



March 13, 2023

Submitted electronically via regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children’s Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issues of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program (CMS-0057-P)

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to provide comment on the *Request for Information regarding Accelerating the Adoption of Standards Related to Social Risk Factor Data* within the recently proposed rule to advance interoperability and improve prior authorization processes. 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 work to develop and promote actionable, bipartisan policies that create opportunities - and remove 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, 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, 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.

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>



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 equip payers and providers providing care for an individual with 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 improving risk adjustment for payment or quality measurement.

As a 2020 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

We applaud CMS and other federal partners' focus on social risk factors and in identifying policies to address systemic drivers of health. **We further agree that it is important to encourage 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. Beyond this, we encourage CMS to also expand incentives and ensure supports are in place for entities to provide access to and make referrals to available resources and to address identified social needs, as appropriate.**

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

1. What are best practices regarding frequency of collection of social risk and social needs data? What are factors to be considered around expiration, if any, of certain social needs data?

CMS should continue ongoing efforts to promote screening for social needs within federal health programs, including through efforts to include new measure concepts that feasibly and accurately assess whether a beneficiary has had their health-related social needs assessed using a standardized screening tool and to assess screenings and referrals to interventions for unmet social needs.

One element to keep in mind with regard to frequency of collection of social needs data is that social needs data are often point-in-time data, meaning it may not reflect a patient's permanent status. Despite this, it is important to reduce harm involved in social needs screening to ensure that patients are not barraged with multiple screenings from multiple providers or entities.

We encourage CMS to coordinate and align with ONC's ongoing work to advance interoperable exchange of health information, including social determinants of health data, which will help providers to understand whether social needs have already been identified, thus reducing duplicative and potentially harmful screenings.

Another important consideration when determining best practices for screening is how to ensure screening is done in a way that ensures culturally appropriate engagement, and reduction of trauma and embarrassment associated with screening questions. CMS should ensure providers and payers incented

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

or required to perform social needs screening are provided with adequate support and training, and should encourage the use of trusted community stakeholders, such as community health workers.

Finally, it is also not enough to just screen for social needs; CMS should consider how to provide incentives and ensure supports are in place to encourage providers and other entities to provide referrals and take steps to address identified social needs. Efforts to screen without equipping providers with the tools to provide access or referrals to available resources or self-navigation resources may unintentionally increase burden and risk patients' trust.

2. 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 (AHC) Model screening tools, however, states, medical associations, and private vendors have also developed a variety of screening tools that range in length, social health domains, and intended populations and settings.⁶

A similar approach to the AHC Model Health-Related Social Needs Screening Tool was finalized in the CY2023 MA and Part D final rule, which requires MA Special Needs Plans (SNPs) to include one or more standardized questions from a list of screening instruments specified by CMS in sub-regulatory guidance on each of three domains (housing stability, food insecurity, and access to transportation) as part of Health Risk Assessments beginning in CY2024.⁷

Specifically, CMS notes in sub-regulatory guidance that SNPs can meet the new requirement in one of two ways – by using a state-required screening instrument that includes questions on the required domains; or by selecting questions on the required domains from validated, health IT encoded screening instruments.⁸ CMS provided these options rather than requiring that all SNPs use the same specific standardized questions on these topics as proposed to provide SNPs with some flexibility to select the specific questions that are most appropriate for their enrollees.

Aligning for Health was supportive of this proposal, as these questions will help SNPs gather the necessary information to inform the development and implementation of each enrollee's comprehensive individualized plan of care.⁹ Information from social needs screenings should be used to connect enrollees to covered services or resources to help meet their needs, if consistent with the enrollee's goals and preferences.

One of the challenges in representing and exchanging social risk and social needs data is the variation inherent in the tools used, and how they are used in practice, which do not always allow for a standardized, interoperable way of collecting and exchanging data that can be aggregated and leveraged to enable insights on health disparities, and to evaluate the success of interventions to address social needs.

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>

⁷ <https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf>

⁸ <https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pa-listing/cms-10825>

⁹ <https://aligningforhealth.org/aligning-for-health-submits-comments-on-cms-ma-and-part-d-proposed-rule/>

Although CMS has begun to include quality measures focused on social needs screening in several of its payment programs, screening for social risk or social needs information by providers is not commonly performed. While providers may want to address their patients' social needs, they do not always have the tools, capacity, or resources to do so. According to a survey by the Physicians Foundation, nine in 10 physicians want to address patients' social drivers of health, but six in 10 lack the time and ability to do so.

