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 Prospective Payment System for Skilled Nursing Facilities Proposed Rule (CMS-1802-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 Prospective Payment System for Skilled Nursing Facilities 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.

NASDOH is grateful to see provisions in this proposed rule which demonstrate CMS' continued commitment to address SDOH and advance health equity.

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

CMS is proposing to add four new SDOH items to be collected as standardized patient assessment data under the SNF Quality Reporting Program starting in FY 2027. Specifically, CMS is proposing to add one question on living situation, two questions on food insecurity, and one question on paying for utilities. CMS is also proposing to modify the question on transportation to make the look-back period for transportation insecurity for 12 months (rather than 6 to 12 months) and simplify the response options.

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. 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 this 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