

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

On September 27, 2021, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could help inform their review of how efforts to address social determinants of health (SDOH) and equity can be further optimized in the context of alternative payment models (APMs) and value-based care generally, and in the context of physician-focused payment models (PFPMs) specifically. PTAC received nine responses from the following stakeholders that are listed below in the order in which their responses were received:

1. [American Academy of Family Physicians](#)
2. [American Academy of Neurology](#)
3. [National Association of ACOs](#)
4. [American Nurses Association](#)
5. [Ascension](#)
6. [Partnership to Empower Physician-Led Care](#)
7. [Aunt Bertha, a Public Benefit Corporation](#)
8. [211 San Diego](#)
9. [Pharmaceutical Research and Manufacturers of America](#)

For additional information about PTAC's request, see [PTAC's solicitation of public input](#).



October 14, 2021

Jeffrey Bailet, MD
Committee Chair
Physician-focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation (ASPE), Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Dr. Bailet,

On behalf of the American Academy of Family Physicians (AAFP), which represents 133,500 family physicians and medical students across the country, I write in response to the [request for information](#) that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) solicited in September 2021 on how alternative payment models (APMs) including Physician Focused Payment Models (PFPMs) can 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; measure the impact of these activities; and address related payment issues. The AAFP was an early participant in the PTAC review process with our proposal for an Advanced Primary Care Alternative Payment Model (APC-APM) and remains fully supportive of the PTAC's role in evaluating PFPMs. We are pleased to respond to this current request for public input.

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?

Community-level data regarding unmet social needs, including food insecurity, housing, transportation needs, access to broadband, and other factors is essential to ensuring important SDOH factors are addressed at the community level. Primary care physicians play an important role in health-related social needs (HRSNs) and can connect patients with community resources when available. Primary care physicians often screen for these types of unmet needs but face barriers to addressing them in a meaningful way.

Due to a lack of standardization in screening tools and electronic health record (EHR) capabilities, recording this type of data adds to physicians' administrative burdens and can take time away from patient care. Health plans and agencies managing state and federal programs should also assist with collecting and sharing these data with primary care physicians. For example, health plans could screen for HRSNs upon enrollment which could be shared with their primary care physician (with permission). State and federal health agencies frequently have access to community-level SDOH information that informs a patients potential social and environmental needs, which could be used for population health planning or risk-stratification purposes.

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In addition to using these types of data to optimize care, they also should be used for risk-adjustment and to ensure primary care practices are being adequately compensated and evaluated to provide the required level of care for high-risk or vulnerable patients.

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?

Advancing health equity requires effective mechanisms to both identify where inequities exist and address the factors that allow it to happen. Many of these occur outside clinic walls. The role of the primary care physician depends on the specific needs of the patient population, the financial support available to support practice assessment of HRSNs, and the availability of community resources available to address them once identified. Many primary care physicians screen for unmet social needs with the desire to connect patients to community resources. However, the lack of evidence-based research and standardized approaches to screening, as well as the lack of a comprehensive community resource strategy, makes operationalization a challenge. In 2017, AAFP surveyed 484 family physicians and found lack of time during the clinic visit, staffing challenges, inability to provide a solution, and insufficient financial support are the primary barriers for not identifying and collecting data on patients' social needs.

Other challenges include the limitations of EHR platforms and maintaining patient privacy of data across organizations. Some EHRs have incorporated social needs screening, but clinicians indicate the screening questions may be inadequate. Other EHRs do not have built-in social needs screening questions, resulting in physicians and care teams using additional digital platforms or paper collection methods to collect and exchange data which is administratively burdensome and results in fragmentation of the patient record.

Some opportunities to better collect, understand, leverage, and report SDOH data include the development, expansion, and updating of web-based platforms to help link individuals to services. Many examples of these web-based platforms exist such as [The Neighborhood Navigator](#), developed in collaboration between the AAFP and Aunt Bertha, specifically for physicians and care teams to locate local community resources for their patients.

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?

Improving interoperability and EHR usability are vital to reducing physicians' administrative burdens and improving the sharing of all patient information (clinical and non-clinical), including SDOH factors and documented HRSNs. Family physicians do not need incentives or utilization measures to increase their use of EHRs and other health technology. As primary care physicians manage and direct care teams, they are well aware of the value of sharing patients' health information and improving care coordination. Instead, EHR systems must be designed to be more user-friendly and readily adaptable to the physicians' clinical workflow without unreasonable expense. The practice time required to acquire these important data and the technology to support its management are important tasks that must be recognized in APMs and PFPMs

Federal agencies should continue to ensure the cost of implementing, maintaining, and updating EHR systems for physician practices is manageable by working with EHR vendors, as well as ensuring APMs adequately recognize these important functions. These costs are particularly prohibitive for small and rural practices, as well as those serving high proportions of patients in underserved communities. These practices may need additional financial and technical support to obtain, implement, and maintain EHRs and other information technology required for successful participation in APMs.

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?

Primary care physicians are trusted partners in patients' healthcare experience. They are well suited to act as an important partner in the data collection process, however they should not be considered the sole source for collection of patients SDOH and equity-related data. To better foster collaboration in data collection, required data should be standardized to ensure the uniform collection of many types of health care data, including HRSNs and demographic characteristics, such as race, ethnicity, and preferred language (REL). Many [states](#) have taken steps to standardize collection of REL data, using legislative and regulatory processes to ensure appropriate collection and use of data to protect patient privacy. Standardizing the data elements used for race, ethnicity, primary language, gender identity, sexual orientation, income status, and other characteristics will help ensure primary care teams can identify and facilitate addressing HRSNs.

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

The AAFP's policy on [social determinants of health](#) outlines how family physicians are uniquely qualified to identify HRSNs with the goal of connecting patients with third-party services and public programs in their community to address those needs. To best address health equity and social determinants of health, we first need a public health infrastructure that is robust and healthy. While physicians and other clinicians, inclusive of all specialties, can assist in identifying and facilitate addressing HRSNs, they cannot and should not be held responsible for resolving community-level SDOH factors.

Existing FFS structures typically do not pay for or support robust activities that address HRSNs within a patient's community, such as community health workers or care coordination, which can disadvantage patients who require more support and the physicians who care for them. As such, APMs need to be designed to adequately resource primary care physicians to support the needs of patients, inclusive of HRSNs, without inappropriately holding primary care physicians responsible for outcomes outside their control.

When designing APMs, the AAFP believes payment for primary care should represent an increased investment in primary care, be prospective, include a comprehensive or global primary care payment, be risk-adjusted, and include evaluation of performance. This type of

payment adequately supports and sustains comprehensive, longitudinal patient-physician relationships. Additionally, these payments should be made within the context of a patient's regular source of primary care to avoid potential fragmentation, such as from third-party direct to consumer telehealth providers.

Not only is this payment infrastructure beneficial to practices intent on delivering wholistic, person-centered care, it's essential to ensuring access to high quality, continuous primary care for patients. When primary care practices are supported by a predictable, prospective revenue stream for the full range of care needs presented by their patients, primary care practices thrive, and patients have better outcomes.

This can be achieved through models that include adjustment of payment rates to provide additional resources to account for the HRSNs of their patient population. One approach, outlined in a recent Health Affairs [blog](#) post and used by the AAFP in the APC-APM, is to use geographic indices of social risk such as the Robert Graham Center's (RGC) [social deprivation index](#) (SDI). The RGC SDI is a composite measure of area level deprivation based on seven demographic characteristics collected in the American Community Survey and used to quantify the socio-economic variation in health outcomes. While there are mechanisms to adjust payments, the larger outstanding question of what it costs to manage populations with increased social risks remains.

To date, many APMs have been focused on the Medicare population, with limited attention provided to Medicaid and safety net providers. The AAFP acknowledges underserved populations should be more intentionally engaged in value-based care and calls for increased collaboration between the Centers for Medicare & Medicaid Innovation (CMMI), Medicare with Medicaid, as well as private payers. Embedding equity as a shared aim regardless of the patient population and across all models will resource providers more efficiently to ensure all patients receive high quality, affordable, patient-centered care.

Additional opportunities to increase equitable access exist, including expansion of geographic testing of models and incentivizing patient participation. Current primary care models have been geographically limited in scope and repeatedly tested in the same regions. Since primary care is uniquely qualified to care for patients of all ages in diverse settings nationwide, efforts should be made to expand where models are tested to increase equitable access and avoid further exacerbation of disparities. Additionally, models should be designed with incentives that remove patient barriers to access, such as waiving co-pays or co-insurance for primary care. Waived co-pays should be covered by the payer rather than being waived by the practice to avoid financially penalizing practices.

We appreciate the opportunity to provide these comments. Please contact Kate Freeman, Manager of Payment and Care Transformation, at 913-906-6168 or katef@aafp.org with any questions or concerns.

Sincerely,

A handwritten signature in black ink that reads "Ada D. Stewart, MD". The signature is written in a cursive style with a vertical line at the end.

Ada D. Stewart, MD, FAAFP
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October 15, 2021

Jeffrey Bailet, MD

Chair, Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health & Human Services
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Bailet,

On behalf of the more than 36,000 neurologists and clinical neuroscience professionals, the American Academy of Neurology (AAN) appreciates the opportunity to provide input to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the importance of including social determinants of health (SDOH) and health equity elements in Physician-Focused Payment Models (PFPMs).

The AAN is firmly committed to embracing the diversity of its members and the patient communities they serve and believes that persistent inequities in health care outcomes exist in the United States, including among Medicare patients. We believe that addressing SDOH is fundamental to achieving better health outcomes and reducing health inequities. To appropriately assess and measure quality and cost of health care we must have standardized tools and data reporting of SDOH at the provider level and improve health literacy at the patient level. As a general matter, we support the creation of confidential reports that allow providers to look at patient impact through a variety of data points, including, but not limited to, LGBTQ+, race and ethnicity, dual-eligible beneficiaries, disability, and rural populations.

Sharing SDOH and equity-related data are important for care coordination and value-based care, however doing so can be especially sensitive and complicated and has the potential for unintended consequences related to perceived bias and breach of privacy. Additionally, interventions related to SDOH often are “non-clinical” in the strictest definition, which can make standardization and data capture difficult in traditional reporting systems and programs. The AAN supports advancing data interoperability through collection of a minimum set of demographic data collection, and incorporation of this demographic information into quality measure specifications. This has the potential for improving the robustness of the disparity method results, potentially permitting reporting using more accurate, self-reported information, such as race and ethnicity, and expanding reporting to additional dimensions of equity, including stratified reporting by disability status.

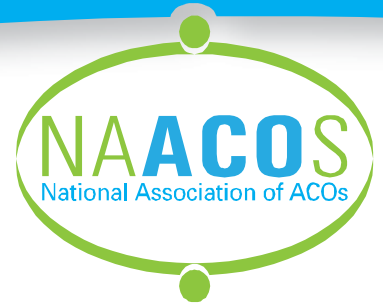
In the current health care landscape, SDOH data collection will likely require incentives for widescale uptake by providers and health systems. There are several tools available to quickly assess SDOH including but not limited to, the American Academy of Family Physicians Social Needs Screening Tool and Health Leads Screening Toolkit, however, they do not seem widely used but might be if a specific incentive was tied to their use. On the payer side, few incentives have been put in place. To date, alternative payment models (APMs), except for the CMS Innovation Center's (CMMI) Accountable Health Communities Model which includes standardized collection of health-related social needs data, have been indifferent to SDOH incentives. Instead, it is left up to individual organizations to determine if health equity investments make a difference in terms of quality and cost of care. Moving forward, all CMMI APMs should include a standardized set of health-related social needs data. Considerable research in health literacy and SDOH is available and specific interventions have demonstrated some improvements in health outcomes. This specific realm may be an appropriate area of first focus to include in PFPMs.

The AAN appreciates the opportunity to share initial comments on this public comment opportunity and looks forward to engaging in the evolving conversations on SDOH and their inclusion in new and existing value-based care models moving forward. Please contact Leslie Kociemba, AAN's Care Delivery Program Manager at lkociemba@aan.com or (612) 928-6094 with comments or questions.

Sincerely,

A handwritten signature in black ink that reads "Orly Avitzur MD". The signature is written in a cursive, flowing style.

