



www.physiciansfoundation.org



info@physiciansfoundation.org

January 13, 2022

National Quality Forum
Measure Applications Partnership
MAPCoordinatingCommittee@qualityforum.org

Re: Public Comment on 2021 CMS Measures Under Consideration (MUC): Drivers of Health

Dear Measure Applications Partnership (MAP):

In submitting these comments, the Physicians Foundation does so not only as the measure developer for MUC2021-134 and MUC2021-134, but also an organization that takes its the direction of physicians from 21 state and county medical societies across the country.

In particular, we offer these comments from the perspective of practicing primary care physicians and specialists across the country. Every day, we encounter patients in our practices who show the physical toll of skipping meals to feed their children. Who have made impossible tradeoffs between refilling their heart medicine or buying food. Who carry the stress of spending weeks trying – and failing – to find a job, as bills pile up and they fear losing their home, as the rent or mortgage goes unpaid.

As our patients struggle to manage these risks in their day-to-day lives, we physicians bear the economic and psychic risk associated with these unaddressed social drivers of health. It is well-documented that these factors lead to physician burnout and effectively penalize physicians caring for affected patients via lower MIPS scores. A recent study in JAMA found that SDOH were associated with 37.7% of variation in price-adjusted Medicare per beneficiary spending between counties in the highest and lowest quintiles of spending in 2017. Yet even with an ongoing pandemic that has painfully brought these issues to the fore, SDOH are still not accounted for in geographic risk-adjustment or cost benchmarks.

We put forward these two first-ever SDOH measures (and the only patient-level equity measures this review cycle) because it is untenable – to patients and their physicians – for these challenges to be much-discussed in articles, speeches, and white papers, yet functionally invisible in our healthcare system's quality and payment frameworks.

We must start somewhere, and we must start now. Via CMS's own Accountable Health Communities model, the proposed SDOH screening measures – MUC21-134 and MUC21-136 – have been tested at scale over five years with 1M+ beneficiaries in over 600 clinical sites – with 40% of the screenings in hospital inpatient or ED settings and 54% in primary care practices. As documented in the *AHC evaluation*, these measures reliably identify: (1) beneficiaries with 1+ health-related social needs; (2) high cost/high use beneficiaries; and (3) racial/ethnic disparities.

Further, as well-documented in the NQF MAP's preliminary analysis, the screening tools and items used in the testing process to generate the data for both measures have been psychometrically evaluated and demonstrated evidence of both reliability and validity, including inter-rater reliability and concurrent and predictive validity (see sample citation below).

We appreciate the MAP's thoughtful and deliberate consideration of MUC21-134 and 136 and note the support for these measures across the Health Equity and Rural Health, Advisory Groups and Clinician Workgroup – and we strongly urge the Coordinating Committee to recognize this by accepting the recommendations of the Clinician Workgroup with respect to MIPS. It is especially important that those clinical practices that wish to collect and report on these SDOH measures have these important efforts recognized through the MIPS program.

We also urge the Coordinating Committee to accept the Hospital Workgroup's recommendation to offer conditional support to MUC21-134. We likewise recognize that Workgroup's questions regarding how CMS and consumers could or should interpret the screen positive rate results required by MUC21-136.

As CMS itself made clear in this discussion, hospitals would satisfy the performance threshold by reporting the screening rate and screen positive rate to CMS for patients who are 18 years or older at the time of admission. Performance is not determined based on the result of the screen positive rate; there is no requirement to demonstrate a rate reduction over time. Variability in this rate would, of course, depend on the institution's community context and patient population.

Hospitals' reporting of the SDOH screen positive rate is valuable to consumers for a number of reasons, including (1) providing transparency of data the institution has collected from those and other consumers who received care at the institution; (2) enabling public and private institutions – including the hospitals themselves – to target community investments based on data consumers provided; (3) allowing consumers to identify which hospitals have familiarity with and expertise in addressing these issues; and (4) enabling quality improvement activities, including making visible variation in health outcomes and costs potentially attributable to the prevalence of these underlying drivers of health and addressing disparities.

We agree that it is important to bridge patients who screen positive for health-related social needs to community navigation services and/or ensure there is an individualized action plan in place for these needs to be addressed. However, physicians are well aware that this is complex and resource-intensive work, which is dependent on the quality of the community resource landscape where their practices and/or health systems are located and their patients live. Hence, the objective of this first phase is focused on collecting DOH baseline data in a standard way to then support a data-driven approach to addressing these health-related social needs, including potential future measures focused on success in navigating patients to the resources they need to be healthy. To establish an SDOH navigation measure in the absence of practices and hospitals reporting baseline SDOH screening data is inadvisable.

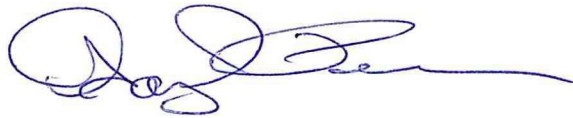
Moreover, it must also be stressed that the validation of any screening tool used to collect data supporting a measure must include the result of the screen. Should the Coordinating Committee recommend the screening rate measure but reject the screen positive rate measure, it will impair the ability of CMS, the measure steward, and program participants to conduct additional validation of the screening rate measure post-implementation and over time.

We expect, and hope that, over time, these SDOH measures can and will be improved – and additional associated measures developed – with the benefit of the input of physicians, other

healthcare providers, and health systems across the country and the data generated by these measures.

We also recognize, however, that given the profound challenges that COVID has wreaked on patients, physicians, and our healthcare system writ large – and the commitment to equity and the reduction in health disparities that CMS and healthcare institutions across the country have declared – that time is of the essence in enacting these first-ever SDOH measures (and the only patient-level equity or SDOH measures under review this cycle). We therefore strongly urge that the Coordinating Committee recommend to CMS MUC21-134 and MUC21-136 for both MIPS and the IQR.

Respectfully submitted,

A handwritten signature in blue ink, appearing to read "Gary Price".

Gary Price, MD, President

A handwritten signature in blue ink, appearing to read "Robert Seligson".

Robert Seligson, Chief Executive Officer

Citations:

- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7652127/>