Informing PTAC's Review of Social Determinants of Health and Equity, and PFPMs: We Want to Hear From You

The **September 2021** public meeting of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) included PTAC's third theme-based discussion to inform the Committee on topics important to physician-focused payment models (PFPMs). This public meeting included a Social Determinants of Health (SDOH) and equity session that was designed to give Committee members information about current perspectives on how addressing SDOH and equity can help to optimize health care delivery and value-based transformation in the context of Alternative Payment Models (APMs) and PFPMs specifically.

There has been an interest in the ability of APMs and PFPMs to identify, account for, and address SDOH and equity as part of their model designs, and to incentivize health care providers to address these issues by screening for patients' social needs and making referrals to community-based organizations and social services as needed[1]. Non-medical, social factors (such as food security; affordable housing; education; transportation; and racial, ethnic, religious, and gender discrimination) have been shown to play an important role in influencing health outcomes and behaviors. The consensus is that addressing SDOH is fundamental not only for achieving better health, but also for reducing inequities in health. Additionally, interest in the topic has grown considerably in light of experiences during the COVID-19 public health emergency, which is known to have exacerbated many longstanding issues relating to SDOH and equity.

SDOH and equity have not been specifically identified by the Secretary of Health and Human Services (HHS) as criteria to be used in PTAC's evaluation of proposed PFPMs. However, several PFPM proposals that were submitted to PTAC between 2016 and 2020 incorporated elements related to addressing SDOH and/or equity (including health disparities) in the context of care delivery, performance measurement, and payment methodology. Therefore, sharing the insights of stakeholders and building on those insights may help to optimize the use of efforts to address SDOH and advance equity in the context of APMs and PFPMs.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides an environmental scan for every proposal reviewed by PTAC to provide background information that can inform the Committee's evaluation of each proposal. To help PTAC prepare for the SDOH and equity theme-based discussion in September, background information was provided regarding relevant terms for addressing SDOH and advancing equity; the role of SDOH and equity in the context of APMs and PFPMs; and issues and opportunities associated with optimizing efforts to address SDOH and equity in APMs and PFPMs. Additionally, the SDOH and equity session that took place in September included: (1) a listening session with PTAC members; (2) a listening session with subject matter experts and one stakeholder who had

[1] Krause T., Schaefer C., and Highfield L. The Association of Social Determinants of Health with Health Outcomes. AJMC. Accessed August 16, 2021. https://www.ajmc.com/view/the-association-of-social-determinants-of-health-with-health-outcomes

previously submitted a PFPM proposal to PTAC; and (3) a panel discussion with a diverse group of subject matter experts. Stakeholders also had an opportunity to make public comments.

PTAC used the Agency for Healthcare Research and Quality's (AHRQ's) working definition of **SDOH**, and the Centers for Disease Control and Prevention's (CDC's) working definition of **health equity**, as a guide for focusing the discussion during the September 2021 public meeting.

> *"SDOH, although experienced by individuals, exist at the community level. Healthcare systems that learn about the communities their patients live in, and the community-level barriers members can face to becoming and staying healthy, can better adapt their recommendations to people's lives. SDOH can be categorized into five key areas: social context, economic context, education, physical infrastructure, and healthcare context."*[2]
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> *"Health equity is achieved when every person has the opportunity to 'attain his or her full health potential' and no one is 'disadvantaged from achieving this potential because of social position or other social determined circumstances.'"*[3]

Three other concepts that are closely related to SDOH and equity are **health-related social needs (HRSNs)**, **behavioral health**, and **health disparities**.

> *HRSNs are defined as "non-medical patient needs that impact health (such as housing instability, food insecurity, and exposure to interpersonal violence)."* [4]
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> *Behavioral health, according to AHRQ, is "an umbrella term that includes mental health and substance abuse conditions, life stressors and crises, stress-related physical symptoms, and health behaviors. Behavioral health conditions often affect medical illnesses." (AHRQ 2021b).*
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> *Health disparities, as defined by Healthy People 2020, are "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender*

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[2] Agency for Healthcare Research and Quality. About SDOH in Healthcare. Accessed July 21, 2021, from https://www.ahrq.gov/sdoh/about.html. A list of the specific SDOH in each of the five areas is provided in Appendix 1.

[3] Centers for Disease Control and Prevention. Health Equity. Accessed July 21, 2021, from https://www.cdc.gov/chronicdisease/healthequity/index.htm.

[4] Billioux, A., Verlander, K., Anthony, S., & Alley, D. Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. Accessed August 5, 2021, from https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf.

identity; geographic location; or other characteristics historically linked to discrimination or exclusion." (Healthy People 2020).

Addressing SDOH can improve equity and reduce disparities. While SDOH exist at the community level, HRSNs and behavioral health needs exist at the individual level. Addressing SDOH at the community level can help to reduce the number of health-related social needs that individuals experience.

PTAC Interests:

Within the broader context of efforts to address SDOH and equity, PTAC is particularly interested in how APMs and PFPMs can help to incentivize health care providers to collect data related to SDOH and equity; use this data to ensure that patients' physical, behavioral health, and social needs are being met (including providing any necessary referrals to community-based organizations); measure the impact of these activities; and address related payment issues.