Orly Avitzur, MD, MBA, FAAN
President, American Academy of Neurology



October 18, 2021

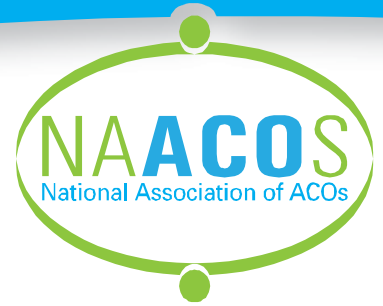
Physician-Focused Payment Model
Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation
Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Social Determinants of Health (SDOH) Request for Input

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC):

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for input (RFI) on how Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs) can help to incentivize health care providers to collect data related to social determinants of health (SDOH) and equity; use this data to ensure that patients' physical, behavioral health, and social needs are being met; measure the impact of these activities; and address related payment issues. Accountable care organizations (ACOs) are groups of doctors, hospitals, and/or other health care providers that work together to improve the quality of patient care while lowering costs. NAACOS is the largest association of ACOs and Direct Contracting Entities (DCEs) representing more than 12 million beneficiary lives through hundreds of Medicare Shared Savings Program (MSSP), Next Generation ACO Model, Global and Professional Direct Contracting Model (GPDC), and commercial ACOs. NAACOS is a member-led and member-owned nonprofit that works on behalf of ACOs and DCEs across the nation to improve the quality of Medicare delivery, population health, patient outcomes, and healthcare cost efficiency. NAACOS is committed to advancing the value-based care movement, and our members, more than many other health care organizations, want to see an effective, coordinated, patient-centric health care system that focuses on keeping all individuals healthy. Strengthening the ACO model and other total cost of care models provides an important opportunity to reduce health inequities.

Improving health equity is critical to delivering high quality care in a cost-effective manner and focusing on the broader concept of an individual's overall health, as SDOH contribute significantly to health outcomes. These social factors cannot be addressed if they are not adequately identified, measured, tracked, and reported. Many ACOs have been doing important work to address social needs and health inequities among their patient populations. Improving and expanding ACOs and other total cost of care models provides an important opportunity to reduce health disparities often caused by negative SDOH and to transition our health system to a culture of value.



NAACOS responses to RFI questions on APMs and health equity and SDOH:

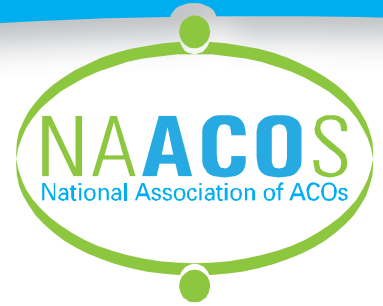
Question 1: *What types of SDOH-related social needs data (e.g., food insecurity, housing or transportation needs) could be collected within the context of optimizing value-based care in APMs and PFPMs, by whom, and how? What kinds of SDOH-related data may be particularly relevant for addressing the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

Standardized collection of SDOH-related social needs data and demographic data is integral to improving care quality and reducing health inequities. Improving health equity and addressing SDOH are critical to delivering high quality care in a cost-effective manner, as research shows that social drivers of health contribute more significantly to health outcomes than medical care.¹ These social factors cannot be addressed if they are not adequately measured, tracked, and reported.² While some ACOs have begun implementing SDOH-screening tools to collect this data, many of these tools are unstandardized or untested, and may not be compatible with electronic medical records (EMRs), making the data less actionable. For ACOs that have begun to address patients' nonmedical needs, the most common needs they have identified are for housing, transportation, and food.³ Having access to accurate data on SDOH affecting their patients would allow ACOs to develop targeted interventions for high-risk populations to eliminate health disparities. Ideally, providers should collect data on patients' SDOH-related social needs within the five domains of SDOH as defined by the Healthy People Initiative, which are economic stability, health care access and quality, social and community context, education access and quality, and neighborhood and built environment.⁴

Question 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 (CBOs), and other partners? What specific capabilities and incentives are needed for smaller safety net providers or rural providers?*

In order for health care providers to be able to effectively share SDOH and equity-related data with partners, industry standards need to be updated. Currently, there is no standardized way to make referrals to CBOs, and the CBO referral platforms that do exist often have limited or no interoperability with electronic health records (EHRs). ACOs need actionable data in order to develop and target effective SDOH interventions to the populations that need them most. NAACOS urges policymakers to work together with health systems and providers, EHR vendors, and community partners to develop standards for data collection and interoperability that will ensure data is uniform and actionable. It is also important to consider the additional financial challenges faced by smaller safety net providers and rural providers, as the upfront costs to implement EHR upgrades for data collection and referral platforms can be prohibitive. Upfront funding or other financial incentives should be provided to ensure that those serving vulnerable populations are not left out of this transition.

NAACOS has also recently authored a white paper with several recommendations on how to improve health equity.⁵ One recommendation to incentivize providers in ACOs to form partnerships with



community organizations and address their patients' SDOH is to develop a supplemental Medicare benefit to allow ACOs to bill Medicare for the management of negative SDOH through a "chronic social determinant management" service modeled after Chronic Care Management (CCM).

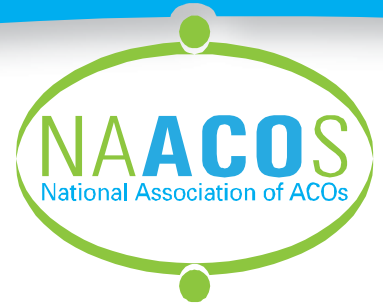
Question 4: *What are some of the identified barriers, challenges, and other concerns for providers, their partners, and patients, related to collecting, using, and/or sharing SDOH- and equity-related data? Are there any additional barriers related to collecting, using, and/or sharing data related to patients' behavioral health needs?*

It has been reported that many ACOs lack data on both their patients' social needs and the capabilities of their potential community partners.⁶ There is an overwhelming lack of standardization in data collection and sharing, which has significantly affected organizations' abilities to address SDOH. A 2019 HHS report provides key recommendations for improving the exchange of SDOH data, including defining and standardizing SDOH data, creating a sustainable infrastructure for SDOH data by improving financial alignment, strengthening the capacity of community organizations, and supporting local and state-based decision-makers.⁷

Another key challenge is that providers lack the time to review SDOH data and address unmet needs with their patients. A 2018 survey by the American Academy of Family Physicians (AAFP) found that 80 percent of providers felt they did not have enough time to properly discuss SDOH with patients during a standard visit.⁸ Adequate reimbursement for the time it takes to collect and assess SDOH data and to discuss individual needs with patients would allow providers the time and resources to effectively address SDOH.

The structure of Health Insurance Portability and Accountability Act (HIPAA) laws also creates challenges for collecting, tracking, and reporting SDOH data. For example, health information exchange (HIE) data requirements create data-sharing barriers for ACOs because they are not considered Medicare suppliers or providers. Even when a patient has given consent for data sharing, ACOs may not be able to share data shared across the ACO and its care plan partners, leading to impediments in communication within ACOs and with CBOs. CMS does not consider care coordination and accountability to fall under payment, treatment, and operations, and therefore ACOs are limited in sharing data for these purposes. However, care coordination is necessary for addressing SDOH and providing integrated, whole-person care.

Additionally, there are concerns about using SDOH and equity-related data inappropriately. For example, in the proposed 2022 Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) requests feedback on potentially adjusting quality measure benchmarks for ACOs serving vulnerable populations. In NAACOS' comments, we stress that CMS must avoid adjusting quality benchmarks for race and ethnicity.⁹ Doing so is endorsing and accepting that for an underserved population, it is acceptable to have lower quality or poor outcomes. Instead, NAACOS offers several recommended policy changes that could help to advance the efforts of quality improvement in relation to improving equity in health outcomes across ACOs. These recommendations include collecting race and ethnicity data in a more standardized way, with incentives for ACOs who are early adopters, updating patient survey data to incorporate health equity, providing incentives to ACOs who attest to using a SDOH screening tool, stratifying a subset of quality measures by race and ethnicity, providing



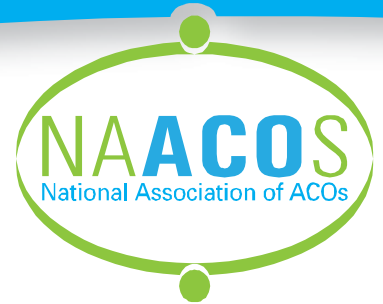
incentives to ACOs for improving quality scores for subpopulations identified as having lower performance, and developing new quality measures to address health equity.

NAACOS continues to call for the alignment of 42 CFR Part 2 (Part 2), which governs patient substance abuse treatment records, with HIPAA. This alignment will improve care coordination and quality improvement and allow ACOs and other providers to deliver the kind of patient-centered, well-coordinated care necessary to improve health outcomes and reduce inequities. While substance use disorder (SUD) affects all racial and ethnic groups, Black and Latinx Americans are less likely to complete treatment for SUD.¹⁰ By equipping providers with the necessary information for coordinated, whole-person care, these disparities can begin to be addressed. Currently, ACOs lack access to the full suite of necessary information to allow them to achieve the goals of well-coordinated patient care, improved quality, and preventive care required to limit opioid overdose deaths and other adverse events associated with SUD. While ACOs are provided claims data through Claim and Claim Line Feed (CCLF) files, these data lack SUD-related information, thus limiting ACOs' ability to treat the whole person and potentially harming patient care and outcomes. We thank Congress for the work done through the Coronavirus Aid, Relief, and Economic Security (CARES) Act to allow the sharing of this important SUD data after initial patient consent. However, while Section 3221 of the CARES Act helped to align Part 2 with HIPAA, implementation has been challenging. For example, Section 3221 did not provide specifics on what is required to obtain the initial patient consent. Additionally, because care coordination is not considered by CMS to fall under treatment, payment, and health care operations, ACOs still lack access to vital SUD-related data on their patients.

Question 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?*

Achieving favorable outcomes for patient populations with greater social risk may be more difficult or require different or additional resources than achieving the same level of outcomes in a more socially advantaged population.¹¹ However, providers are often not compensated for addressing these social risk factors in order to improve health outcomes. Due to the lack of investment in this area, providers are not able to address these concerns with their patients and are often discouraged from even screening for unmet social needs without being able to connect patients with adequate, appropriate resources.¹² In order to support services aimed at addressing social needs of patients and advancing health equity, providers need both upfront funding to implement programs and reimbursement for services provided. NAACOS recommends providing ACOs with both grant money and adjusted financial benchmarks to support this work.

Under current policy, CMS uses Hierarchical Condition Category (HCC) prospective risk adjustment models to calculate beneficiary risk scores and adjust ACOs' financial benchmarks to reflect the increased cost for treating patients with high clinical risk factors that are beyond an ACO's control. Each HCC has a corresponding risk adjustment factor (RAF) score that is used by CMS to determine the medical complexity of a patient and to calculate the amount CMS will anticipate allocating for that beneficiary in the upcoming performance year. The intention behind this risk adjustment methodology



is to adequately cover the costs of providing covered benefits to beneficiaries. However, RAFs do not include social risk factors that can have a significant impact on health and health outcomes. In order to fully capture the risk level of a beneficiary and the costs associated with caring for that patient, changes need to be made to current risk adjustment calculations. Current MSSP benchmarking methodology should be updated to fairly and appropriately compensate providers caring for vulnerable or underserved populations with greater social risk factors to reflect the differential costs associated with achieving positive health outcomes for these populations.

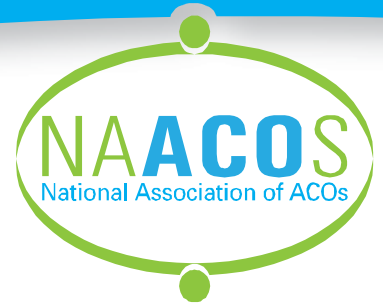
Additionally, ACOs should be given additional flexibilities with Medicare rules to deliver supplemental benefits that address SDOH or health equity. As population health-focused organizations, ACOs are incentivized to address health equity in order to improve the total quality of care for the populations they serve. NAACOS recommends that ACOs be offered additional flexibilities to deliver benefits related to transportation, housing, food insecurity, as well as supports for other social needs. There is precedent in Medicare for allowing such flexibilities, recently illustrated by new policies in Medicare Advantage (MA) that allow premium dollars to go towards addressing social needs. The Bipartisan Budget Act of 2018 expanded the types of benefits that may be offered by MA plans for chronically ill patients.¹³ Some examples of supplemental benefits that may be offered include food, pest control, indoor air quality equipment, structural home modifications, and others. Since ACOs are held accountable for the total health outcomes of the populations they serve and the total cost of care, they should be allowed similar flexibilities in how they allocate resources to meet the needs of a certain population. Caring for patients with greater social risk requires more time and resources, and providers will not be able to meet the needs of these patients without appropriate flexibilities and funding.

Question 10: *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?*

There are several opportunities to address health equity via quality measurement for ACOs. There are many quality measures that CMS currently considers to be “topped out,” meaning performance is high among most reporting the measures; however, these measures may show additional room for improvement when stratified by social risk factors such as income level, as an example. Stratifying quality measures by social risk factors may allow ACOs to target tailored interventions designed to have the most meaningful impact on underserved populations. Other metrics that could be used include standardized collection of race/ethnicity data, patient feedback data on equity, and standard use of a SDOH screening tool. NAACOS also recommends the development of new measures that address health equity at the population health level. We recommend that CMS collaborate with ACOs to help identify the most appropriate, population-health focused measures on equity.

