can be useful for administrative use and payment adjustment, information about an individual's social risk and needs has been shown to be sensitive, and individuals are often hesitant to disclose this information for fear of bias, misuse, or discrimination. Asking beneficiaries to disclose this information without also offering them services and supports to address identified needs may lead to increased distrust, impact reliability of data overtime, and worsen disparities.

Request for Information on Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs

*CMS requested input on important considerations across five specific areas as it seeks to advance the use of measurement and stratification across its programs as tools to address healthcare disparities and advance healthcare equity.*

We applaud CMS's commitment to achieving equity in healthcare outcomes for Medicare beneficiaries by supporting providers' quality improvement programs and pursuing standardized and parsimonious mechanisms across CMS's quality reporting programs. NASDOH agrees that advancing health equity will require efforts across and beyond the healthcare system, and aligning efforts is essential. We thank CMS for the opportunity to comment on this focus on healthcare disparities reduction and how measures can be effective tools for provider quality improvement activity and accountability.

- *CMS asked about potential approaches for measuring healthcare disparities through measure stratification in CMS quality reporting programs.*

  NASDOH agrees with CMS, and ASPE in its previous work, that measuring and reporting quality specifically for beneficiaries with social risk factors, stratifying measures by social risk factors, and encouraging the development of health equity measures such as these for incorporation into quality reporting programs is an important part of reducing disparities. We agree that "within-provider," and "across-provider" performance are both important when assessing disparities, and that disparities performance measurement should also consider absolute performance. Providers who have minimal 'within-provider' disparities, but overall poor performance are not improving health equity. Similarly, providers who perform similarly as other providers who serve individuals with the same social risk or demographic factors are not improving health equity if all providers are performing poorly.

  As CMS notes earlier in the proposed rule, availability of social risk and other demographic data is needed to facilitate accurate and valid assessments. We want to reiterate a point CMS makes elsewhere in the proposed rule that direct data, reported by individuals using a standardized tool

and process, about social risk factors and demographic data that CMS would stratify performance by, is preferred. Lacking direct data, robust analysis should be conducted to establish the validity and reliability on indirect or inferred data.

We appreciate CMS's sensitivity to measurement bias and potential reliability issues associated with insufficient sample sizes, and commitment to safeguarding against incorrect conclusions resulting from these concerns. We recommend that CMS strongly weigh and prioritize strategies that safeguard against perverse incentives that may arise from requiring stratified measure reporting. One example might be that providers are incentivized to refuse to serve, seek to reduce the number of beneficiaries served, or selectively pick beneficiaries served based on social risk or demographic factors to improve stratified performance rates. This is of greater concern should stratified performance rates be made public or be incorporated into payment programs. CMS notes that access measures are important tools to reduce this perverse incentive, and we agree. Another approach is to consider how CMS can assess the social risk and demographic factors of beneficiaries served overtime to ensure there are not dramatic shifts from year to year. Whatever strategy is used, it is essential that this issue be thoughtfully addressed otherwise stratification could unintentionally widen healthcare disparities.

- *CMS sought feedback on its guiding principles for selecting and prioritizing measures for disparity reporting across CMS quality reporting programs.*

  NASDOH agrees with CMS that it is not possible to calculate stratified results for all quality measures and we would discourage CMS from doing so because of the significant burden it would introduce. We support the systematic principles CMS outlined for use in prioritizing measures for disparity reporting across programs, including prioritizing existing clinical quality measures, measures for which an identified disparity or outcome exists for a selected social or demographic risk factors, measures where there is a sufficient sample size to stratify performance, and prioritizing access, appropriateness of care, and outcome measures. Overtime and as performance gaps were closed, CMS could consider where new measures would be more appropriate, and where new stratification could be appropriately introduced.