PTAC seeks to build upon the insights of stakeholders and use those insights and considerations to further inform the Committee's review of proposals and recommendations that the Committee may provide to the Secretary relating to this topic. The background information and discussions held during the September 2021 public meeting will serve to inform PTAC on this topic. PTAC is now seeking additional information on the types of SDOH- and equity-related data that could be collected by health care providers within the context of optimizing value-based care in APMs and PFPMs; best practices, barriers, and challenges related to the collection and sharing of that data; and payment mechanisms for incentivizing and adequately reimbursing health care providers' efforts related to addressing SDOH and advancing equity in the context of APMs and PFPMs. Therefore, PTAC is requesting stakeholder input on the questions listed below.

Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Questions to the Public:

1. What types of SDOH-related social needs data (e.g., food insecurity, housing or transportation needs) could be collected within the context of optimizing value-based care in APMs and PFPMs, by whom, and how?
    - What types of SDOH-related data are available and particularly useful but may be underutilized? What kinds of SDOH-related data may be particularly relevant for addressing the needs of specific populations, such as Medicare beneficiaries?

- What are some best practices and protocols that providers could adopt to ensure the availability of standardized, accurate, and validated data collection on social risk factors and social needs (e.g., using ICD-10 Z codes (Z55-Z65) to collect data on social needs through claims)?

2. What types of equity-related data are currently being captured by providers within the context of optimizing value-based care in APMs and PFPMs to help implement efforts to intentionally advance health equity?

    - What types of equity-related data (e.g., race and ethnicity) are currently not being captured, but could potentially be captured to assist in achieving these goals?

3. How can health care providers effectively share SDOH- and equity-related data with payers, community-based organizations, and other partners across the continuum of care?

    - How can providers be incentivized to form partnerships through data platforms and referral systems that link the health care and social services sectors to facilitate efforts to address SDOH and equity?
    - What data interoperability or other data sharing challenges need to be addressed to facilitate information sharing between health care providers, community-based organizations and other partners?
    - What specific capabilities and incentives are needed for smaller safety net providers or rural providers?

4. What are some of the identified barriers, challenges, and other concerns for providers, their partners, and patients, related to collecting, using, and/or sharing SDOH- and equity-related data?

    - Are there any additional barriers related to collecting, using, and/or sharing data related to patients' behavioral health needs?

5. Are there any potential unintended consequences related to collecting, using, and/or sharing SDOH- and equity-related data?
6. What are examples of successful processes and tools for collecting, using, and/or sharing SDOH- and equity-related data, to generate actionable insights for patient-centered care?

    - Are there any processes and tools that have been particularly successful for addressing the needs of specific populations, such as Medicare beneficiaries?

7. What types of investments *are needed* to support services aimed at addressing the social needs of patients and advancing health equity, and by whom?

- What are the necessary funding streams and payer mechanisms for supporting activities and infrastructure related to addressing SDOH and equity for health care providers?
- What are the necessary funding streams and payer mechanisms for supporting activities and infrastructure related to addressing SDOH and equity for community-based organizations?
- What are best practices for community level assessments of social needs of patients and how local community-based organizations can address those needs?

8. What types of investments *have been made* by payers, health care providers, social service providers, and communities to assess and address patients' social needs?
9. What role have APMs played in incentivizing activities related to addressing SDOH and advancing equity?

    - What services related to addressing SDOH and advancing health equity have received reimbursement under value-based payment models?
    - What payment methodologies have been most effective in incentivizing efforts to address SDOH and equity, particularly for high-risk patient populations?
    - How can patients be incentivized to participate in these efforts?

10. What kinds of SDOH- and equity-related quality and performance measures *have* health care providers been required to report and/or meet? Please describe if any of these measures have been linked to payment.

    - What other types of process measures, outcome measures, and/or other performance metrics *could* be used in the context of APMs and PFPMs to encourage provider accountability and meaningfully reflect the impact of efforts to address SDOH and advance equity?
    - What kinds of performance metrics are particularly relevant in the context of specific populations, such as Medicare beneficiaries?

11. Based on your experience, what is the evidence regarding the effectiveness of various activities related to addressing SDOH and equity in improving quality and reducing health care costs?

    - What activities related to addressing SDOH and equity have been particularly effective in improving quality and/or reducing health care costs for specific populations, such as Medicare beneficiaries?

12. Are there any other important questions that remain unanswered relating to the incorporation of efforts to address SDOH and equity into APMs and PFPMs?

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Where to Submit Comments/Input: Please submit written input regarding any or all of the above questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Note: Any comments that are not focused on the topic of APMs and PFPMs for SDOH- and equity-related services and efforts by physicians and related providers caring for Medicare fee-for-service (FFS) beneficiaries, or are deemed outside of PTAC's statutory authority, will not be reviewed and included in any document(s) summarizing the public comments that were received in response to this request.

Appendix 1: Additional Details on AHRQ's Definition of SDOH

"SDOH, although experienced by individuals, exist at the community level. Healthcare systems that learn about the communities their patients live in, and the community-level barriers members can face to becoming and staying healthy, can better adapt their recommendations to people's lives. SDOH can be categorized into five key areas:

- Social context: (e.g., demographics, social networks and supports; social cohesion; racial, ethnic, religious, and gender discrimination; community safety; criminal justice climate; civil participation).
- Economic context (e.g., employment, income, poverty).
- Education (e.g., quality of day care, schools, and adult education; literacy and high school graduation rates; English proficiency).
- Physical infrastructure (e.g., housing, transportation, workplace safety, food availability, parks and other recreational facilities, environmental conditions, sufficiency of social services).
- Healthcare context (e.g., access to high-quality, culturally and linguistically appropriate, and health literate care; access to insurance; healthcare laws; health promotion initiatives; supply side of services; attitudes towards healthcare; and use of services."

Source: https://www.ahrq.gov/sdoh/about.html