



## ***Public Comment on Proposed Drivers of Health Measures***

*January 12, 2023*

The evidence is clear that what we measure matters. The right measures equip providers with data to identify and address unmet needs, and it allows policymakers and payers to account for social drivers of health (DoH) in payment models. Without appropriate measurement, the social factors promoting or harming health are invisible, with particularly negative consequences for communities of color who are affected by structural racism and the inequities it creates. Further, without measurement, communities are also hamstrung in their efforts to mobilize resources for building the necessary workforce and partnerships to invest in upstream DoH. In short, measuring DoH is foundational to investing in health.

Commonwealth Fund research and the work of our grantees indicate the value of standardized and consistent measurement to identify and address peoples' health-related social needs. Evidence and experience strongly show that quality measures related to the drivers of health 1) lead to better identification of people's health-related social needs; 2) enable providers to collaborate with community-based organizations to connect people more consistently to needed social services; and 3) reflect on-the-ground movement among clinicians to screen for and help address patients' health-related social needs. Standardizing these measures (related to screening, screen positive rates, connection to community services, and resolution of need) not only helps avoid proliferation and fragmentation, but also enables more robust tracking of progress over time.

Adoption of MUC2022-098, MUC2022-111, MUC2022-053, and MUC2022-050 would play an important role in advancing health equity and addressing patients' health-related social needs that manifest from upstream DoH. Reflecting the growing adoption of this approach across the sector, clinical practices in CMS's own Innovation Center models are navigating patients to social services and following up to determine if the patient received the resource. The Commonwealth Fund recently conducted an [analysis of all 40+ CMMI models](#) and "found evidence of participants in 20 models connecting beneficiaries to social services and CBOs to address identified DOH needs, [only] five of which were required to do so."

Participants in these models reported that they "commonly engaged multidisciplinary teams, including peer counselors, community health workers, and social workers to identify available services and facilitate referrals for beneficiaries." The Medicare CPC+ Year 3 evaluation, for example, found that 93% of the 1,241 physicians in the Track 1 practices reported that they acted on the SDOH screening results (and 74% actively linked patients to supportive community-based resources), even though they were not required to do so.

Models screening for social needs occurs across nearly all clinical disciplines, including a focus on renal, oncology, and behavioral health practices and patients across the country. The 2021 Comprehensive End-Stage Renal Disease Care Model evaluation, for example, reported that "[m]any beneficiaries are protein malnourished and don't eat enough fresh produce. Some beneficiaries go to the hospital to get meals." As a result, ESRD Seamless Care Organizations (SCOs) began acknowledging food insecurity as a factor in patient non-adherence to nutritional guidelines. For instance, one SCO partner provided food gift cards to both low-income beneficiaries and those above the poverty level and began a pilot program with a food bank to better meet patients' nutritional needs and improve adherence.

It is crucial to note that every MAP Advisory Group, Workgroup, and Committee that reviewed the SDOH screening measures last year noted the imperative to link screening to measures focused on patient navigation and referral to SDOH resources, as these measures under review propose to do. Further, stakeholders overwhelmingly called on CMS to enact SDOH navigation and resource referral measures alongside the SDOH screening measures during the public comment for last year's NQF MAP process and in responding to CMS's proposed rules including the screening measures.

CMS's enactment of these measures would enable alignment with and build on recent momentum with the finalized CY2023 IPPS rule and Physician Fee Schedule and further advance standardized federal measures that assess and act on patients' social needs. Most important, when stratified by race and ethnicity and combined with broader data collection improvement efforts, these DoH measures would make often invisible social factors visible, particularly for communities of color.

Only when these factors are brought to light and measured in a standardized way will we be able to align our collective resources and take action to achieve equitable health outcomes for all.

Sincerely,



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