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March 10, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–0057–P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–0057–P. Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program

Dear Administrator Brooks-LaSure:

Thank you for soliciting feedback on the Centers for Medicare & Medicaid Services (CMS)'s Request for Information, "Accelerating the Adoption of Standards Related to Social Risk Factor Data." We commend CMS on its request for input on the barriers the healthcare industry is facing with respect to using industry standards and opportunities to accelerate adoption of data collection standards related to social risk factor data.

The Pew Charitable Trusts (Pew) is a non-profit research and policy organization dedicated to informing the public, improving public policy, and invigorating civic life with several initiatives focused on strengthening the quality of patient care and supporting public health. Specifically, Pew's Public Health Data Improvement project conducts research, provides technical assistance, and advocates for policies, resources, and public health department practices to enable the rapid and effective use of health care data to advance Americans' well-being.

Thank you again to CMS for the opportunity to provide input and for your continued attention to this issue. We appreciate your engagement on advancing public policies affecting the nation's health. Please contact Kyle Kinner (kkinner@pewtrusts.org) in our Government Relations practice for additional information or questions.

Sincerely,

Kathy Talkington
Director, Health Programs
The Pew Charitable Trusts

Comments Addressing CMS's Request for Information: Accelerating the Adoption of Standards Related to Social Risk Factor Data

Pew commends CMS's efforts to seek input on the barriers the U.S. healthcare industry is facing with respect to using industry standards and opportunities to accelerate adoption of data collection standards related to social risk factor data. When providers consistently collect standardized social risk factor data, they can use the data to inform care and connect their patients to support services to address their social needs and achieve better health outcomes. CMS plays a critical role in ensuring that healthcare providers in value-based payment arrangements can collect and exchange standardized social risk factor data to ensure better care for patients and reduce reporting burdens on patients, providers, and social care providers.

Despite significant investments and meaningful progress made in improving access to health care across the country, health inequities continue to adversely affect disadvantaged communities, with social determinants of health (SDOH) driving disparate health outcomes. Inequities in SDOH are the root causes of social risk factors at the individual level.[i] For example, a community may have broadly lacked access to health care providers during the COVID-19 pandemic, but sub-populations experiencing poverty in that community may have encountered additional or different barriers to accessing care, resulting in higher morbidity and mortality rates than populations living above the poverty line.[ii]

Many of today's health inequity challenges require community-based interventions beyond healthcare. Collaboration between healthcare, public health, and social services is critical for addressing both SDOH and social risk factors within communities: while healthcare providers and human services agencies primarily address the needs of individuals, public health departments work with a variety of partners to improve community conditions, including social and structural factors, enabling prevention and improved access to services that impact health.[iii] Social risk factor data analyzed at the population level, by public health practitioners, is of great value to healthcare providers, public health agencies, and community-based organizations (CBOs) alike, but standardized data exchange among these entities is critical to leveraging information to its fullest extent for improving both individual- and population-level health.[iv] Without consensus on which data elements should be collected and more widespread adoption of standards for critical data elements, successful data exchange across health system and public health stakeholders will be less likely to occur.[v]

Recommendation: The public health community, such as federal, state, territorial, local, and tribal public health agencies and their partners, should be actively involved in discussions related to the development and adoption of social risk factor data collection standards, as well as guidelines and processes for data exchange between healthcare providers, public health agencies, and CBOs.

Social risk factor data, analyzed at the population level, can be used by providers, public health agencies, and CBOs to improve health outcomes, but meaningful, bi-directional exchange of standardized data between these entities is critical to enable this to occur.

Many healthcare providers value the use of individual-level social risk factor data in their daily practice: these data can help with decision-making at the patient level. For example, incorporating information on housing and food insecurity into a patient's care can help drive medical decisions and referrals to community-based resources.[vi] Among the provider community, there is a growing understanding of the importance of population-level analysis of social risk factor data.[vii, vi] When social risk factor data is shared with public health agencies, epidemiologists can conduct analyses and share their findings with health care providers, which will enable providers to better understand risk factors that are prevalent in their communities and more fully assess how to appropriately screen at-risk patients for social risk factors and connect them with community resources.[viii] Population-level analysis of social risk factor data can also play an instrumental role in understanding the distribution of risk factors in a community and identifying gaps in social and economic services, which can inform local investments in public health infrastructure, CBOs and a community's capacity to address the risk factors.[i,vii]

A recent survey of the healthcare sector found that specific SDOH and social risk factor data elements are prioritized for collection over others: the majority of respondents collect data on health insurance coverage and health behavior (e.g., smoking), but there were lower levels of prioritization of other data elements such as housing and food insecurity. There is no broad consensus across the healthcare industry on which key social risk factor data elements need to be collected and there is a lack of incentives for collecting these elements compared to other elements tied to value-based care contract terms, such as smoking status.[i] The public health community should be actively involved in discussions with health care providers and CBOs around which social risk factor data elements should be collected on a routine basis; these conversations can result in a greater understanding among providers about how this data can be used for population-level analysis, which can in turn benefit providers and CBOs alike.