Question 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?*

There are many challenges faced by ACOs and other APMs to address SDOH and health equity. For example, Stark Law and Anti-Kickback Statute (AKS), as they are currently written, create challenges for ACOs to be able to effectively address SDOH and coordinate care. Under existing waivers, there is



significant uncertainty concerning whether, as well as the extent to which, an incentive program offered to a physician with respect to assigned MSSP patients may, without creating potential Stark Law issues, also be offered to the same physician for non-MSSP patients. This makes it difficult for ACOs to establish SDOH initiatives, as there are concerns about which patients qualify for these programs, and it limits the potential for these programs to have a meaningful impact on SDOH, as enrollment and benefits change regularly. This also creates confusion for providers, limiting uptake.

Additionally, capacity and workforce training issues are an impediment to addressing SDOH. Addressing SDOH requires significant change management and workforce development for which most organizations do not have the funding or bandwidth. Policymakers need to work to ensure that medical education includes training on addressing social determinants. Existing clinicians should be provided with the necessary training and technical assistance on how to implement policies and initiatives to measure and address the negative SDOH of their patients.

Importantly, it must be emphasized that relying on good data to address health equity is critically important to the success of these efforts. It is critical to note that we cannot embark on these changes without also giving clinicians and ACOs the tools and resources they need to implement and deploy interventions to reduce these inequities and to improve patient care for underserved populations. There must also be a recognition that health equity solutions will be localized and, therefore, will need to look different in different locations, markets, and populations. Finally, as these policy options are considered, it is important to recognize the additional burden that may be placed on clinicians, and, therefore, it will be critical to find ways to minimize this burden. NAACOS encourages any efforts to address SDOH and health equity to be collaborative and include the voices of diverse patients, community partners, providers, and other key stakeholders.

Conclusion:

Thank you for the opportunity to provide comments on the PTAC RFI on addressing social determinants and health equity in APMs and PFPMs. Should you have any questions about our comments, please contact Allison Brennan, SVP, Government Affairs, at abrennan@naacos.com.

Sincerely,

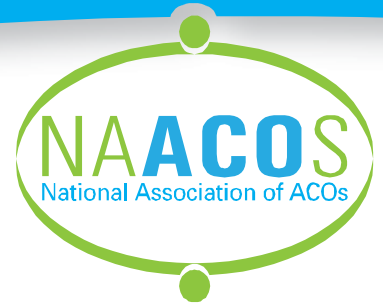
A handwritten signature in black ink, appearing to read "Clif Gaus", is positioned below the word "Sincerely,".

Clif Gaus, Sc.D.
President and CEO

¹ [https://www.ajpmonline.org/article/S0749-3797\(15\)00514-0/fulltext](https://www.ajpmonline.org/article/S0749-3797(15)00514-0/fulltext)

² <https://www.nap.edu/read/12875/chapter/1#xiii>

³ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0727>



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- ⁴ <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>
- ⁵ <https://www.naacos.com/acos-and-health-equity-white-paper>
- ⁶ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01266>
- ⁷ <http://reports.opendataenterprise.org/Leveraging-Data-on-SDOH-Summary-Report-FINAL.pdf>
- ⁸ https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-survey-results.pdf
- ⁹ <https://www.naacos.com/naacos-proposed-2022-mpfs-comments>
- ¹⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3570982/>
- ¹¹ <https://www.healthaffairs.org/doi/10.1377/hblog20210414.379479/full/>
- ¹² <https://www.annfammed.org/content/17/6/487.full>
- ¹³ https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_III_HPMS_042419.pdf

October 18, 2021

Jeffrey Bailet, MD
Chair
Physician-Focused Payment Model Technical Advisory Committee
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically to: PTAC@hhs.gov

Dear Chairman Bailet:

On behalf of the American Nurses Association (ANA), I am pleased to respond to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)'s request for input to inform PTAC's review of social determinants of health (SDoH) and equity, and physician-focused payment models.

ANA appreciates PTAC's interest in SDoH and equity in Medicare. The Medicare population is diverse in age, race, ethnicity, socioeconomic status, geographic residence, and other demographic indicators. Amidst this diversity are groups of beneficiaries with health-related social needs of various types. A recent article in the Journal of the American Medical Association (JAMA) reported on a study of Medicare spending across U.S. counties, finding that SDoH were associated with variations in per-beneficiary spending. The authors concluded, "Addressing SDoH can provide another means to lower health care spending and presumably reduce disparities in health. Further studies are warranted to examine the impact of interventions addressing SDoH on health care spending and to test appropriate ways to incorporate social factors into risk adjustment formulas."¹

Nurses, in addition to providing quality care to patients, often serve as advocates for their patients, and are best positioned to identify factors that could result in inequitable health outcomes. Nurses also reflect the people and communities they serve—allowing them to recognize the challenges faced by their patients and ensure that their patients receive culturally competent, equitable health care services. Nurses are leaders in implementing processes that further quality patient care and highlight existing gaps in care delivery, leading to measurable improvements. The National Academy of Medicine's expert Committee on the Future of Nursing 2020-2030 recently released a report, Charting a Path to Achieve Health Equity.² The report serves as a detailed blueprint for engaging nurses "in the complex work of aligning public health, health care, social services, and public policies to eliminate health disparities and achieve health equity."³

¹ Zhang, Yongkang et al. Social Determinants of Health and Geographic Variation in Medicare per Beneficiary Spending. Journal of the American Medical Association. June 2021. Accessible online at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780864>

² National Academies of Sciences, Engineering, and Medicine. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. 2021. Accessible online at <https://nam.edu/publications/the-future-of-nursing-2020-2030/>.

³ Ibid.

We encourage PTAC to consider broadly how innovative payment models for clinical care can address SDoH and reduce health inequities. As discussed more below, PTAC's review should center on payment models that compensate team-based care, support nurse leadership to identify patients' health-related social needs, and coordinate appropriate health-related social services. In response to questions posed in PTAC's request for public input, our comments below address:

1. **Collection and Use of Social-Needs and Equity-Related Data (Questions 1-3);**
2. **Barriers to Collecting, Using, and Sharing Data (Question 4);**
3. **Selected Nurse-Led Model Profiles (Questions 6 and 11);**
4. **Investments Needed (Question 7):**
5. **Quality and Performance Measurement (Question 10); and**
6. **Other considerations (Question 11)**

1. **Collection and Use of Social-Needs and Equity-Related Data (Questions No. 1-3)**

Medicare can play a significant role, through payment strategies, to ensure that clinicians are using state-of-the-art information tools and have incentives to adopt improvements as they come online. Much of the automated data currently used in health care is not sufficient to support models that aim to address SDoH and reduce disparities. For instance, although ICD-10 codes have been expanded to account for SDoH, there is more work to be done to develop useful codes and encourage uniform use.⁴ This will create expanded possibilities for innovation, more streamlining of documentation, better system utilization, and data mining to find broader insights needed to reduce disparities.

In the meantime, providers and health care practices should be encouraged optimizing tools available to identify, document, and address social needs in Medicare subpopulations. Data and data strategies should follow seamless patient-centered care that accounts for social needs and links individuals with resources in their communities that will optimize their outcomes.

Social Needs Data. Information appropriate for assessing health-related social needs of Medicare patients includes (but is not limited to) housing status and factors such as caregivers and dependents in the home; utilities; access to nutritious food; personal safety and risk of violence or neglect; transportation; language/literacy; access and proficiency with digital tools; eligibility for federal and state assistance such as Supplemental Security Income (SSI), Supplemental Nutrition Assistance (SNAP), senior housing, Medicaid benefits, and community behavioral health.

Equity-related data. Information to support understanding and efforts to improve health equity in the Medicare population includes (but is not limited to) gender, age, LGBTQ identification, race, ethnicity, disability, income and employment, past insurance status and regular source of care, rurality, and history of justice involvement. Practice leaders with high volumes may be able to analyze review this information, and establish benchmarks in comparison to the community at large.⁵ Driving population

⁴ See Foley, Margaret, PhD, RHIA, CCS. Improving ICD-10-CM Coding for Social Determinants of Health. Journal of the American Health Information Management Association. April 2021. Accessible online at <https://journal.ahima.org/improving-icd-10-cm-coding-for-social-determinants-of-health/>

⁵ Some sources of population level SDoH are: State Health Facts, <https://www.kff.org/statedata/>; County Health Rankings, <https://www.countyhealthrankings.org/>

outcomes at higher levels, for instance in defined Medicare subpopulations, will require coordinated federal efforts to collect and analyze relevant data sets.

Clinical and Supportive Roles. Effective care models build in practice capacity for assessment and care coordination that drives to high-value outcomes, accounting for SDoH. Team-based care is demonstrated to be effective for higher risk populations.⁶ Nurses are central to organizing and supporting the patient’s health care experience, among diverse populations and across care settings. Their care coordination decisions contribute to successful outcomes and increase efficiency, thereby enhancing the value of care. Registered nurses are a vital part of any effort to design, implement, and evaluate care coordination systems within and among institutions, organizations, and communities.⁷ Along with a Nurse Care Manager (NCM) or other qualified staff who coordinates within the practice and externally as needed, practices should consider engaging a community health advocate/specialist who is familiar with community-based referral sources and is skilled at finding and securing available services.

Meaningful approaches to addressing Medicare disparities must align payment incentives according to how care is delivered and by whom. Skilled clinicians such as RNs and advanced practice registered nurses (APRNs) should be eligible to participate in, and benefit from, incentive payment programs designed to address SDoH. The structure of new and existing value-based payment models should be reviewed and amended if necessary to reward all clinicians who contribute to desired outcomes. PTAC is in a good position to recommend any policy changes needed to refine payment models in this way.

Best Practices and Protocols. Care models that account for SDoH generally need to be structured as a collaboration among clinicians, organizations, and local agencies. One important component is information technology that is dynamic, patient-centered, adaptable, and user-friendly within the care group. Dynamic electronic health records (EHRs) have customized fields, allowing for comprehensive assessment, referral records, and follow-up flags, among other features. Care managers, care coordinators, and supportive personnel should have adequate training to maximize the usefulness of relevant EHR tools. In the absence of full, secure interoperability, these staff should be empowered to develop strategies for external sharing of key information to document care, progress, and outcomes. In addition, practice leaders should embrace narrative forms of reporting and anecdotal accounts to strengthen community networks and potentially attract non-Medicare funding as appropriate, to enhance care. ANA acknowledges that upfront investments in clinician operations may be needed to equip practices with appropriate IT. PTAC could recommend federal payment strategies that accelerate deployment of standardized health IT that accounts for SDoH across care settings.

2. Barriers to Collecting, Using, and Sharing Data (Question No. 4)

In addition to IT-related challenges and deficiencies which may exist at the practice level, ANA has heard from nurses and other stakeholders that work culture, prioritization, and internal constraints may create

⁶ See Hardin, L. et al. Cross-sector collaboration for vulnerable populations reduces utilization and strengthens community partnerships. *Journal of Interprofessional Education and Practice*. October 2019. Accessible online at <https://doi.org/10.1016/j.xjep.2019.100291>

⁷ American Nurse Association (ANA). The Essential Role of Registered Nurses in Care Coordination. Position Statement. February 2021. Accessible in summary at <https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/care-coordination-and-registered-nurses-essential-role/>.

barriers to collecting, using and sharing SDoH-related data. Time itself is often the most formidable barrier. It takes time to develop the trusted patient relationship for which nurses are known, so that the patient is comfortable divulging personal information about their health-related social needs. In this connection, adequate training and realistic policies to protect patient privacy are needed, so that health information can be timely and appropriately shared. Protocols and processes should build in time and staff capacity for pre-visit record review and care.

3. Nurse-Led and Team-Based Model Profiles (Questions 6 and 11)

Below are a few examples of care models that utilize teams or nurse leadership in Medicare or care of older persons. It should be noted that replicating some of these approaches at scale in Medicare might require federal and state policy changes to allow nurses to practice to the full extent of their education and training.