Surveys of providers have found that financial resources and incentives, and time, are most often cited as barriers to screening.¹⁰ Notably, providers may receive additional reimbursement for collecting social risk factor information given social determinants are listed under risk for complications and/or morbidity or mortality of patient management, noting SDOH as one of the components for moderate level of medical decision making. However, efforts to screen without ensuring availability and access to resources to support whole person care may unintentionally increase burden and risk patients' trust. Therefore, we encourage CMS to consider policies that would encourage both standardized screenings and referrals to address health-related social needs.

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.

3. 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.

A recent report published in the *American Journal of Managed Care*, for example, highlighted opportunities and challenges that MA plans face in making decisions related to the supplemental benefits they offer to address the social needs of beneficiaries.¹¹ Data collection, generation and analysis was cited as one major barrier in better informing interventions to address social risk factors, highlighting the need to ensure interoperability of new and existing data sources and address gaps in evidence on certain social care interventions to help inform future supplemental benefit offerings.

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, including social determinants of health data. For example, we applaud efforts by the Office of the National Coordinator for Health IT (ONC) to incorporate social determinants of health data into the U.S. Core Data for Interoperability (USCDI) version 2, and CMS' efforts to point to ONC's data standards in its interoperability regulations. We also support and applaud the work of several HHS agencies in their efforts to advance the concept of community care hubs.¹²

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

¹¹ <https://www.ajmc.com/view/how-medicare-advantage-plans-use-data-for-supplemental-benefits-decision-making>

¹² <https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs>

Comprehensive, standardized, and timely data is a key component to successful care coordination and to connect individuals to needed services to address their health and social needs. But data sharing also requires that community-based organizations (CBOs) and other entities have the technical capability and capacity to seamlessly share data with the health care system or health care organizations. Unfortunately, social service organizations and CBOs have not benefitted from the same level of infrastructure and systems funding and support as health entities have, and often experience difficulty in connecting with health care organizations. Many CBOs do not have the capacity to invest in the tools and functionality required to connect with individual primary care providers or other entities that would allow for seamless closed loop referrals and data exchange.

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. As HHS officials note in their description of community care hubs, integrated hub or network models can 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 integrated, collaborative networks across the country.

We further recommend CMS:

- Provide sustainable funding for the technological infrastructure and human intervention needed to connect the health and social services sectors together and ensure that funding can flow where the referrals are going. These investments to connect health care entities and social services organizations can help to reimburse CBOs, track capacity, and understand the true cost of and where such organizations are successful in addressing basic needs. Funding should be woven into the reimbursement methodology through value-based payment or other alternative payment methods to ensure that social care services are reimbursed for all members.
- Bolster CBO capacity, including by providing CBOs with support and assistance in navigating health care partnerships and in addressing data sharing exchange. Partnerships between CBOs and trusted community partners such as community health workers or other health care supports help to close gaps in care and focus on more upstream challenges – improving outcomes.
- To better understand health equity and social influencers of health, we recommend that these issues – and their related captured data – not be considered in isolation. Rather, we urge that the clinical and social risks be viewed together to get a complete patient picture.

4. 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 or other entities 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

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



Additionally, while the Gravity Project is continuing to lead the way in developing consensus-based and comprehensive standards for social risk and social needs data capture in EHR systems,¹⁴ and ONC has included SDOH data standards in UCSDI version 2, adoption and use of social determinants of health standards is not yet commonplace.

In 2021, CMS and Medicare contractors issued guidance on use of Z codes to capture SDOH.¹⁵ These updated coding guidelines are a significant step forward to supporting whole person care. However, a CMS 2021 report on the utilization of Z codes for social determinants of health found that social needs data had only been collected and reported for 1.59 percent of Medicare beneficiaries, a fraction of the likely population with social needs.¹⁶ CMS should promote the use of these Z codes by providers, including through additional training, guidance, and incentives, to better and more consistently identify social needs in beneficiaries.

