



January 4, 2021

Submitted via regulations.gov

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications (CMS-9123-P)

Dear Administrator Verma:

Thank you for the opportunity to provide comment on the *Request for Information regarding Accelerating the Adoption of Standards Related to Social Risk Data* within the recently proposed rule to reduce provider and patient burden by improving prior authorization processes and promoting patients' electronic access to health information. We appreciate your continued efforts and commitment to ensuring providers and payers participating in federal health care programs can better understand and coordinate to address individuals' health and social needs.

Aligning for Health is an advocacy organization that brings together a broad coalition of members focused on improving health and wellbeing through interventions related to better aligning health and social needs. We are supported by an Advisory Board of individuals representing public health, mental health, housing, community development, human services, and many other sectors. As a coalition, we are focused on creating opportunities - and removing challenges - for states and local governments, health care organizations, and non-health care organizations to work together to develop cross-sector, coordinated solutions to address both health and social needs.

As CMS notes, the conditions or environments that we inhabit, including our communities, our homes, and our access to healthy foods, education, employment and transportation, all impact our health outcomes and use of health care services. Social risk factors and social needs increase the risk of, and exacerbate existing, chronic conditions and lead to poorer health outcomes.¹ Additionally, surveys have found that respondents who self-report poor health and higher health care utilization, and who experience high inpatient or ER utilization, are more likely to report multiple unmet social needs.²

Unfortunately, our current health and social services programs and systems - as well as their underlying infrastructure - function largely independently of one another, making coordination of care and services,

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/>

² <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/insights-from-the-mckinsey-2019-consumer-social-determinants-of-health-survey>



data sharing, and financing difficult to achieve. These challenges serve to further strain the safety net and place additional burden on the people it serves.

The continued development and growth of value-based care is increasing the attention paid to the critical factors impacting individuals' health that occur outside of a doctor's office. Providers, health systems, and payers alike are taking steps to better identify individuals' social needs and risk factors, and to build connections with social service providers and community-based organizations to provide referrals and to coordinate care.

Documenting social risk and social needs data in health records and promoting greater exchange of such data will ensure payers and providers delivering care to an individual have a more comprehensive view of the factors affecting the individuals' health. Moreover, social risk and social needs data can be leveraged to provide insights on best practices and drivers of health disparities, and for risk adjusting payment or quality measurement. This documentation is the foundational first step toward care models that drive better alignment between health and social needs to improve patient outcomes. We believe that the outcome-focused care delivery systems of the future must rest on a data foundation that provides health organizations with meaningful information about both health and social risks.

However, as a recent HHS Report to Congress on Social Risk Factors in Performance in Medicare's Value-Based Purchasing Program notes, "beneficiary social risk information is not routinely or systematically collected across the health care system, and there is not always standardized terminology to capture beneficiary social risk information."³

Therefore, we agree that it is important to encourage and incentivize greater identification, documentation, and exchange of social risk and social needs data by removing barriers and by providing education and incentives for providers and payers.

Below, we provide additional comments in response to the specific questions posed.

1. What are the challenges in representing and exchanging social risk and social needs data from different commonly used screening tools? How do these challenges vary across screening tools or social needs (for example, housing, food)?

There are currently several social risk screening tools in use across the country. The most used tools include the PRAPARE⁴ and the Accountable Health Communities⁵ screening tools, however, states, medical associations, and private vendors have also developed a variety of screening tools that range in length, social heath domains, and intended populations and settings.⁶

One of the challenges in representing and exchanging social risk and social needs data is the variation inherent in the tools used by health care organizations, which do not necessarily allow for a standardized way of collecting data that can be aggregated and leveraged to enable insights on heath disparities and to evaluate the success of interventions to address social needs. Moreover, many social service and community-based organizations use a variety of screening tools and a different documentation system,

³ <https://aspe.hhs.gov/system/files/pdf/263676/Second-IMPACT-SES-Report-to-Congress.pdf>

⁴ <https://www.nachc.org/research-and-data/prapare/>

⁵ <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

⁶ <https://sirenetwork.ucsf.edu/SocialNeedsScreeningToolComparisonTable>



developed by the Alliance of Information and Referral Systems (AIRS), to capture information on social needs, enhancing the difficulty in coordinating care and exchanging data across sectors.⁷

Additionally, although most national medical professional organizations recommend screening and documentation of social needs,^{8,9} providers are not generally required nor incentivized to use social needs screening tools or to collect comprehensive social risk or social needs information. While a recent study found that over 65 percent of physician practices and over 90 percent of hospitals reported screening for at least one of a variety of social risk factors, as CMS notes, a far smaller proportion of physician practices and hospitals reported performing comprehensive screenings for the five key social needs (housing, food, transportation, utilities, and safety needs).