Nurse-Led and Team-Based Transitional Care. Post-hospital home care is planned and led shortly after admission by an APRN who engages with patients, family, and providers to optimize communication and patient education and avoid the need for post-acute skilled nursing. Compared to standard care, the **Transitional Care Model** has demonstrated better outcomes on re-hospitalization measures, as well as patient satisfaction. One four-year study of patients with heart failure demonstrated an average cost savings of around \$5,000 per patient.⁸

Trinity Health System in Grand Rapids, MI, created its **Complex Care Center** for emergency departments (EDs) to link patients and providers to appropriate support. A customized EHR tool flags potential needs and alerts users to the existence of community-based providers and collaborative care opportunities. Evaluations showed decreased needs for ED and hospital care, and significant cost improvements. For instance, inpatient/observation admissions decreased by 34 percent in the intervention population over a one-year period. Total direct expenses for this group decreased from \$7.1 million pre-intervention to \$4.2 million post-intervention.⁹

The Missouri Quality Intervention (**MOQI**) Model was funded by CMS to reduce hospitalizations from nursing homes. Led by an on-site APRN, MOQI provides direct care to residents and trains facility staff on tools to improve early assessment and intervention when residents' conditions change. One study of the MOQI model with 11 facilities over five years documented \$32 million in savings from reduced hospitalizations.¹⁰

An example of coordinated care led by an NCM is **Senior ASSIST**, profiled as an Edge Runner exemplar by the American Academy of Nursing (AAN). A geriatric-trained NCM provides in-home assessments and

⁸ American Academy of Nursing (AAN). Making Transitional Care More Effective and Efficient. Edge Runners Profile. Accessible online at <https://www.aannet.org/initiatives/edge-runners/profiles/edge-runners--making-transitional-care-more-effective---efficient>; see also Transitional Care Model. University of Pennsylvania School of Nursing. Accessible online at <https://www.nursing.upenn.edu/ncth/transitional-care-model/>

⁹ AAN. Complex Care Center. Edge Runners Profile. Accessible online at <https://www.aannet.org/initiatives/edge-runners/profiles/edge-runners--complex-care-center>

¹⁰ Rantz, Marilyn, PhD, RN, FAAN et al. Better Care, Better Quality: Reducing Avoidable Hospitalizations of Nursing Home Residents. Journal of Nursing Care Quality. 2015. Available online at <https://agingmo.com/wp-content/uploads/2017/10/JNCQ-MOQI-Reducing-Hosp-304-2015.pdf>. See also University of Missouri Sinclair School of Nursing. MOQI and related items. Accessible online at <https://nursinghomehelp.org/articlecategory/moqi-initiative/>

follow-up care, educating patients in safe medication use, home safety, nutrition, etc. The NCM shares information about the patient's condition with a physician, and links patients to community supports as needed. The program has demonstrated high patient satisfaction, with 91 percent saying they believe their health was improving; and high clinician satisfaction, with 80 percent of physicians saying patient self-care-management improved. In a separate study, clinical health indicators were shown to improve, and decreases in ED and hospital use were documented.¹¹

The American Academy of Nursing (AAN), through its **Edge Runners** initiative, supports and recognizes nurse-led innovation in health care delivery.¹² The Edge Runner project profiles are an excellent evidence base of models and tools for improving care and costs through nursing skill and capacity.

4. Investments Needed (Question 7)

Practices seeking to address meaningfully the health-related social needs of Medicare patients need resources in the form of upfront and ongoing investments in dynamic health IT. Practices must also build capacity to coordinate care through team approaches, as well as operating resources to support teams.

5. Quality and Performance Measurement (Question 10)

In measuring health outcomes and the impacts of services for SDoH, providers and payers should consider and select relevant patient-reported outcomes. Additionally, key process measures that account for care management and coordination are useful to hold practices accountable for addressing patients' health-related social needs. These measures include timely SDoH assessments and regular follow up for higher risk patients. Immunization and preventive services should be measured for clinical quality and included for value-based payment.

Payers and policymakers should commit to ongoing development and refinement of appropriate nurse-sensitive quality and performance measures so that the direct impacts of nursing care in SDoH models are considered in new SDoH and equity models. The Measures Applications Partnership (MAP) of the National Quality Forum has convened a Health Equity Advisory Group that will inform Medicare decisionmakers on measuring progress on SDoH. ANA is participating in this process with technical expertise and policy perspective.

6. Other Questions (Question 11)

In the request for input, PTAC invites comments on "other important questions that remain unanswered relating to the incorporation of efforts to address SDoH and equity" in new Medicare physician payment models.

ANA recommends PTAC consider the impact of telehealth and digital health trends on strategies to address SDoH in Medicare. The tremendous increase in access to telehealth in recent years, with Medicare payment flexibilities and other reforms, must be assessed in the context of SDoH. Models should allow for individual patient access to telehealth tools as an option, while ensuring in-person care if the patient prefers. Further, payment models should recognize the value of all clinicians who provide or support telehealth care. More broadly, policymakers should assess ways to leverage telehealth to

¹¹ AAN. Senior ASSIST: Bridging a Gap in Services for the Community Dwelling Elderly. Accessible online at <https://www.aannet.org/initiatives/edge-runners/profiles/edge-runners--senior-assist>

¹² AAN. Edge Runners. Accessible online at <https://www.aannet.org/initiatives/edge-runners/profiles>.

reduce disparities, while monitoring and responding to signals that expanded telehealth is exacerbating existing inequities.

ANA also encourages PTAC to consider implications of Medicare SDoH models for Medicare beneficiaries under age 65 with disabilities. This group makes up around 15 percent of the Medicare population, and is also diverse in health and health-related social needs. PTAC and other policymakers should articulate how proposed models would meet these beneficiaries' identified needs and preferences, based on engagement with stakeholders.

ANA is the premier organization representing the interests of the nation's 4.3 million registered nurses (RNs) through its state and constituent member associations, organizational affiliates, and the individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on healthcare issues that affect nurses and the public. RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four APRN roles: nurse practitioner, certified nurse midwife, clinical nurse specialist, and certified registered nurse anesthetist.¹³ ANA is dedicated to partnering with health care consumers to improve practice, policies, delivery models, outcomes, and access across the health care continuum.

If you have any questions, please contact Ingrida Lusic, Vice President for Policy and Government Affairs, at Ingrid.Lusic@ana.org or (301) 628-5081.

Sincerely,



Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer / EVP

cc: Ernest Grant, PhD, RN, FAAN, ANA President
Loessa Cole, DNP, MBA, RN, NEA-BC, FACHE, FAAN, ANA Chief Executive Officer

¹³The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.



Ascension

Jeffrey Bailet, MD
Chair
Physician-focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation (ASPE)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

October 18, 2021

Submitted via Email: PTAC@HHS.gov

Re: Request for Public Input on PTAC's review of Social Determinants of Health (SDOH) and Equity, and Physician-Focused Payment Models (PFPMs)

Dear Dr. Bailet:

Ascension appreciates the opportunity to submit comments on the *Request for Public Input on PTAC's review of Social Determinants of Health and Equity, and Physician-Focused Payment Models (PFPMs)*.¹

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. As one of the leading non-profit and Catholic health systems in the U.S., Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. In FY2021, Ascension provided \$2.3 billion in care of persons living in poverty and other community benefit programs. Ascension includes more than 150,000 associates and 40,000 aligned providers. The national health system operates more than 2,600 sites of care – including 142 hospitals and more than 40 senior living facilities – in 19 states and the District of Columbia, while providing a variety of services including clinical and network services, venture capital investing, investment management, biomedical engineering, facilities management, risk management, and contracting through Ascension's own group purchasing organization.

We appreciate the opportunity to provide comments to the PTAC as the Committee works to gather and use 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 Alternative Payment Models (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.

From the beginning of our ministry, Ascension has been wholly committed to serving all persons, with special attention to those who are poor and vulnerable, and to improving the health and well-being of our communities. In advancing health equity for the persons we serve, Ascension's vision is that every person receiving care has the opportunity to attain his or her full health potential, while no one is

¹ aspe.hhs.gov/sites/default/files/documents/0e4b049b4d034b3274ee1d7d08a1ab27/SDOHandEquity-RFI.pdf

disadvantaged from achieving this potential because of race, ethnicity, culture, religion, socioeconomic status, healthcare access, or other socially-determined circumstances. We understand that achieving health equity requires eliminating unjust barriers to the normal range of health opportunities, which can be environmental, social, financial, as well as barriers endemic to the healthcare system itself. Achieving health equity thus requires valuing everyone equally, with focused and ongoing efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. We also understand that achieving an equitable healthy community requires a systematic and collaborative approach.

Our long-standing and relentless commitment to enabling our patients to achieve health equity focuses in several areas, including:

- Identifying and eliminating disparities in health outcomes (due to race, ethnicity, religion, language preference, place of residence, insurance status, or income) and removing gaps in care;
- Strengthening our workforce by equipping all of our associates, including an engaged core of nurses, physicians and advanced care clinicians, with tools to competently and compassionately serve our diverse populations;
- Strengthening our Community Health Ministry to serve our persons where they live, work and, play, and collaborating with like-minded partners to provide care needs;
- Advocating for quality and affordable access to healthcare and therapeutics for all persons we serve; and
- **Fostering a culture of diversity and inclusion across all areas of our ministry that enriches our leadership, governance, associates, and diversity of suppliers – reflecting the communities we serve.** This includes launching, within the past year, a new justice-focused framework called ABIDE, which is built upon the hallmarks of Appreciation – Belongingness – Inclusivity – Diversity – Equity.² Our commitment is to Listen–Pray–Learn–Act on matters of disparities and inequities.

In recent years, Ascension has undertaken a systemwide effort to make healthcare more equitable. Ascension’s leadership has called on all our sites of care to establish national goals around healthcare equity and to reduce disparities. We believe that improving health equity involves addressing the societal risk factors that have an impact on vulnerable populations’ health. To achieve these goals, Ascension convened health equity forums, attended by hundreds of our system and facility leaders. The conclaves were used to further leaders’ understanding of variables driving health inequity and to develop strategies. Out of our work, a five-pronged strategy was developed that includes:

- Establishing health equity as a strategic priority for all of Ascension’s care sites, including hospitals, long-term care facilities, and outpatient locations;
- Putting in place structures and processes to ensure that Ascension facilities can collect and use patient demographic and socioeconomic data **in a standardized way**—including the collection of patient race, ethnicity, and language data system wide;
- Deploying specific strategies including clinical improvement initiatives that address social risk factors related to health;
- Decreasing the implicit bias that staff may have when delivering care, such as misunderstandings that may arise when patient and caregiver do not speak the same language, or have different ethnicities or belief systems; and
- Partnering with community organizations to improve health and health equity.

² Additional information can be found at: <https://www.ascension.org/Our-Mission/diversity-and-inclusion>

As PTAC recognizes, in vulnerable communities, even if quality care is available, social and economic factors often prevent individuals from being able to obtain healthcare services or achieve health goals. These can include: food security; housing; employment and income/poverty level; domestic and community violence; crime/public safety; environment (*e.g.*, clean water and air); healthy workplaces, schools, and transportation; literacy, educational attainment, and early childhood development; and social cohesion or civic engagement. While there are many ways providers work to help address the underlying social conditions affecting their patients' health, the American Hospital Association has identified three general paths – which may provide a guide for considering how best to support providers working to address risk factors among patients:

- *Screening and information*: Providers systematically screen patients, either remotely or in person, for health-related social needs and discuss with patients the impact this may have on their health.
- *Navigation*: Providers offer navigation services to assist patients in accessing community services.
- *Alignment*: Providers partner with community stakeholders to align local services more closely with the needs of patients.

Among other things, PTAC solicits input on 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. It is critical for Ascension that our providers are able to uniformly assess and identify potential social risk factors among all patients – including Medicare beneficiaries – using one “language” or approach, because patients are not defined merely by their coverage status, insurance carrier, or APM attribution. We have found that standardization is vital to our success in driving towards health equity, as it will foster the development and sharing of best practices within and among clinical settings, health systems, and delivery designs. Today, however, we must navigate and seek commonalities across differing assessment standards that have been implemented across the myriad programs and sites of care that exist today. We therefore strongly encourage PTAC to focus its efforts on driving toward standardization of data capture and measurement, leveraging resources currently available and accessible to providers, and streamlining administrative burden across value-based programs.

The Agency for Healthcare Research and Quality (AHRQ) has also found that “[o]ne of the biggest barriers most health systems face in improving quality and reducing disparities within their own walls is systematically identifying the populations they serve, addressing the needs of these populations, and monitoring improvements over time.”³ AHRQ further found that the principal challenges in obtaining race, ethnicity, and language data for use in quality improvement assessments include **a lack of standardization and understanding of why the data are being collected**.⁴ And as key thought leaders have recently articulated, “while essential, vigilance and evaluation alone are insufficient for achieving greater equity. The idea that disparities are ‘unintended’ consequences of payment policy must be abandoned, and instead, an **explicit new intention and goal must be set to reduce disparities through payment programs**.”⁵

³AHRQ, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, Introduction* (April 2018), at: <https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldata1.html>

⁴ *Id.*

⁵ Liao JM, Lavizzo-Mourey RJ, Navathe AS. *A National Goal to Advance Health Equity Through Value-Based Payment*. JAMA. Published online June 04, 2021. doi:10.1001/jama.2021.8562.