- *CMS requested input on social risk factor and demographic data that could be used to stratify measures to identify disparities.*

  NASDOH recommends the prioritization of demographic factors identifying race, ethnicity, sexual orientation, and gender identity as a starting point. We know healthcare outcomes vary by these demographic factors; as CMS cites later in the proposed rule, studies show that belonging to a racial or ethnic minority group or being a member of the LGBTQ+ community is often associated with receiving lower quality of care, having a worse experience of care, and having worse health outcomes even after accounting for social risk factors. Further, because of systemic and institutionalized racism and discrimination, these groups are also more likely to experience adverse SDOH which influence health risks and healthcare outcomes. These demographic factors are also ideal for stratification because there are existing survey questions already in use to identify them, and individuals are familiar with answering these questions. Finally, other measure development organizations, like the National Committee for Quality Assurance (NCQA), are pursuing similar stratification approaches. While NCQA assesses health plan performance, this would be an opportunity for CMS to align measurement approaches across the healthcare system.

Proposed Hospital Commitment to Health Equity Measure Beginning with the CY 2023 Reporting Period/FY 2025 Payment Determination and for Subsequent Years

*CMS is proposing to adopt the attestation-based structural measure, Hospital Commitment to Health Equity, into the Hospital Inpatient Quality Reporting (IQR) Program beginning with the CY 2023 reporting period/FY 2025 payment determination.*

NASDOH applauds CMS for pursuing opportunities to address healthcare disparities and advance equity specific to the Hospital IQR program. We agree with the assertion that hospital leadership plays an essential role in promoting hospital quality and safety, improved experience of care, and better patient outcomes, and assessing organizational commitment to health equity and accessibility can be an important component of a health equity strategy.

NASDOH agrees with CMS that this structural measure is an important first step toward health equity in hospitals and catalyzing important work to improve preventable health disparities. We also strongly encourage CMS to consider what will come next – including how it will move beyond this measure to assess whether hospitals are making the needed investments in workforce training, leadership development, and other related areas essential to improve equity and health outcomes. CMS notes that this measure is not intended to encourage hospitals to take action on any one given element, but instead to analyze their data to understand many factors to deliver more equitable care. It is essential that we quickly move beyond assessing structures to assessing action taken and impact to ensure that our efforts are achieving the health equity and disparities reduction goals to which CMS is committed.

Proposed Screening for Social Drivers of Health Measure & Proposed Screen Positive Rate for Social Drivers of Health Measure

*CMS is proposing to adopt two screening measures, Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health, into the Hospital Inpatient Quality Reporting (IQR) Program beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination.*

NASDOH strongly recommends that CMS enact both proposed measures: "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health" for the reasons cited by CMS in its proposed rule, including that they:

- Advance health equity by addressing the health disparities that underlie the country's health system, a key Biden-Harris Administration priority;
- Make visible to the healthcare system the impact of food insecurity and other drivers of health on patients – including fueling health disparities;
- Support hospitals and health systems in actualizing their commitment to address disparities and implement associated equity measures to track progress;
- Encourage meaningful collaboration between healthcare providers and community-based organizations to screen and connect patients to the resources they need to be healthy; and
- Guide future public and private resource allocation to promote collaboration between hospitals and health systems and invest in leveraging assets and addressing capacity and other gaps in the community resource landscape.

NASDOH also urges CMS to include screening for all five of the SDOH domains and clarify its language in the proposed rule that the screening measure numerator and calculation should provide that patients are screened for all five SDOH domains. These SDOH measures will be instrumental in minimizing

fragmentation and provider/patient burden and enable alignment across public and private quality and payment programs.

Considering the particular challenges in screening for interpersonal violence, including the necessary privacy required to disclose this information and the threat to individuals in disclosing this information, it is imperative that CMS be explicit about the complexities of carrying out screening in this domain and require providers to be sensitive of these complexities when designing and implementing the screening process around interpersonal violence.

Additionally, NASDOH urges CMS to add language to the proposed rule allowing entities outside of health care to screen for the five domains, including community-based organizations in the social service sector. Often, community-based organizations are best positioned to conduct this screening due to their history and trust within the community. NASDOH encourages CMS to include in the rule language allowing providers under Medicare to partner with, and ideally contract with, community-based organizations, to conduct screening on the five domains above.

NASDOH appreciates the opportunity to comment on these important proposals For more information on NASDOH and our members, please visit our website at www.nasdoh.org or contact Sara Singleton at Sara.Singleton@leavittpartners.com.

Sincerely,

*Sara Singleton*

Sara Singleton
Principal, Leavitt Partners and Advisor to NASDOH