Surveys of providers have found that financial resources and incentives, and time, are most often cited as barriers to screening.¹⁰ One way CMS could incent increased collection of social risk and social needs information is to allow expenses incurred in the collection of that data to be calculated in the numerator of the Medical Loss Ratio (MLR), rather than as an administrative expense. Doing so would allow resource-stretched providers to ensure that they can fully identify and provide the care individuals need.

Notably, providers participating in value-based models are more likely to screen for social needs, likely due to increased incentives to reduce costs and improve quality and more financial flexibility to provide the care needed.¹¹

Finally, it is important to ensure that providers understand the value and importance of asking and documenting information on social risk and social needs. CMS should provide education and technical assistance and work with payers and providers to ensure that providers have the tools and resources available to make referrals or to assist when social needs are identified. Additionally, data collection processes should seek to reduce any additional burden on providers.

2. What are the barriers to the exchange of social risk and social needs data across providers? What are key challenges related to exchange of social risk and social needs data between providers and community-based organizations?

Unfortunately, the siloed way in which health care, public health, and social services are paid for and administered has limited cross-sector coordination and data sharing across organizations in the health and social service sectors. Breaking down the siloes and incentivizing connectivity and coordination between programs and systems will help to ensure that they are most effective in improving health and wellbeing.

Over the past few years, CMS and HHS have made strong investments and taken significant steps to promote and require interoperability and exchange of health data. However, social service and community-based organizations (CBOs) have not benefitted from the same level of infrastructure and systems funding, and often experience difficulty in connecting with and sharing information with health care organizations.

⁷ <https://www.unitedway.org/partners/alliance-of-information-and-referral-systems>

⁸ <https://sirenetwork.ucsf.edu/PMAstatements>

⁹ <https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf>

¹⁰ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2751390>

¹¹ Ibid.



Statewide or regional efforts to connect health care organizations and CBOs for purposes of electronic referrals, outcomes tracking, electronic resource directories, and care coordination help to bridge some of these gaps. Integrated network models like North Carolina's NCCARE360 bring together CBOs, private foundations, health care organizations, and technology vendors to provide a common point of connection and resources, alleviating the burden of multiple one-off connections and exchanges. Coordinated networks also provide users with greater insight on resource availability and allocation across health and social services providers. CMS and HHS should continue to promote, and should work with Congress to catalyze, further development of such statewide or regional, integrated networks.

Additionally, HIPAA privacy and security regulations have also served to limit data sharing and communication between health care and social service organizations. While HIPAA protections on the exchange, disclosure, and use of protected health information ensure that individuals' health information remains secure are important to maintain, they can create a barrier for engagement by CBOs and social service organizations. The recently proposed modifications to the HIPAA regulations¹² would provide an express permission for covered entities to disclose protected health information to social services agencies, CBOs, home and community services providers, and other third parties that provide health-related services to individuals for individual-level care coordination and case management. If finalized, these rules would provide greater clarity on allowed disclosures, ensuring improved coordination.

3. What mechanisms are currently used to exchange social risk and social needs data (EHRs, HIEs, software, cloud-based data platforms, etc.)? What challenges, if any, occur in translating social risk data collected in these platforms to Z-codes on claims?

Challenges in capturing social risk and social needs data in the EHR limits the exchange of such data between health care organizations. As noted earlier, social risk and social needs information is largely collected by providers through one of several screening tools. However, different tools ask variants of similar questions and do not necessarily correspond to data standards in EHRs in a standardized way.¹³ While the Gravity Project is currently leading the way in developing consensus-based comprehensive coding standards for social risk and social needs data capture in EHR systems,¹⁴ a uniform, widely accepted data model does not yet exist for representing social determinants in an EHR."¹⁵

Thank you again for the opportunity to provide comments on this important issue. Please do not hesitate to let us know if you have any questions. I can be reached at mquick@aligningforhealth.org.

Sincerely,

Melissa Quick
Melissa Quick
Co-Chair, Aligning for Health

¹² <https://www.hhs.gov/sites/default/files/hhs-ocr-hipaa-nprm.pdf>

¹³ <http://healthleadsusa.org/wp-content/uploads/2019/03/HITEQ-ICD-10-Z-codes-for-SDoH-June-2017.pdf>

¹⁴ <https://www.hl7.org/gravity/>

¹⁵ <https://www.nap.edu/catalog/25467/integrating-social-care-into-the-delivery-of-health-care-moving>