NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

September 6, 2022

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

Re: CMS-1770-P, Calendar Year (CY) 2023 Medicare Physician Fee Schedule 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 Calendar Year (CY) 2023 Medicare Physician Fee Schedule 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.

<u>CMS is seeking comment on the potential future inclusion of two new structural measures, Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health in the Alternative Payment Model Performance Pathway (APP) measure set.</u>

As we commented on the FY 2023 Hospital Inpatient PPS proposed rule, NASDOH strongly recommends that CMS include both proposed measures, Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health in the APP measure set. These measures:

- 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 health care 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 health care 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 appreciates that the proposed rule notes the Screening for Social Drivers of Health measure would assess screening for five SDOH domains— food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. Screening across these domains provides a clearer picture of the individual's needs in order to highlight where additional screening may be needed, as well as the scope of services that are needed to improve care and health outcomes. Additionally, given the number of existing screening tools, we encourage CMS to allow the use of any valid screening as long as a single tool is used consistently.

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.

<u>CMS is proposing to include a new health equity measure, Screening for Social Drivers of Health, in the Merit-based Incentive Payment System (MIPS) measure set.</u>

NASDOH strongly recommends that CMS include the Screening for Social Drivers of Health measure in the MIPS measure set for the reasons mentioned above.

<u>CMS is seeking public comment on the following two potential approaches for measuring health equity in MIPS and MVPs: assessing the collection and use of self-reported patient characteristics; and assessing patient-clinician communication. Specifically, CMS requested comment on the following questions in order to understand the feasibility and usefulness of a measure that promotes the collection of self-reported patient characteristics data to provide potential opportunities for the use of patient characteristics data to understand the status of health and health care equity:</u>

- *Would the use of a consistent screening tool(s) to collect social drivers of health information improve our ability to meaningfully compare performance across clinicians, such as performance on a measure assessing referrals for identified social needs or if measures are stratified based on*

identified needs? How are clinicians collecting and using this type of health information to inform clinical care?

NASDOH believes direct data, reported by individuals using a standardized tool and process, about social risk factors and demographic data is the best approach. 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. The use of a consistent screening tool and a standardized process can help alleviate this burden.

We also note 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. 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.

- *Is the proposed quality measure, "Screening for Social Drivers of Health," appropriate for use in the foundational layer of MVPs? If so, then such inclusion would require most or all eligible clinicians to screen for social drivers of health during patient encounters.*

NASDOH strongly recommends that CMS includes the Screening for Social Drivers of Health measure in the foundational layer of MVPs which would be consistent with the goal of screening for SDOH across all patients and CMS programs.

- *Is it appropriate to develop a quality measure to assess clinician referrals to community-based services upon screening positive for a social driver of health, including food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety?*

NASDOH believes it is important to encourage meaningful collaboration between health care providers and community-based organizations to screen and connect patients to the resources they need to be healthy. NASDOH notes that many clinicians 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, and guidance and training for clinicians should also be made available. In some cases, CBOs are best positioned to conduct this screening due to their history and trust within the community. NASDOH encourages CMS to ensure a quality measure on clinician referrals to community-based services upon screening positive for a social driver of health does not discourage clinicians from partnering with CBOs to conduct the screening where appropriate.

- *Would it be beneficial to: stratify either outcome or process measures by patient demographics; and/or stratify either outcome or process measures by identified social needs, such as food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety?*

NASDOH recommends the prioritization of demographic factors identifying race, ethnicity, sexual orientation, and gender identity as a starting point. We know health care outcomes vary by these demographic factors and 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 health care system.

Additionally, 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.

Lastly, NASDOH strongly encourages CMS to consider what will come next – including how it will move beyond quality measures for SDOH screening to what is done with this information. 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. 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.

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