Beyond the challenges around data and definitional standardization, and understanding of needs and availability of best practices, there also remains a need for one single tool that can be scaled across multiple practices, states, and models. While some helpful tools have emerged in recent years and prove helpful for certain practices or in certain care delivery models, like the *Accountable Health Communities Health-Related Social Needs Screening Tool*⁶, our practitioners found themselves hindered by a relative lack of widely available, cross-cutting, best practice screening tools. Our long-term goal is to develop one screening tool that can be used across the enterprise, which will allow us to better identify patient needs as they arise, identify and predict trends across the country, and strategically utilize resources at a national level or through community partners with whom we can engage to best address our patients' needs. As we move in this direction, we encourage PTAC to also consider ways to both support this and similarly innovative tools, as well as to better align various models' screening and assessment requirements to create greater consistency.

PTAC also solicits input on 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). We strongly encourage PTAC to evaluate opportunities for better leveraging and promoting uptake of the ICD-10 "Z" codes referenced by PTAC, which identify non-medical factors that may influence a patient's health status. Existing Z codes identify issues related to a patient's socioeconomic situation, including education and literacy, employment, housing, lack of adequate food or water, or occupational exposure to risk factors like dust, radiation, or toxic agents. PTAC should consider updating and promoting existing agency recommendations about how SDOH Z-codes can be utilized to improve outcomes.⁷ PTAC should also consider utilizing data from self-reporting via portal questionnaires. We would also encourage PTAC -- as we have encouraged CMS -- to consider opportunities to support education for beneficiaries on the need to share information that is often sensitive and highly personal, as well as for providers on the availability and utility of existing billing codes. PTAC could offer such education while developing additional codes for social needs care that could be made available across Medicare, Medicaid, and private insurance providers, as need is identified. This approach would help to incentivize increased and improved screening and data collection, which can in turn facilitate referrals for social service supports.

As PTAC looks to collect, use, and measure the impact of activities arising out of data related to SDOH and health equity, we encourage PTAC to consider promoting the use of actionable and readily available data that might seem otherwise routine; in fact, one opportunity for strategically changing inequities upstream can start by finding the geographic distribution of health, particularly the life expectancy by zip code. This information demonstrates the power of geography in determining health outcomes as well as conveying the unfair nature of the distribution of health. Measuring and stratifying by zip code will identify geographic disparities but also provide an avenue for location-based approaches to reducing inequities in health outcomes. Other recent recommendations suggest that "existing performance measures could also be used not only to measure how clinicians perform overall, but how they perform for marginalized patients. Early candidates for this use could include measures that capture conditions and areas of care where both clinicians can influence outcomes and marginalized patients face well-known disparities (e.g., hypertension and cancer screening). Using this approach. . . could also guide efforts to link equity-based measures to risk adjustment, incentives, and other components of payment programs."⁸

⁶ Available at: <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>

⁷ <https://www.cms.gov/files/document/zcodes-infographic.pdf>

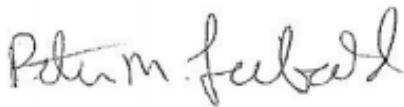
⁸ Liao, et al., at E2.

Finally, as PTAC advances efforts to improve health equity through APMs, PFPs, and other models, we again note that *achieving* an equitably healthy community requires a systematic and collaborative approach. Helping patients navigate community organizations and social services that can address the social risk factors impacting health access and outcomes is a key aspect of achieving health equity. Systems and entities that are effectively addressing barriers to good health often employ care navigators or health access workers who work with low income and/or uninsured populations to connect them with the organizations and resources they need to improve health and well-being -- whether health insurance, transportation, medication, or otherwise. One of the publicly available resources that our providers have found useful is Aunt Bertha⁹. Aunt Bertha is the largest closed loop referral network in the United States. The service allows consumers, patients, and providers to search for free and reduced-cost social services based on zip code. Individuals seeking information and referrals can search the Aunt Bertha database of verified programs at no cost and from a variety of platforms. Facilitating further use of Aunt Bertha by providers and consumers will be an additional step in the right direction. Gathering and sharing of best practices across providers, programs, and payors is another valuable service PTAC can provide. If Ascension can be helpful in such gathering and sharing, we stand ready to serve.

Conclusion

We appreciate your consideration of these comments. If you have any questions, or if there is any additional information we can provide, please contact Mark Hayes, Senior Vice President for Policy and Advocacy for Ascension, at 202-898-4683 or mark.hayes@ascension.org.

Sincerely,

A handwritten signature in cursive script that reads "Peter M. Leibold".

Peter M. Leibold
Executive Vice President and Chief Advocacy Officer
Ascension

⁹ <https://www.auntbertha.com/>



October 18, 2021

Submitted via email at PTAC@HHS.gov

Dr. Jeffrey Bailet
Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Request for Information (RFI) on Informing PTAC's Review of Social Determinants of Health and Equity, and PFPs:

Dear Chair Bailet:

Thank you for the opportunity to provide comment on the PTAC's Social Determinants of Health and Equity and Physician-Focused Payment Models (PFPs) Request for Information (RFI). We welcome the opportunity to share our view on how alternative payment models (APMs) can play a role in addressing social determinants of health and in optimizing health care delivery.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care physician market. We believe that it is impossible to achieve truly value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians, California Medical Association, Florida Medical Association, and Medical Group Management Association. We also have individual and small medical group supporters across the country, many of whom are independent physicians or practices and wish to remain so.

Our members believe that independent physicians and practices are well-positioned to continue to lead the value-based care movement, achieving superior results in value-based care models through their commitment to improving outcomes and reducing costs. For many practices and physicians, a key part of value-based care is addressing social determinants of health. Independent practices and physicians are often integral parts of their communities. Identifying and addressing unmet needs is part of the longitudinal patient-physician relationship and is made possible through non-utilization based reimbursement models that allow providers to spend time with their patients, assessing their needs and connecting them to services even when there isn't a specific code to bill for doing so.

To address social determinants of health through APMs and PFPs, federal and state policymakers must: 1) standardize data collection for social determinants of health indicators; 2) encourage physicians and practices to adopt value-based care models which inherently give more incentives for physicians to incorporate social determinants of health into their practices; 3) adopt more holistic measures of model success that incorporate the social determinants of health; and 4) develop value-based care models that meet the needs of small practices and underserved groups.

Additional specific comments on Questions 4, 9, 10, and 12 can be found below.

SPECIFIC COMMENTS

Question 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?

To effectively implement programs that address social determinants of health, providers have to understand the needs of the communities they are serving. Some physicians – including many that participate in value-based care models --- are already screening for social determinants of health indicators. However, it is often not physicians’ primary area of expertise. Further, the process for identifying and assessing these needs can be burdensome and is not standardized across providers. It can also be difficult for practices from a resource and staffing perspective.

Additionally, not all EHR platforms are equipped to screen for social needs data. Some have screening capabilities, but providers report the questions may be insufficient. Other times EHR platforms may not be equipped at all for social determinants of health screening, forcing providers to resort to paper collection methods or other digital platforms. This creates problems both from an administrative and privacy standpoint.

Federal policymakers should invest in comprehensive social determinants of health data collection. Data elements used for race, ethnicity, primary language, gender identity, sexual orientation, income status, and other characteristics should be standardized to address disparities in a systematic way throughout the health care system. Physician practices should also be reimbursed to increase intake of these additional screenings which will be critical to addressing social determinants of health; this can be done through value-based payment mechanisms.

Once data has been collected and standardized, data should be used and leveraged to best serve beneficiaries. Web-based platforms that help link individuals to services can be key to making sure beneficiaries receive the services they need that physician practices cannot provide.

Question 9: What role have APMs played in incentivizing activities related to addressing SDOH and advancing equity?

- a. What services related to addressing SDOH and advancing health equity have received reimbursement under value-based payment models?**
- b. What payment methodologies have been most effective in incentivizing efforts to address SDOH and equity, particularly for high-risk patient populations?**

Value-based care allows for more flexibility to make the needed upstream investments in social determinants of health. Social and environmental factors account for at least 20 percent of premature deaths in the United States¹. Physicians need to know how to identify and address social determinants of health to be successful in promoting positive health outcomes for individuals and populations. Traditional fee-for-service payment methodologies do not pay for or support the needed care coordination and investment in community social needs needed to address the social determinants of health. Value-based care provides a critical opportunity to do this, as it creates the incentive structures for physicians to invest in upstream care and in increased care coordination with medical and non-medical providers. It also incentivizes payers and physicians to proactively identify the social risk factors and unmet social needs that pose a barrier or threat to an individual’s health.

¹ <https://www.healthaffairs.org/doi/10.1377/hblog20171025.721263/full/>

However, some patients will have more needs, both medical and social, and will incur higher costs to the practice. As a result, developing an adequate risk-based payment adjustment is necessary to encourage physicians serving vulnerable groups to participate in value-based care models. Existing risk adjustment methodologies do not fully account for social needs, leaving physician practices to be unfairly penalized for taking on the most at-risk patients.

Question 10a: 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?

Federal policymakers should adopt more holistic evaluation of model success to include the social determinants of health. Including metrics related to quality, access, and equity would be beneficial in aligning metrics/incentives in multi-payer models tailored to underserved or vulnerable communities.

Addressing social risk factors, as mentioned above, should be incorporated as important factors for model success, even if improvements aren't linked to lower costs. Often, these types of interventions lead to preventive care and downstream savings, which may or may not be considered during formal model evaluations. We believe that policymakers should take a holistic approach in measuring the full range of benefits realized by payment and delivery system reform models.

Question 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?

We believe physicians are best positioned to drive delivery system transformation. Physicians – especially independent physician practices – are the lynch pin of our nation's health care system. They have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. They are the most powerful tool we have to foster an affordable, accessible system that puts patients first and play a critical role in addressing social determinants of health and value-based transformation.

We encourage APMS to be accessible to a wide range of physicians, including physicians choosing to remain independent. The physician workforce is not homogenous. Instead, there are physicians in large practices and small practices, in rural and urban settings, in a variety of different employment arrangements. CMS should consider the unique circumstances of physicians in independent practice when developing models, ensuring that there are options available for this cohort of the workforce and recognizing that models that are appropriate for large hospital-led groups and/or large physician practices may not be appropriate for all.

This is good not only for physicians, but also for patients. We believe that the primary care physician-patient relationship is most powerful when there is patient choice and provider competition within local markets. Having trust between physician and patient is critical for addressing disparities. To build on this trust, we encourage federal policymakers to more intentionally design models from the beginning for underserved communities. Traditional APMs have been focused on Medicare, and changing some aspects to fit the needs of Medicaid and safety-net providers can make the difference between someone accessing the care they need and delaying it indefinitely. Furthermore, models should be tested all across the country and in different communities to make sure they meet the needs of all Americans.

* * * * *



Thank you for the opportunity to comment on the RFI. Please do not hesitate to reach out to me if the Partnership to Empower Physician-Led Care can be a resource to you. I can be reached at kristen@physiciansforvalue.org or 202-640-5942.

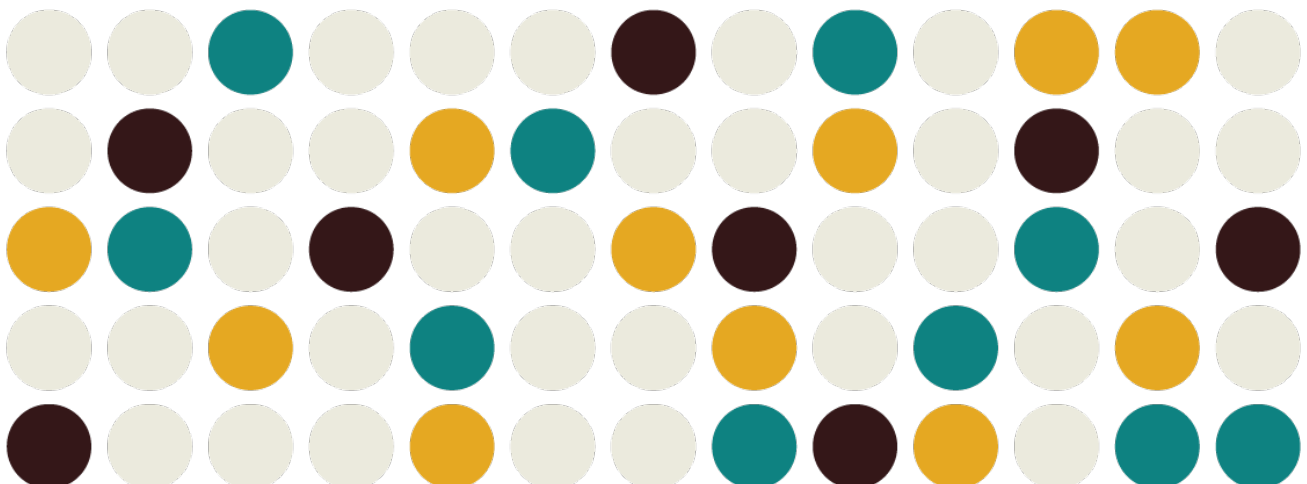
Sincerely,

Kristen McGovern
Executive Director

Response to the Physician-Focused Payment Model Technical Advisory Committee Request for Information

Informing PTAC's Review of Social Determinants of Health and Equity, and
Physician-Focused Payment Models

October 18, 2021





Response to PTAC SDOH and Equity RFI

Founded in 2010, Aunt Bertha, a Public Benefit Corporation runs the largest Social Care Network in the United States and has served more than seven million Americans. Our mission is to connect all people in need with the programs that serve them with dignity and ease. As part of fulfilling this mission, we will always maintain findhelp.org, a free and anonymous search tool for identifying free and reduced cost programs in every U.S. ZIP Code. Our network is used by over 250 health systems, health plans, community health centers, and health departments in the United States to manage social care referrals, as well as tens of thousands of Community Based Organizations (CBOs).

