September 2, 2022

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Covered California Comments on the Proposed Rule, Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2023 (CMS-1770-P) (RIN 0938-AU81)

Dear Administrator Brooks-LaSure:

Covered California applauds the Centers for Medicare and Medicaid Services (CMS) thoughtful approach to advancing health equity as demonstrated by the new proposed rule Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2023. This proposed rule would further the adoption of measures focused on key influences of individual health outcomes that fall outside of the traditional healthcare system but have a significant impact on individual and community health.

Specifically, we urge CMS to adopt the first-ever "Screening for Social Drivers of Health" measure in the quality performance category measure set for the Merit-Based Incentive Payment System (MIPS) for the reasons cited in the proposed rule[1] – and to ensure alignment with this same measure now adopted for the Hospital Inpatient Quality Reporting (HIQR) Program in the Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2023 Rates final rule.[2]

Likewise, it is critical that CMS apply to MIPS the same "Screen Positive Rate for Social Drivers of Health" measure it has adopted for the HIQR program to align measures across hospital and provider payment programs and allow CMS to achieve its stated goals in the proposed rule.[3] We also urge CMS to include both the "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health" measures into the APM Performance Pathway (APP) measure set so they can be incorporated into the Medicare Shared Savings Program (MSSP).

As stated by CMS in the proposed rule, by screening for and identifying unmet needs such as housing instability, lack of transportation, utility difficulties, food insecurity, and interpersonal safety, physicians enrolled in MIPS and Accountable Care Organizations

[1] 87 Fed.Reg. 46279 (July 29, 2022).
[2] 87 Fed.Reg. 49202 (Aug. 10, 2022).
[3] 87 Fed.Reg. 46280 (July 29, 2022).

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(ACO) in MSSP will be in a better position to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes.

Public health and economic research overwhelmingly indicates how important it is to measure and address these drivers of health (DOH), but as we noted in our April 19, 2022 letter on this topic, there has been no unified approach across the United States, leaving the healthcare sector without validated and standardized tools to do so. CMS's introduction of these DOH measures is critical to avoid fragmentation and provider/patient burden and enable alignment across public and private quality and payment programs. We also note the opportunity for alignment of these proposed measures with CMS's CY2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs final rule[4] (providing that special needs plans must complete enrollee health risk assessments including SDOH) and its ACO Realizing Equity, Access, and Community Health (REACH) Model (requiring patient-level SDOH data collection).

Covered California believes these measures will be a foundational tool because they will provide a standard set of measures to collect patient-level DOH data in a federal quality or payment program. Covered California's Qualified Health Plan Issuer model contract includes requirements to screen all enrollees for food insecurity using the two food insecurity questions in the Accountable Health Community Health-Related Social Needs Screening Tool. Covered California set these requirements with an initial limited focus on hunger due in part to our belief that we should follow established national standards, particularly in evolving areas such as assessing, measuring, and addressing social drivers of health.

Individuals and agencies invested in reducing health disparities know from decades of research – including CMS's own social needs screening data – that racial and ethnic minorities screen positive for facing challenging drivers of health at higher rates. Given this demonstrated inequity, we strongly recommend that CMS enact both proposed measures. Requiring screening but not reporting the results would significantly limit the utility of the screening measure. In particular, the screen positive rate measure is crucial not only to enable point of care interventions to address an individual beneficiary's unmet social needs but also to illuminate the prevalence of such needs at a systems level, so that we know how and where to invest and where to prioritize our resources. Absent such data, providers, plans, and purchasers will not know how to redistribute resources and how to adjust payment, and so we again commend CMS for including both of these measures in the proposed rule.

In response to CMS's solicitation for comments,[5] the use of standard SDOH screening tools would likely improve the ability to compare performance across clinicians, but such standardization could be a near-term barrier to data collection. Consistent with CMS's own guidance in the Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2023 Rates final rule,[6] we recommend that CMS initially allow for flexibility in

[4] 87 Fed.Reg. 27704 (May 9, 2022).
[5] 87 Fed.Reg. 46155 (July 29, 2022).
[6] 87 Fed.Reg. 49205 (Aug. 10, 2022).

SDOH screening tools used by practices, but over time should require use of one of a set of reliable and commonly used tools.[7]

CMS should also incorporate the proposed MIPS quality measure "Screening for Social Drivers of Health" into the population health foundational layer of MIPS Value Pathways (MVP).[8] As CMS notes in the proposed rule, its Equity Plan for Improving Quality in Medicare documents that "complex interactions among individual need, clinician practice/behavior, and availability of community resources significantly impact healthcare access, quality, and ultimately costs."[9] Presently there is a significant equity gap in the MVP foundational layer. The current MVP population health foundational layer measures are clinically oriented (readmission and admission rates), which are influenced by SDOH,[10] including in the context of specialty care.[11] The SDOH screening measures are essential cross-cutting, equity-relevant measures to add to the population health foundational layer.

Finally, as CMS moves forward the measures above, it should also implement its proposed Advanced Investment Payments (AIPs) to ACOs in MSSP as a critical step in enabling clinical practices to partner with communities in acting on the SDOH it identifies in its patient population.[12]

As documented in the CMMI Accountable Health Communities first model evaluation report, 74% of navigation eligible beneficiaries who were screened with the same DOH measures put forward in this proposed rule opted in for navigation.[13] At the same time, key barriers to successful resource navigation included insufficient community resources for referrals, difficulty maintaining an up-to-date community resource inventory, and high caseloads making it difficult to provide in-depth, high-quality navigation.

In proposing these AIPs, CMS recognizes these barriers, that "it is important for health providers who may not have expertise in providing social services to work with those community-based organizations that do have such expertise", and the financial resources required for these clinic-community partnerships to be successful.[14] Recognizing that clinical practices often struggle to partner with community-based organizations because the latter lack the technological, human, or other infrastructure required to deliver sufficient services or enter into contractual arrangements, CMS should make explicit that the AIPs for "SDOH strategies" may be used to underwrite this community capacity/infrastructure necessary to provide the requisite social services.

We appreciate your call for bold action – and commitment to an ambitious agenda to realize this goal. We view the enactment of these dual DOH measures as an expression

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[7] See CMS, A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights (Aug. 2022).
[8] 87 Fed.Reg. 46282 (July 29, 2022).
[9] 87 Fed.Reg. 46280 (July 29, 2022).
[10] Baker, et al., *Social Determinants Matter for Hospital Readmission Policy: Insights From New York City* (April 2021) Health Affairs, Vol. 40, No. 4.
[11] Mohanty, et al., *The Impact of Social Determinants of Health on 30 and 90-Day Readmission Rates After Spine Surgery* (Mar 2, 2022) 104 Journal of Bone & Joint Surgery p. 412.
[12] 87 Fed.Reg. 46098 (July 29, 2022).
[13] CMS, Accountable Health Communities Model Evaluation, First Evaluation Report (Dec. 2020).
[14] 87 Fed.Reg. 46102 (July 29, 2022).

of this commitment and a crucial step in the direction of equitable access, quality, and outcomes for all. We look forward to continuing our partnership with you to advance health equity through the identification and implementation of measures focused on influences of health outcomes. If you have any questions or would like more information about the proposed rules' impact on individuals' access to affordable coverage, please feel free to contact us.

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