A separate CMS report from April 2022 found low rates of Z code utilization in Medicare Advantage at the enrollee-level and the claims level.¹⁷ Among the sample, only 0.94 percent of MA enrollees in 2017 and 1.07 percent of MA enrollees in 2019 had one or more medical claims with Z codes, which represents a 14.4 percent increase from 2017 to 2019. Only 0.08 percent of medical claims in 2017 and 0.076 percent of medical claims in 2019 had Z codes. The most common Z codes used were problems related to living alone, disappearance and death of a family member, homelessness, and problems in relationship with spouse or partner.

CMS should continue to promote the use of these Z codes by providers, including through additional training, guidance, and incentives, to better and more consistently identify social needs of beneficiaries.

While updated SDOH coding guidance assists with enhancing the capture of structured data, limitations at the provider level persist. In a recent data highlight, CMS attributes low utilization of Z codes to their relatively recent introduction, changing guidance on their use, and lack of explicit financial incentives for their use.¹⁸ CMS also notes that “Recent changes to evaluation and management (E&M) coding altered the basis on which providers could bill for higher-intensity services (and higher payment) to focus on the time spent with the patient or the complexity of medical decision-making required,” which may add some incentive to record Z codes.

In addition, it is important to emphasize how Z codes can be used in combination with proper risk adjustment to capture the needs and complexities of patients and drive enhanced care management. Patient-centered risk adjustment, also known as categorical risk adjustment, combined with social risk documented through Z codes would give providers something clinically meaningful and actionable.

Moreover, workforce shortages limit a provider organization’s ability to educate, train and hire staff to ensure that proper documentation is occurring. SDOH data elements, when captured accurately and frequently in structured claims data, help health care managers, providers and policymakers gain the insights needed for strategic, quality-driven, and equitable health care planning.

Additionally, data sets do not always include all patient information, which can be a challenge in getting the full picture and knowing which individual is receiving which services. Finding ways for SNAP, WIC,

¹⁴ <https://www.hl7.org/gravity/>

¹⁵ <https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf>

¹⁶ <https://www.cms.gov/files/document/z-codes-data-highlight.pdf>

¹⁷ <https://www.cms.gov/files/document/data-highlight-april-2022.pdf>

¹⁸ <https://www.cms.gov/files/document/data-highlight-april-2022.pdf>



housing-related programs, and other federal programs to become part of the claims data system would be helpful in connecting these dots.

5. Please identify opportunities and approaches that would help CMS facilitate and inform effective infrastructure investments to address gaps and challenges for advancing the interoperability of social risk factor data.

On December 29, 2022, President Biden signed the Consolidated Appropriations Act, 2023 (CAA,2023) into law. The \$1.7 trillion package included significant investments in many key social determinant of health policies, funding, and initiatives.¹⁹

We were thrilled to see **Section 2201, Addressing Factors Related to Improving Health Outcomes**, which authorizes the HHS Secretary to award \$35 million a year in grants, contracts, or cooperative agreements to states or other eligible entities: to support the implementation of strategies to address factors related to health outcomes; to establish, maintain or improve technology platforms or networks to support coordination and information sharing; implementation of best practices; and supporting considerations of factors related to health outcomes in preparing for and responding to public health emergencies.

This section included language from the *Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act*, a bill that would serve as a catalyst to enable states, through public-private partnerships, to leverage local expertise and technology to coordinate care and measure the impact of social care interventions on health, health care spending, and community wellbeing.²⁰ The section also included language related to the *Social Determinants Accelerator Act*, which would provide planning grants and technical assistance to state, local, and Tribal governments to help them devise innovative, evidence-based approaches to coordinate services and improve outcomes and cost-effectiveness.²¹

As Section 2201 is implemented, we encourage CMS to work with other HHS partners to make this funding available to build the interoperable infrastructure to advance exchange and use of social risk factors data. This infrastructure would help leverage technology and increase capacity of the health and social services sectors to improve coordination and overall health outcomes.

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 mquick@aligningforhealth.org.

Sincerely,

Melissa Quick
Co-Chair, Aligning for Health

¹⁹ <https://www.appropriations.senate.gov/imo/media/doc/JRQ121922.PDF>

²⁰ <https://aligningforhealth.org/lincact/>

²¹ <https://aligningforhealth.org/social-determinants-accelerator-act/>