We appreciate the opportunity to respond to the Physician-Focused Payment Model Technical Advisory Committee's (PTAC) request for information regarding the social determinants of health and equity, and physician-focused payment models (PFPMs).

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?

Understanding patients' social care needs across many domains is critical for improving health outcomes. Ten years ago we developed a social services [taxonomy](#) - a simple way to categorize human services and human situations. By collecting data on social needs using standardized categories, we are able to better understand underlying population needs. These social needs data - when paired with health, demographic, and other data - can help providers holistically address the nuanced needs of the communities they are serving.

The Social Care Record is comprised of hundreds of data elements including social risk, needs, services, notes, documents, referrals, connections, cases and more. We support data collection with strict permission-based access and privacy policies to support optimizing value based care.

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?

A wide array of data elements are relevant to intentionally address health equity, including socioeconomic data, county-level policy data, income data, lifespan data, and more. At present, many available data elements are not systematically used to inform state-level policy. For example, our data could be leveraged to better understand the services people are seeking,



identify gaps in need relative to availability of services, and inform strategic intervention and funding to address social determinants of health. During the COVID-19 pandemic, our search data illustrated in real-time how the absolute need for social care services increased, and how the relative needs for services, such as food, health care, and housing, shifted. We believe there is extraordinary potential to use this data to address needs, and to be more responsive to changing needs in real time.

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?

Across Providers: There are many systems of record (e.g., EHRs, case management systems, social care referral platforms, population health platforms) used to assess and store information related to social risk and social needs. Vendors need to agree to ‘rules of the road.’ What information should be shared to allow for the best care of the patient while respecting their privacy? Once that set of data is outlined, vendors need to agree (as they did with the Consolidated Clinical Document Architecture (CCDA)) how the information is formatted and what standards are used. Vendors also need to ensure there is a way to view and store that data.

Provider and Community-Based Organizations (CBOs): CBO’s are often already on a system of record, and we need to strive to minimize the burden for CBOs. CBOs should not have to go to more than one place to check for referrals. This is especially important when there are providers with different EHRs sending referrals to a single CBO. These organizations typically do not have the time or capacity to check in multiple systems.

In addition to standardizing what information gets sent to a CBO, there needs to be standardization around what information should be sent back to providers. There are different types of outcome responses - simple vs. complex response (got help vs. patient received 3 weeks of food) - that need to be considered.

CBO Choice: CBOs should be able to choose a preferred system of record that respects their mission, privacy requirements, regulatory requirements, reporting, and obligations to funders. “State Run” platforms that force CBOs to use a specific tool is a monopolistic approach that hurts nonprofits and limits adoption. We should support integration and interoperability with CBO systems - not force behavior that only serves an industry.

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?

Data Privacy: There are inadequate consumer privacy protections governing the way data is shared with third-parties to support care coordination. Social care referrals are fundamentally different from referrals in health care. An individual’s referral for assistance to leave an abusive relationship should not, by default, be shared with everyone in a broad network of healthcare and social service providers.



We believe in a per-referral consent model, in which CBOs access referrals based on their coordination of care responsibilities and referrals remain private, with individuals having the choice to opt-in to share their personal information with each referral.

To help protect each person and their private information, we recommend PHI only be disclosed according to the following requirements:

- The PHI disclosure is relevant and necessary for the social service provider to receive an application, determine eligibility, act on a referral or service request, and otherwise provide appropriate services to a patient.
- At time of disclosure, the covered entity reminds the patient that their PHI information will be disclosed to a specific entity for the purposes of care coordination.
- The PHI disclosure is only made to the defined provider or network of specified providers that are identifiable and available to the person and do not change.
- PHI should never be disclosed to:
 - an unidentifiable and unspecified network of entities,
 - a dynamically changing network of entities, or
 - a network whereby such unknown entities can own or control re-disclosure of the PHI.

Data Standards: While there are a number of standardized assessment tools (e.g., PRAPARE) that organizations adopt to identify social needs, some choose to customize these or create their own. This is beneficial to those organizations because it allows for collection of more specific or nuanced data elements. However, it makes exchanging information across organizations challenging because there are no existing standards that align assessment results with code sets (e.g., ICD-10, SNOMED). In addition to assessment data, there is also a need to standardize referral outcomes - both simple (e.g., got help, did not get help, not eligible) and more complex outcomes (e.g., received 3 lbs of food, attended two hours of nutrition classes).

While there are ongoing standardization initiatives, such as the Gravity Project, the question is - who should be the long term steward of all social care related data elements?

5. Are there any potential unintended consequences related to collecting, using, and/or sharing SDOH- and equity-related data?

Social needs assessments collect information about a person who may be in a vulnerable situation. A patient may provide answers that they only want shared with a limited number of people. Due to the sensitive nature of this information, there needs to be the ability to control permissions around who can and cannot see assessment answers. While sharing this information is important for longitudinal care management, protecting people’s privacy is critical if organizations are to have their trust and be able to help. Automatic assessment results sharing should not be the assumption.

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?



At Aunt Bertha, we provide a platform that allows healthcare entities to collect social care needs data. They pair the social needs data with electronic health record systems and/or population health platforms, providing valuable insights into correlations between social care interventions and improved health outcomes, through a lens of health equity.

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?

Funding can come from government sources through waivers and grants, from healthcare entities (such as health care systems and payers), and from philanthropy. We need to use all of these streams for success, and we need to allow flexibility in existing funding streams to encourage innovation.

When thinking about investments to address social needs, we need to make sure we think outside of healthcare. Addressing social needs is not a single industry's problem. The best way to make the biggest impact with investment is to do so across sectors, in a way that recognizes the varied ways individuals interact with an array of services and systems to meet their health-related social needs. Each patient the health system takes care of could be a student at the local community college, a parent with children in the local school district, a resident of a subsidized housing unit, or a recipient of SNAP benefits. We need to see workforce, education, healthcare, and other industries come together to create a more sustainable, effective, and efficient social care ecosystem.

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?

We work with a number of payers, health care providers, and government entities that are directly investing in social care. They are spending dollars on social care. In some cases they are ordering these goods and services (such as home delivered meals, home modifications, and housing support) from CBOs or they're paying commercial vendors for certain services (such as pest control) that aren't commonly provided by CBOs.

Submitted on behalf of Aunt Bertha, a Public Benefit Corporation

From: Suzie Bechtol <sbechtol@211sandiego.org>

Sent: Monday, October 18, 2021 6:21 PM

To: PTAC (OS/ASPE) <PTAC@hhs.gov>

Cc: Karis Grounds <kgrounds@211sandiego.org>; Beth Johnson <bjohnson@211sandiego.org>

Subject: RFI Response: Informing PTAC's Review of Social Determinants of Health and Equity, and PFPMs

Good Afternoon –

We thank you for the opportunity to respond to this Request for Information (RFI).

Please see attached for our RFI responses. 211 answered the questions most relevant to our work as a Community-Based Organization (CBO). The questions we answered are highlighted in yellow and the answers are in BOLD.

211 San Diego serves as the steward for San Diego's [Community Information Exchange \(CIE\)](#). The CIE is not a member of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) but rather an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make bi-directional referrals to create a shared longitudinal record. By focusing on these core components, a CIE enables communities to shift away from a reactive approach to providing care toward proactive, holistic, person-centered care.

Here is a link to the CIE toolkit that details how to build a CIE in a community: <https://ciesandiego.org/toolkit/>

Here is a link to a listing of articles that reference CIE and its utilization here in San Diego: <https://ciesandiego.org/latest-news/>

Again, we thank you for this opportunity and would be more than happy to expand on any of the information provided.

Have a wonderful afternoon.

Best,

Suzie

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?
 - a. 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?
 - b. 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?
 - a. 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?

Healthcare providers can effectively share SDOH by leveraging local Community Information Exchanges that are inclusive of both bidirectional referral information, SDOH screening information and other care coordination information. This also includes having technology infrastructure that supports community-based organizations existing record management systems through interoperable technology solutions that are led by local collective impact organizations within the community. This will ensure local equity-related data elements are included based on the needs of the individuals being served.

- a. 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?

Some examples of incentives that have been successful include, reimbursement for SDOH services, requirements by Medicaid in contracting and procurements, including SDOH and CBO partnerships in quality metrics. To address elements of equity, ensuring local data ownership is a key piece of trust for successful implementation and adoption.

- b. 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?

Ensuring true interoperability, single sign-on does not mean interoperability and investments need to be made into community-based organizations to be able to not have to duplicate data entry for healthcare. This does not mean adopting a referral platform to accept new social needs referrals, but the opportunity to document

c. What specific capabilities and incentives are needed for smaller safety net providers or rural providers?

Some examples of capabilities include, technology infrastructure, privacy/security and legal support, capacity building funding.

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?

As the steward of the premier Community Information Exchange in the nation, 211 San Diego is uniquely positioned to speak to the broad challenges related to sharing social determinants of health and equity-related data. Over the past decade we have spent time meeting with our partners, clients, and other communities around the barriers and challenges to data sharing. We have found that the challenges span across key areas: trust, data governance, legal concerns, operations, and technical infrastructure:

- The lack of data standards between social and health care is a barrier that makes data sharing across sectors cumbersome. Current efforts risk spreading systemic failures inherent in today's health care sector to other sectors of care.
- The confusion around state and federal rules and regulations around consent, privacy, and security causes uncertainty and fear resulting in lack of process, particularly in behavioral health. Further, existing regulations need to be updated to align with the current electronic and technological possibilities and sector capacities. Even with standard recommendations, these policies also need to be required by healthcare to adopt, challenges to get healthcare agencies (specifically health insurance) to actually share data is limited.
- Among the social sector, the data exchange marketplace currently funnels investments to technology vendors. Currently, the assumption is that technology is the solution to address the fragmented social determinants of care system. The need is for authentic trust-building and community-based organization capacity building through community engagement and organizing, requiring process changes in all sectors. This could result in meaningful use of data exchanges across sectors. The financial structures and payment models need to extend beyond technology solutions and intermediary contract holders, as well as direct providers.
- Key power holders like those that are responsible for funding and regulating the system of care must establish system requirements, incentives, contractual obligations, and penalties to motivate participation.
- Data governance and ownership is a critical consideration, while national and statewide frameworks, standards, rules, and regulations are needed, it should not come at a cost of ignoring local infrastructures, unique community assets, and centering the voice of those most impacted by the inequities of the existing systems.
- Not including community members and partners in the planning and design of the data sharing system impedes the development of trust and often leads to the design of inefficient systems that are not fully utilized by partners.
- Often times, community perspectives are not included in the decision-making structure, causing alignment and prioritization issues between the community and institution.

- Data collecting methods, use, and analysis are driven by institutional goals rather than community goals, causing hesitancy on the part of providers and clients to participate in the system.
- Often times, data is used is for institutional benefit rather than community benefit (ie data collecting methods and analysis driven by institutional goals rather than community goals)
- Smaller organizations, particularly community-based organizations with little funding, do not have the support needed to navigate business agreements and other legally binding agreements tied to data sharing.
- Community-based organizations have little to no capacity to adopt new workflows related to data sharing.
- Providers that experience high turnover have a difficult time adopting the system because the amount of time and effort needed to train new users.
- The data sharing technology that has been purchased does not integrate with every system, requiring some providers to abandon their current system – a costly and time-consuming process. This scenario is especially difficult for small, community-based organizations that are being pressured to learn and adopt a new technology in addition to maintaining their own.
 - a. Are there any additional barriers related to collecting, using, and/or sharing data related to patients’ behavioral health needs?
 - i. Challenges and barriers tend to be on the patient/client and organization level. Individuals do not want to share behavioral health status if they don’t trust data ownership (how the data is used or shared). Additionally, organizations and providers are concerned around sharing behavioral health information because there is a lack of clear definitions around sharing and re-sharing of behavioral health information.

