

November 15, 2018

Brenda Destro
Deputy Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Avenue, S.W, Room 415F
Washington, DC 20201

RE: Request for Information: IMPACT Act Research Study on Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Dear Ms. Destro:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the request for information (RFI) on provider and health plan approaches to improving care for Medicare beneficiaries with social risk factors.

The AHA commends the Office of the Assistant Secretary for Planning and Evaluation (ASPE) for adopting a holistic approach to examining the links between social risk factors, health care outcomes and value-based payment programs. America's hospitals and health systems are deeply committed to identifying and eliminating disparities in health care outcomes. We appreciate ASPE's interest in understanding how hospitals are using information about the social risk factors faced by their patients and communities to improve care for all patients. At the same time, we applaud ASPE's continued attention to the need to account for the impact of social risk factors beyond provider control in value-based payment programs. ASPE's December 2016 report to Congress showed the extent to which provider performance on outcomes such as readmissions, patient experience and cost are impacted by social risk factors, and laid out several policy approaches to appropriately adjust measures and program designs for them.

In short, the AHA believes that efforts to eliminate health care disparities must go hand in hand with efforts to account for social risk factors in value-based payment programs. To support this goal and inform ASPE's next report on addressing



social risk factors scheduled for 2019, we offer insights on how social risk factor information is captured and used in hospitals. **We also recommend that ASPE promote further work to create standards for capturing social risk data in electronic health records (EHRs), and examine approaches to adjusting measures in value-based payment programs that go beyond the approaches in current Centers for Medicare & Medicaid Services (CMS) programs.**

CAPTURING AND USING SOCIAL RISK FACTOR INFORMATION IS A DYNAMIC PROCESS

Social risk factor information often is integral to shaping a patient's care plan.

Social risk factors can impede a person's ability to maintain or return to a state of health. Hospitals have reported that a number of social risk factors are particularly impactful to shaping the trajectory of patients' care. These include, but are not limited to:

- *Safe and stable housing*, including whether a patient can safely live alone, cope with any access challenges (e.g., stairs), maintain a clean environment, and afford housing (which affects stability).
- *Access to food*, including availability and affordability of nutritious foods in their communities and ability to prepare meals that support recovery.
- *Transportation*, including how individuals can access health providers, prescriptions and food.
- *Social interactions*, including whether a patient lives alone or has connections with family and friends.
- *Personal safety*, including whether there are any potential issues with abuse, or whether community violence affects the individual's activities.

Hospitals and health systems also have shared that they find value in capturing social risk factor information across the full breadth of their patient population, rather than just for those whom they suspect have a social risk factor.

However, collecting social risk factor information in the clinical record and using it to shape the care plan is a complex and dynamic process. Hospitals and health systems face an array of choices in determining at what point of care to capture the information. They could use admission interviews conducted by an intake nurse. They could capture the information during outpatient visits using clinicians or other non-clinical members of the care team. They could have patients fill out paper forms or use electronic mechanisms. In some cases, more sensitive information (e.g., issues around violence or abuse) may be best captured through conversations with a clinician the patient trusts rather than through forms. Hospitals generally make their choice of data

collection approach based on the needs of their patient population and their own processes. However, the choices do create some variability in what information is captured, its completeness and its accuracy.

The initial capture of social risk factor data is only the beginning of the challenge for hospitals. Social risk factors can change over time, adding to the complexity of keeping those data accurate and up to date as patient needs and circumstances evolve.

Furthermore, for the data to help shape care, they must be accessible to clinicians at the point of care. Many hospitals have pointed to EHRs as a potential mechanism for not only capturing social risk factor data in a more standardized fashion, but also making it accessible to clinicians when delivering care. However, as detailed further below, much work remains before hospitals can accurately capture social risk factor data in EHRs.

ENHANCING STANDARDS FOR CAPTURING SOCIAL RISK FACTOR DATA IN EHRs

The EHR certification standards developed by the Office of the National Coordinator for Health IT (ONC) hold promise for promoting greater standardization of social risk factor data in EHRs. However, significant gaps in standards remain. ONC's EHR certification criteria, test procedures and test tools are used to confirm that an EHR can capture, incorporate and send data in accordance with standard codes. The certification criteria and the testing procedures for some data – such as demographics (as outlined in §170.315(a)(5)) – are specific.

