NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

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

Re: Fiscal Year (FY) 2025 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update Proposed Rule (CMS-1806-P)

Dear Ms. Brooks-LaSure,

On behalf of the National Alliance to Impact Social Determinants of Health (NASDOH), we thank you for the opportunity to provide comments in response to the FY 2025 Inpatient Psychiatric Facilities Prospective Payment System Proposed Rule.

About NASDOH

Founded in 2018 by Governor Mike Leavitt and Dr. Karen DeSalvo, NASDOH is a multi-sector coalition of stakeholders working to advance widespread adoption of effective policies and programs to address health-related social needs as well as the underlying social and economic conditions in which people live—often called social drivers of health (SDOH). NASDOH brings together stakeholders from different geographic regions with expertise in health care, public health, social services, patient and consumer perspectives, information technology, and business to share learnings, develop policy recommendations, and build consensus on solutions to address SDOH. NASDOH's work focuses on improving regulatory and reimbursement frameworks, supporting funding opportunities, and addressing practical challenges to implementing and sustaining public and private sector efforts to address SDOH as a core component of advancing health equity.

Inpatient Psychiatric Facility (IPF) Proposed Changes

The Consolidated Appropriations Act of 2023 requires IPFs to collect and submit standardized patient assessment data on specified categories. This data is intended to enable CMS to propose future revisions to the IPF payment system to more accurately pay for care, monitor quality, and assess for disparities in behavioral health care. In the proposed rule, CMS solicits comments on meaningful data elements for collection that are appropriate for the acute inpatient psychiatric care setting and potential criteria for the development and implementation of the Patient Assessment Instrument. CMS specifically asks about Standardized Patient Assessment Data Elements that would provide insight about any demographic factors (for example, race, national origin, primary language, ethnicity, sexual

orientation, and gender identity) as well as SDOH (for example, housing status and food security) associated with underlying inequities. CMS noted some of these SDOH data could be used to risk adjust or stratify measures collected for the IPF Quality Reporting Program and asked if that would make the measures more meaningful.

NASDOH believes direct data, reported by individuals using a standardized tool and process, about social risk factors and demographic data is a useful approach for assessing social risks and HRSNs. NASDOH recommends stratification based on demographic factors including race, ethnicity, sexual orientation, and gender identity as well as stratification by social risk factors such as food, housing, transportation, interpersonal violence, and social isolation. 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. NASDOH also 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.

As health care providers are increasingly screening for and collecting data on social risk factors and HRSNs, NASDOH encourages CMS to consider supporting data portability and screening interoperability across inpatient and outpatient facilities. Data should be collected and stored using technical standards that allow for the exporting and use of that data across different technologies and platforms, Additionally, CMS and providers should consider how patients engage with the health care system to support screening interoperability and avoid unnecessary duplication of screenings and assessments. While repetition of screenings and assessments at appropriate intervals can support the identification of emerging or changing needs, duplication may lead to mistrust.

In December 2023, NASDOH convened multiple stakeholders, representative of payers, providers, community-based organizations, social service providers, public health, and technology resources across the country. At this convening, stakeholders discussed the various social needs related screening measures and how quality measures and quality programs can best meet patient needs and policymakers' objectives. Participants also discussed the goals and outcomes of screening, variability of tools and processes for screening, incorporating data from social needs screening into clinical care and decision making, funding needs for screening and addressing HRSNs, including building community capacity, and supporting multi-sector involvement. The result of the convening was ten principles for adoption, updating, and implementing quality measures related to social needs. We encourage CMS to consider these principles in furthering SDOH-related policies within quality reporting and payment programs.

1) Improving Outcomes—Quality measures are an important tool for advancing the use of culturally sensitive social needs screenings, connecting people to services that improve outcomes, and advancing health equity.
2) Meeting Patient's Needs—SDOH-related quality measures should be designed and implemented primarily to advance the health and well-being of individuals, including through the delivery of social services and supports. SDOH-related measures should prioritize holistic improvement in the patient's health and well-being rather than focusing on reducing the number of social needs.
3) Screening Intervals and Duplication—Implementation of quality measures should consider how patients engage with the health care system and avoid unnecessary duplication of screenings. While repetition of screenings at appropriate intervals can support the identification of emerging or changing needs, duplication of screenings may lead to mistrust.
4) Strengths-Based Approach—SDOH-related quality measures should be designed to highlight assets and support strengths-based solutions rather than focusing on deficits and imposing specific interventions to address individual HRSNs.
5) Incorporate Feedback—Feedback from patients on their experiences of SDOH-related screenings should be used to inform updates to quality measures.
6) Harmonized Measures—A core set of measures harmonized across quality and payment programs would support adoption and reduce the administrative burden for patients, providers, payers, social workers, community health workers, and others involved. Determinants of health that impact health equity should be a part of measures used, including integrated healthcare, community resiliency, physical environment, socioeconomics, and community trauma.
7) Using Existing Data—Collection of data to inform SDOH measures should, whenever possible, draw from existing data sources to minimize additional data collection burden on all involved.
8) Screening Tools and Administration—Quality measures should allow for the use of a variety of validated screening tools and entities that are screening should have flexibility to determine how screenings are conducted.
9) Shared Responsibility and Commitment—Identifying and addressing HRSNs is a shared responsibility. Therefore, quality measures should be driven and informed by engagement with patients and impacted communities and should encourage meaningful collaboration between health care, public health, and social service, and other sectors to screen and connect patients to the resources they need. Additionally, each sector must be committed, supported, and empowered to address patient needs, improve outcomes of individuals and communities they serve and hold each sector accountable for performance.
10) Data Justice—Screening data should be shared with the communities it originates from to advance community-level efforts to address SDOH. The data should be useful and updated regularly, consistently, and accurately.

NASDOH appreciates the opportunity to comment on FY2025 IPF proposed rule. 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