5. Are there any potential unintended consequences related to collecting, using, and/or sharing SDOH- and equity-related data?

Historically, the way in which public health systems have gathered and interpreted data has created harms that are disproportionately born by communities of color. This has contributed to a service delivery infrastructure that could reinforce systemic racism and white supremacy by harming marginalized communities, exacerbating local resource inequity, and distorting the perceptions of populations who rely on public services.

To minimize harm, institutions must honor the data contributed by patients, particularly those from underserved communities, by promoting more inclusive and equitable data practices. This can be achieved by planning data sharing systems with the commitment that the system and operations around the system will be anti-racist and promote equity. Absent an explicit commitment to equity and anti-racism, institutions are at risk of:

- a. developing a system that puts the needs of the organizations before the community members it serves,
 - b. exploiting historically neglected and underserved populations that should be guiding the design and direction of the data sharing system, and
 - c. harming instead of uplifting the community it serves.
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?

San Diego's [Community Information Exchange \(CIE\)](#) is a successful, proven tool for collecting and using SDoH to generate actionable insights for patient-centered care.

San Diego's CIE is the nation's premiere example of a mature, cross-sector network working to align the system of care built from within the community of service providers. Today, the CIE is an ecosystem comprised of a growing network of 107 partner organizations with more than 1,400 individual service provider users across health, human services, and social sectors (including health plans, hospitals, federally qualified health centers, CBOs, housing providers, food banks, etc.) that uses Social Determinants of Health (SDoH) screenings and assessments, a resource database, and an integrated technology platform to deliver holistic person-centered care and inform community care planning.

The CIE offers local health care partners and community resource providers rich data sets to better understand individual and population interactions within health and social service systems. With an initial focus on social service referral reliability and efficiency, San Diego's CIE created an infrastructure for cross-sector communication and coordination among its local social service partners and, over time, expanded its Partner Network to include community clinics, hospitals, and health plans. This organic formation and cultivation provides solid infrastructure for true collaboration and systems-changing impacts. The technological infrastructure enables closed-looped referrals between network partners, provides various search functionality as well as an integrated, longitudinal client record that holds SDoH information relevant to the services each organization's system provides. A critical component of CIE is the technical ability for data integration through middleware software allowing multidisciplinary partners at diverse levels of sophistication to maintain their existing information systems and contributing individual-level data into CIE's communitywide client record.

211 San Diego has continued to expand the CIE partner network and enhance the CIE technology, broadening its reach to all people in need in San Diego County. Currently, the CIE holds approximately 240,000+ unique longitudinal client records, each with over 200 data points across 14 SDoH domains. Having the ability to evaluate the acuity of individual, population health and social needs and rank those needs on a continuum from crisis to thriving has enabled our ability to research the role social determinants can play in informing and motivating network-wide investment in cross-sector population health interventions such as the CIE.

Community Information Exchanges are being developed throughout the Country and represent local applications of best practices that can be leveraged for all.

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

Community Information Exchanges target all populations, and specifically with older adults in early implementation with research with a [CIE San Diego older adult cohort](#)

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?
 - a. Significant invest among healthcare and government has been focused on technology solutions to address social needs. Investment in shared governance (inclusive of community members), CBO capacity building, CBO technology infrastructure, including interoperability,

The CIE started as a concept for technology-enabled care coordination designed to connect social and healthcare providers to improve care for individuals and families that were most disconnected from needed resources and services. In its nascency, the CIE was a coordinating platform between social services, law enforcement, and healthcare communities to streamline and improve care. Upon piloting the CIE, the first use cases involved addressing the needs of three cohorts of different target populations: people without housing, older adults, and veterans. Evaluation studies in partnership with two top universities, the University of California San Diego's Caster Family Center for Nonprofit and Philanthropic Research, and San Diego State University's Institute for Public Health were conducted to ascertain the impact and efficacy of using the CIE model to coordinate care among these groups with the goal of improving client health and well-being.

Findings from the evaluation study showed that, with respect to people without housing who were enrolled in the CIE, sharing client-level information positively impacted client outcomes, resulting in a 26% reduction in Emergency Medical Services (EMS) trips and a 44% improvement in housing retention for clients who received coordinated support from the CIE network. Additionally, the findings showed that once enrolled in the CIE, older adults (n=2,900) experienced a 30% reduction in EMS transports, translating to a potential cost savings of \$777,571 for San Diego County. The reduction in EMS transports also resulted in a reduction in Emergency Room (ER) visits that was estimated to an added cost savings of \$514,901.2 Furthermore, the evaluation study provided critical information on ways to enhance the CIE to improve its efficacy, proved the benefits and potential impact of cross-sector collaboration, and provided an initial cost-savings analysis for the CIE.

- a. 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?



October 18, 2021

To: Members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Re: Social Determinants and Health (SDOH) Equity Request for Input

Submitted via email to: PTAC@HHS.gov

Members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC):

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to comment on your Request for Input (RFI), which seeks feedback on the types of social determinants of health (SDOH) and equity related data that could be collected by health care providers within the context of optimizing value based care in alternative payment models (APMs) and physician-focused payment models (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.

PhRMA represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier, and more productive lives. Since 2000, PhRMA member companies have invested more than \$1 trillion in the search for new treatments and cures, including \$91.1 billion in 2020 alone. With the introduction of new treatments and vaccines, PhRMA member companies are also playing an important role in the continued fight against the COVID-19 virus.

We have long supported the goal of promoting efficient delivery of high-quality, patient-centered care, and PhRMA welcomes the opportunity to provide input on how addressing SDOH and health equity can help to optimize health care delivery and value-based transformation in the context of APMs and PFPMs. PhRMA believes that APMs – particularly those that incorporate increased financial risk-sharing for providers – must start from a foundation of patient engagement and care coordination, include stronger accountability for delivering clinical and care outcomes that matter to patients, and provide a mechanism to support access to new tests and treatments.

While the APMs and PFPMs being developed and tested through the Center for Medicare & Medicaid Innovation (the Innovation Center) represent an important test of methodologies for delivery and financing of care for patients, we also believe that there are additional safeguards necessary to ensure such models are providing the data necessary to inform policies to improve care coordination and provide more equitable access to care for Medicare beneficiaries. Consistent with our priority of building a more just, equitable health care system, PhRMA

believes that diversity, equity, and inclusion are essential to the discovery of new medicines and that people of all ethnic and racial backgrounds should have equitable access to treatment.¹ We are encouraged that the PTAC and the Secretary of Health and Human Services (HHS) are focused on addressing this critical issue, commend the PTAC members for seeking public input, and look forward to working with you and other stakeholders to address the important issues raised.

While SDOH and equity have not specifically been included by the HHS as criteria to be used in the evaluation of proposed PFPs, several proposals submitted to PTAC in recent years have incorporated elements related to addressing SDOH and/or equity (including health disparities) in the context of care delivery, performance measurement, and payment methodology. Recently, leaders from the Centers for Medicare & Medicaid Services (CMS) laid out their vision for the Innovation Center over the next decade, which included anchoring health equity as the centerpiece of every model.² We share in this laudable goal of prioritizing health equity across value-based models in ensuring providers are fairly measured and evaluated, while encouraging novel approaches to reducing health disparities.

PhRMA supports the focus on emphasizing health equity and collection of data to reduce disparities within APMs and PFPs. There is a continued need for the development of payment models that can test approaches to overcome systemic access barriers to routine and preventative health care, including the use of medicines and vaccines. Access to provider-recommended prescription medicines helps patients manage their health conditions, decreases avoidable health care use and costs, reduces mortality, and allows patients to live longer and healthier lives. Inequities in medication access are often rooted in community-level factors like where we live, work, and play; lack of adequate coverage and access to providers; and systemic racism and discrimination. We are concerned by the numerous studies demonstrating that certain racial/ethnically diverse populations have lower medication utilization and/or adherence than their White counterparts.^{3,4,5} PhRMA is committed to closing gaps in medication access to improve the health and well-being of all Americans.

To promote equity in access to providers, screenings, preventative care, treatment plans and medicines, it is critically important to ensure payment models account for the role of SDOH, including mistrust and negative lived experiences in the health care system, and health disparities. Providers must first understand the inequities that exist and address their own

¹ PhRMA, “Building a Better Health Care System: PhRMA’s Patient-Centered Agenda” <https://phrma.org/report/Building-a-Better-Health-Care-System-PhRMAs-Patient-Centered-Agenda>

² Brooks-LaSure C, Fowler L, Seshamani M, Tsai D. Innovation At The Centers For Medicare And Medicaid Services: A Vision For The Next 10 Years. Health Affairs Blog. August 12, 2021. <https://www.healthaffairs.org/doi/10.1377/hblog20210812.211558/full/>

³ Mehta KM, Yin M, Resendez C, Yaffe K. Ethnic differences in acetylcholinesterase inhibitor use for Alzheimer disease. *Neurology*. 2005 Jul 12;65(1):159-62. doi: 10.1212/01.wnl.0000167545.38161.48. PMID: 16009909; PMCID: PMC2830864.

⁴ Lauffenburger JC, Robinson JG, Oramasionwu C, Fang G. Racial/ethnic and gender gaps in the use of and adherence to evidence-based preventive therapies among elderly Medicare part D beneficiaries after acute myocardial infarction. *Circulation*. 2014; 129:754–763.

⁵ Schmittiel JA, Steiner JF, Adams AS, et al. Diabetes care and outcomes for American Indians and Alaska natives in commercial integrated delivery systems: a SURveillance, PREvention, and ManagEment of Diabetes Mellitus (SUPREME-DM) Study. *BMJ Open Diabetes Res Care*. 2014;2(1):e000043. Published 2014 Nov 17. doi:10.1136/bmjdr-2014-000043

implicit biases before they can approach care delivery in an empathetic, culturally competent and patient-centric manner. This can be aided through more robust data collection to inform provider performance and guide the development of incentives. Our comments will be focused on the following: advancing the collection and sharing of SDOH and equity data; and improvements in quality measurement to better account for health equity.

Advancing collection and sharing of SDOH and equity related data

A robust, interoperable data infrastructure that includes consistent measures of health outcomes associated with race, ethnicity, language, gender identities, age, income, sexual orientation, and social determinants of health is imperative to assess and make progress toward equality and reducing disparities in care.^{6,7} Key opportunities to improve the robust collection of SDOH data for the purpose of advancing equity in APMs and PFPs include: promoting the collection of patient-centered, intersectional, and standardized SDOH and equity related data; developing and implementing ethical and culturally sensitive practices to collect these data; and promoting interoperability to enhance data sharing.

Collect patient-centered, intersectional, and standardized SDOH and equity related data:

Current Federal standards for race/ethnicity data are not sufficiently granular to reflect diversity among smaller disadvantaged communities.⁸ PhRMA suggests that the Innovation Center and other Federal agencies consider testing, piloting, and facilitating activities to generate standardized, granular data on ethnically diverse populations in Medicare, so that data representing diversity across a broad range of cultures, backgrounds and lived experiences can be synthesized and assessed in value-based payment models.^{9,10}

Efforts to advance demographic data collection should also seek to collect information on social factors and their intersection with demographic information.¹¹ Intersectionality, a term coined by legal scholar Kimberlé Crenshaw, describes how intersecting systems of oppression (e.g., racism and sexism) have multiplicative impacts on an individual's life experiences.¹² Using a framework such as intersectionality to guide better collection of data on demographics and

⁶ COVID-19 shows why united action is needed for more robust international health architecture. World Health Organization. 30 March 2021. <https://www.who.int/news-room/commentaries/detail/op-ed---covid-19-shows-why-united-action-is-needed-for-more-robust-international-health-architecture>

⁷ Statement by HHS Secretary Xavier Becerra on the President's FY 2022 Discretionary Funding Request. CMS.gov. 9 Apr 2021. <https://www.hhs.gov/about/news/2021/04/09/statement-hhs-secretary-xavier-becerra-presidents-fy-2022-discretionary.html>

⁸ Office of Management and Budget (1997). Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. <https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf>

⁹ The Initiative on Asian Americans and Pacific Islanders. The White House. Available at: <https://obamawhitehouse.archives.gov/administration/eop/aapi/data/data>

¹⁰ U.S. Department of Health and Human Services Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language and Disability Status. Department of Health and Human Services. October 31, 2011. Available at: <https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status#IV>

¹¹ Nick G, Schloss K, Lexas HM, et al. A Social Determinants Perspective of the Intersection of Ageism, Racism, and Social Isolation During COVID-19. Behavioral Health News. Jan 1, 2021. Available at: <https://behavioralhealthnews.org/a-social-determinants-perspective-of-the-intersection-of-ageism-racism-and-social-isolation-during-covid-19/>

¹² Crenshaw K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. Stanford Law Review, 43(6), 1241-1299. doi:10.2307/1229039

characteristics, such as race/ethnicity, sexual orientation, gender identity, socioeconomic status, geographic location, and social needs, can reduce disparities in quality of care at intersections that influence health outcomes and patient experiences.