However, for other data in the EHR certification standards – including many related to social risk factors – the testing approach is not prescribed. As a result, social risk data may be collected routinely but perhaps not consistently or in support of a patient population identified as needing particular services. For example, the social, psychological, and behavioral data certification criteria (§170.315(a)(15)) requires EHRs to be certified to capture data in eight domains: financial resource strain, education, stress, depression, physical activity, alcohol use, social connection and isolation, and exposure to violence. Certified EHRs are required to capture whether the individual provides a level of response to each domain but are not certified to indicate if the individual declined to respond to the question. The criteria also permit EHRs to capture information in text fields rather than structured codes. Furthermore, the testing approach for this certification criteria is self-declaration.

Additional work is needed to standardize the data collected in electronic form, test EHRs to confirm the consistent implementation of the standards, and crosswalk the standard data to social risk factor measures or well-established social risk factor screening tools. **The AHA recommends ASPE collaborate with CMS, ONC, providers, and EHR and health IT vendors to develop or refine standards, implementation requirements and guidelines to support the effective capture and use of social risk data in EHRs.**

The successful development of these EHR standards could enable further development of tools to help identify and address social risk factors at the patient and population level. At the patient level, a positive screen for a social risk factor could provide a clinical decision support tool linking clinicians to internal or community partner resources that may benefit a particular patient. At the population level, hospitals may be able to use mapping and visualization tools to help illuminate geographic areas of communities that are particularly at risk, or better detect associations between social risk factors and health outcomes. This could better target interventions and hospital population health strategies.

ENHANCING APPROACHES TO SOCIAL RISK FACTOR ADJUSTMENT

The AHA applauds CMS's recent actions to begin accounting for social risk factors in a few of its value-based payment programs. However, we encourage ASPE to assist CMS and all stakeholders by continuing to explore alternatives to the current approach to inform future policymaking. For example, in the Hospital Readmissions Reduction Program (HRRP), CMS places hospitals into peer groups based on the proportion of dual-eligible patients they treat. And the physician Merit-based Incentive Payment System (MIPS) includes a complex patient bonus awarding clinicians and groups up to five points based, in part, on the proportion of dual eligible patients they treat.

The ideal data for use in adjusting for social risk factors should: 1) have a conceptual and statistical relationship to the outcomes being measured; 2) use a readily available data source; and 3) be collected in a consistent way using standardized definitions. Dual-eligible status has all three of these characteristics, which is why we believe it is appropriate to use in the HRRP and MIPS at this time.

Nevertheless, dual-eligible status also has important limitations as a risk adjustor. Most notably, there is variation in the generosity of state Medicaid program benefits, and, in the long run, the adjustor may be sensitive to differences in state-level decisions. Dual-eligible status also may not fully reflect the poverty in communities. For example, it would not fully reflect the proportion of homeless in communities.

The use of peer groups – such as in the HRRP – obviates the need to change the risk adjustment models for underlying quality measures. However, the use of peer groupings involves somewhat subjective choices about where to set the cut points of a particular group. Those hospitals at the upper end of one quintile and those at the lower end of the next quintile would have similar proportions of dual-eligible patients, but would be placed into different quintiles for performance comparison purposes. This is true regardless of the number of peer groups chosen to use to evaluate performance.

The science of quality measurement is dynamic, and there are a number of options that we encourage CMS to evaluate for improving the risk adjustment approach. One particularly promising set of data that could be used in the shorter term are census-tract data on poverty rates and income. Census variables like poverty rate and income are readily available, and could be mapped to a hospital's patient population using zip codes. Moreover, census data could be a more direct measurement of poverty than dual-eligible status, and would not be sensitive to differences in state Medicaid programs. Hospitals also are beginning to use ICD-10 CM codes to record patient-level information related to social risk factors, such as housing, literacy and education. The codes should bolster efforts to track trends at a population level. In the future, the codes also could be evaluated for their suitability in risk adjustment models. In the long-term, social risk factor data derived from EHRs may be superior to both claims-based and other administrative data as they may better align with the dynamic process of assessing and responding in real time to patients' changing social risk needs. However, as noted in the previous section, work remains to foster stronger standards around the EHR-based capture of social risk data.

The AHA appreciates your consideration of these recommendations. Please contact me if you have questions or feel free to have a member of your team contact Akin Demehin, director of policy, at ademehin@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development