While some SDOH information can be captured in administrative health care claims data, collection of these data is currently limited. A recent study found that among the 33 million Medicare fee-for-service beneficiaries in 2019, just 1.6 percent had claims with codes related to social determinants of health.¹³ CMS acknowledges the existence of barriers to the use of z codes, including the lack of financial incentives tied to utilization of z codes and provider hesitancy because treatment of protocols for non-medical needs are unclear. The lack of robust data collection on SDOH in Federal, state, and local programs decreases the ability to measure variation in outcomes associated with APMs and PFPMs. We recommend that the Innovation Center conduct assessments with providers and patients to better understand the barriers to the collection of social determinants of health in claims data and work towards policies to promote robust collection of social determinants of health data in administrative claims in an ethical manner and consistent with legal requirements.

Nevertheless, robust collection of patient data should target the social needs that matter most to patients, which may not all be captured by current coding systems. PhRMA suggests that the Innovation Center engage community experts and health equity researchers to (1) identify which demographic and social needs data elements patients consider to be most important; and (2) develop a subset of standardized measures that can be utilized in administrative data systems across systems, payers, and communities.

Develop and implement ethical and culturally sensitive practices to collect SDOH and equity related data:

Direct engagement with community stakeholders (e.g., community-based organizations and community leaders) can help the Innovation Center reach, collect, and pilot SDOH-related social needs data initiatives in a culturally sensitive manner. Stakeholders may include community leaders and organizations that have historically served predominately disadvantaged groups, such as HBCUs, Tribal groups, and other entities.

Additionally, research shows that reimbursing community health centers (CHC) for integrating SDOH data into clinical workflows helps to increase the success of these workflow changes in primary care settings.¹⁴ Consistent with these findings, we recommend that Federal agencies, including the Innovation Center, consider providing financial and/or non-financial incentives to CHCs for time spent on providing feedback and/or collecting data to advance the government's efforts to engage disadvantaged communities.

¹³ Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019. Centers for Medicare and Medicaid Services. SeptSept 2021. <https://www.cms.gov/files/document/z-codes-data-highlight.pdf>. Accessed 12 October 2021.

¹⁴ Inga G, Bunce A, David, J, et al. Initiating and Implementing Social Determinants of Health Data Collection in Community Health Centers. Population Health Management. Feb. 2, 2021. Available at: <https://doi.org/10.1089/pop.2019.0205>

Although PhRMA strongly supports more robust collection of data, we recognize that increased surveillance and monitoring is not without potential harms to communities. For example, many disadvantaged communities have legitimate fears of sharing personal information due to negative potential consequences.¹⁵ The collection of data should serve to improve health care programs for disadvantaged communities, not provide a means for discrimination for harming individuals. We recommend that the Innovation Center and HHS consult engagement experts to implement safeguarding of data elements, ensuring that personally identifiable information remains protected throughout the process.

In addition, we recommend that the Innovation Center engage with experts to pilot strategies to mitigate against use of patient information that can potentially negatively impact patient access or care. For example, some artificial intelligence algorithms rely on demographic information to determine treatment regimens. There is evidence that these algorithms can lead to bias in treatment decisions¹⁶ and potential racial discrimination across different conditions, such as cardiac or kidney care.^{17,18} For example, there are concerns that the use of race/ethnicity in the Vaginal Birth After Cesarean (VBAC) calculator, a clinical tool to estimate the likely success of vaginal birth after cesarean delivery, leads to racial disparities in cesarean birth deliveries, with Black women being more likely than White women to be offered cesarean deliveries, which are associated with poorer birthing outcomes.¹⁹ This issue is potentially alarming given that maternal mortality is three to four times higher among Black women as compared to White women.²⁰ We recommend that the Innovation Center support efforts and activities to understand the extent of discriminatory practices or unintended biases with use of increased data collection, such that data collected for the purpose of enhancing equity in payment models is not used to perpetuate harms within disadvantaged communities.

At the same time, many disadvantaged communities may be hesitant to adopt new technologies due to concerns about misuse and distrust. Therefore, we suggest that the Innovation Center also work with experts in community-based research/advocacy organizations to ensure that the concerns of disadvantaged communities are recognized and addressed in the planning and implementation of efforts to expand data collection in diverse communities.

Promoting interoperability and data sharing:

Enhancing interoperability of data collection systems can promote electronic data sharing among plans and reduce burdens on providers, pharmacists, and patients. For example, doctors spend

¹⁵ Luque JS, Soulen G, Davila CB, et al. Access to health care for uninsured Latina immigrants in South Carolina. *BMC Health Serv Res* 18, 310 (2018). <https://doi.org/10.1186/s12913-018-3138-2>

¹⁶ Algorithmic Bias In Health Care: A Path Forward, " Health Affairs Blog, November 1, 2019. DOI: 10.1377/hblog20191031.373615

¹⁷ Kent C. A Race to the Bottom: How AI Encodes Racial Discrimination within Medicine. *Medical Technology*. https://medical-technology.nridigital.com/medical_technology_sep20/ai_racial_discrimination_medicine

¹⁸ Vyas, Darshali A., Leo G. Eisenstein, and David S. Jones. "Hidden in plain sight—reconsidering the use of race correction in clinical algorithms." (2020): 874-882.

¹⁹ Vyas DA, Jones DS, Meadows AR. Challenging the Use of Race in the Vaginal Birth after Cesarean Section Calculator. *Women's Health Issues*; 2019: 29 (3). <https://doi.org/10.1016/j.whi.2019.04.007>

²⁰ Reproductive Health. Center's for Medicare and Medicaid. <https://www.cdc.gov/reproductivehealth/drh/about-us/index.htm>. Accessed September 7, 2021.

about four hours per week on administrative tasks such as addressing drug formulary issues, prior authorization requests, and clarifying claims information.²¹ Currently, fewer than 15 percent of administrative health care transactions are fully electronic, including eligibility verification, checking on claim status, prior authorization, and clinical information submitted with claims.²² There is an opportunity for the Innovation Center and related entities, such as health care practices, community-based organizations, and health systems, to promote data sharing such that social needs and race/ethnicity data can be further employed and measured in APMs and PFPMs.

Improving holistic quality measurement to better address disparities, account for equity

PhRMA supports current efforts by CMS to incorporate health equity through various aspects of the Medicare Quality Payment Program, and we reiterate the recommendations we made in our comments regarding future potential stratification of quality measures in the Merit-based Incentive Payment System (MIPS) program.^{23,24} Additionally, we emphasize that health disparities will not be improved, nor health equity attained, through a single quality measure or measure set. We believe that the concept of health equity must be woven and integrated throughout the construct of APMs and PFPMs more broadly.

We support considerations for risk-adjustment and reporting of quality benchmarks for performance-based payments based on disparities in patient populations to ensure providers are not unfairly impacted or disincentivized from providing high-quality care for vulnerable populations, especially with respect to episode-based resource measures. Existing quality and cost measures should be also evaluated to ensure they do not mask and/or worsen health disparities that could lead to care stinting and should be appropriately stratified or adjusted to recognize population differences.

There is also a need for consistent use of measures of access and equity across APMs and PFPMs, particularly where there is a need to understand whether vulnerable populations are appropriately accessing screening, diagnostics, and treatment or where there is evidence of health disparities in the management and outcome of specific diseases. We support the stratification of measure results by race and ethnicity to create proper incentives to prioritize advancing racial equity among Medicare beneficiaries and Medicaid enrollees. Robust short- and long-term monitoring and evaluation of value-based programs that report or provide adjustments based on disparities data will be critical to prevent unintended consequences and can yield important learnings to inform future models, if necessary. We caution that the collection and possible reporting of risk-adjusted demographic data should not be used in discriminatory manner that

²¹ Blanchfield et al. (2010). Saving Billions of Dollars- And Physicians' Time-By Streamlining Billing Practices. Health Affairs, 29(6), 1248-1254. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0075>

²² CAQH, 2018 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings, 2019. <https://www.caqh.org/sites/default/files/explorations/index/report/2018-index-report.pdf>

²³ 86 Fed Reg 39104 – 39907.

²⁴ PhRMA's comments. RE: Request for Information – Closing the Health Equity Gap in CMS Quality Programs in Medicare FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2021. Centers for Medicare and Medicaid. Available at: <https://www.phrma.org/Equity/Comments-on-CMS-Request-for-Information-on-Closing-the-Health-Equity-Gap-in-CMS-Quality-Programs>

could exacerbate care inequities (e.g., if a facility and provider were less likely to take in a sicker patient due to their likelihood for worse outcomes).

Looking ahead, PhRMA encourages the development and implementation of equity-focused quality measures that assess vulnerable patient populations' abilities to access screening, diagnostics, and treatment, and which consider the accessibility of care. In considering which quality measures to incorporate into future models, we encourage the PTAC to work closely in partnership with CMS, other federal agencies, and external groups (e.g., ASPE, the NQF MAP Health Equity Advisory Committee) to evaluate APM quality measure sets to ensure that the measures included in these models are not masking inequities in patients' ability to access screening, diagnostics, preventative care, treatment, and follow-up.

Conclusion

We encourage the PTAC and HHS Secretary to continue to maintain a transparent process with continued public notice and comment periods such as this RFI. Providing transparency in the submission and development of APMs and PFPMs will ensure that all interested stakeholders and those who have clinical, real-world expertise in specific areas of measurement can provide input on all aspects of the proposals, including potential unintended consequences.

PhRMA believes that all stakeholders, including those representing the life sciences research and development sector, can contribute meaningfully to the development of APMs and PFPMs and we look forward to continued engagement. There are also opportunities to improve accountability and stakeholder input into model testing in establishing meaningful safeguards for patients. CMS Innovation Center models should be developed with input from impacted stakeholders prior to their announcement through a request for applications or proposed rule.²⁵ Stronger safeguards are also needed at model launch to protect beneficiaries, including a monitoring and evaluation strategy appropriate to the risks associated with the model and providing for notification of impacted beneficiaries.

As HHS continues to pursue the goal of advancing equity throughout the Federal government, as specified in the January 2021 Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,²⁶ it should ensure that progress is appropriately measured. We propose that the Innovation Center measure progress on advancing equity through payment models through equity evaluations. We recommend that plans for equity assessments should be included in the Innovation Center's strategic plan to ensure that funds and future efforts are put toward programs and initiatives that will have the greatest impact on improving health for underserved communities.

PhRMA appreciates the opportunity to comment on the future direction of APMs and PFPMs, including approaches to better address health disparities through enhanced data collection,

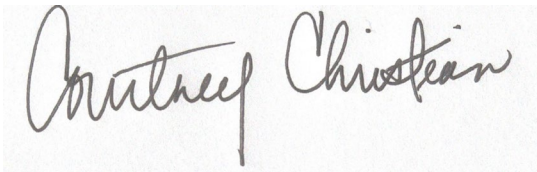
²⁵ Social Security Act § 1115A(a)(3).

²⁶ The White House, "Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," available at <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

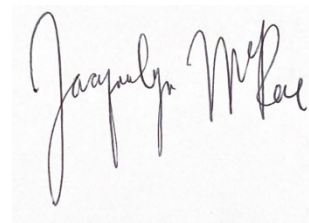
reporting, and incentives. As these models continue to be developed and evolve, having the right types of measures and SDOH data in place can serve as a catalyst for providers to be recognized and incentivized to inform care delivery in ways that reduce health disparities and elevate care quality for all.

We look forward to the progress of the APMs and PFPMs the PTAC may consider. Please do not hesitate to contact Jacquelyn McRae (JMcRae@phrma.org) if we can provide additional information or answer any questions related to our comments.

Sincerely,

A handwritten signature in black ink that reads "Courtney Christian". The signature is written in a cursive style with a large initial 'C'.

Courtney Christian, MPA
Senior Director, Policy and Research

A handwritten signature in black ink that reads "Jacquelyn McRae". The signature is written in a cursive style with a large initial 'J'.

Jacquelyn McRae, PharmD, MS
Director, Policy and Research