Moreover, as public health agencies have extensive experience in incorporating a variety of datasets into population-level data analysis, they can facilitate data sharing, integration, and analysis of distinct data sources.[ix] This may include individual, line-level data collected in healthcare settings, by CBOs, and by local and state government agencies. Merging these data sources will result in more robust analyses at the population-level and can provide a more complete picture of a patient's current health status and well-being, aiding providers in ensuring patients receive optimal treatment and are referred to appropriate community resources.[viii]

Finally, it is important to consider the sensitive nature of collecting social risk factor from patients and the resulting benefit of these data at the individual- and population-levels. Findings from a 2020 study conducted by Pew highlight patient privacy concerns with the collection and sharing of SDOH data, such as questions about whether the information collected could lead to assumptions about the patients and contribute to discrimination, and whether privacy and security around these data elements could be maintained.[vi] The collection of sensitive social risk factor data must benefit the individuals who are providing the data and the communities in which they live. Therefore, it is critical to evaluate how the exchange of this data contributes to better patient and population outcomes. As the public health community has extensive experience in conducting systematic program evaluations to monitor the impact of public health programs and interventions on the health of a community, public health agencies can play a leading role in evaluating the impact of this data collection at both the patient and population levels and ensuring that patient privacy interests are respected.[x]

To ensure the adoption of data standards that will enable bidirectional exchange, CMS should actively involve the public health community in discussions and decision-making around social risk factor data:

The public health community has long played critical roles in SDOH and social risk factor work, including acting as a convener to foster multi-sectoral partnerships; an integrator to collect, analyze, and translate data for surveillance and decision-making, and a change-maker, generating data-driven solutions to reduce inequities in SDOH.[xi] With public health's depth of experience in developing and adopting data standards to ensure more robust epidemiological analysis, this community understands the barriers that a variety of organizations face when it comes to the adoption of data standards and collection and exchange of this sensitive data.[xii,xiii] Moreover, as social risk factor data can be used by healthcare providers, public health, and CBOs alike, the public health community can provide unique insights into:

- Which social risk factor data elements need to be collected and at what frequency.
- Overcoming barriers to exchanging these data sources between end users of the data.
- Mechanisms currently used to collect, exchange, and use the data.
- Efforts to facilitate greater standardization of the data elements.
- Privacy issues and concerns around collecting and using the data.

Examples of the effective role of public health in SDOH and social risk factor data exchange are highlighted below.

Pew's Calling All Sectors (CAS) Initiative: In 2019, Pew launched CAS, a cross-sector initiative in nine states and Washington, D.C. to address maternal and child health issues and improve health equity at the community-level. One key factor contributing to the success of this initiative was cross collaboration among departments of health, social services, and health care providers and organizations. This collaboration resulted in improved health data exchange across the sectors, driving changes in policy and practice. For example, D.C. Health partnered with a federally qualified health center to obtain SDOH and social risk factor data from electronic health records and is now working to gain access to Medicaid data to further inform their work to improve equity in the community. As such, these types of partnerships can further enable the collection of data elements that are needed to inform population-level analyses, which can inform prevention approaches in communities and drive improved outcomes.[vi, viii]

The Center for Disease Control and Prevention's (CDC) cross-departmental collaborations: The CDC has collaborated with other federal agencies to leverage population-level analyses to address community needs such as affordable housing. Under an interagency agreement with the Department of Housing and Urban Development, the CDC is providing evidence-based approaches for affordable senior housing programs. This work includes the development of a strategic framework that identifies goals to support state and local public health and housing agencies to partner and achieve local priorities. Moreover, through its Good Health and Wellness in Indian Country program, CDC collaborated with tribal organizations to strengthen links between community programs and access to clinical services to promote health among Indian/Alaskan tribal populations.[i]

The Gravity Project: The Gravity Project was launched in May 2019 as a multi-stakeholder collaboration that aimed to develop, test, and validate standardized SDOH data for use across a variety of health and public health sectors. Gravity convened over 1,800 participants from across the health and human services ecosystem, including public health experts. While Gravity made significant progress in the technical aspects of developing SDOH data standards, more work is necessary to develop standards for social risk factor data and to ensure that this data is actionable for providers, public health, and CBOs.[xiii] Future convenings hosted by CMS should bring together the wide variety of stakeholders included in the Gravity project but should focus on developing consensus around social risk factor standards and how this data is used by decision-makers.

The COVID-19 pandemic highlighted health inequities in communities across the country and opportunities for data to inform improvements moving forward.[xiv] While healthcare providers can use social risk factor data to inform care and connect patients with support services, the public health community can leverage this data for analyses that benefit the provision of individual care and address inequities at the population level. Improving the collection and exchange of standardized social risk factor data elements is necessary for capitalizing on these opportunities. The public health community must be involved in discussions related to the adoption of these data standards, as well as guidelines and processes for cross-sectoral data exchange.

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[i] Whitman A, De Lew N, Chappel A, Aysola V, Zuckerman R, Sommers B. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. *Assistant Secretary of Planning and Evaluation, Office of Health Policy.* 2022

[ii] Jyothi M, Davis MB. Social and Clinical Determinants of COVID-19 Outcomes: Modeling Real-World Data from a Pandemic Epicenter. *medRxiv.* 2021. doi:10.1101/2021.04.06.21254728

[iii] DeSalvo KB, Wang YC, Harris A, Auerbach J, Koo D, O'Carroll P. Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century. *Prev Chronic Dis.* 2017;14. doi: http://dx.doi.org/10.5888/pcd14.170017

[iv] The Office of the National Coordinator for Health Information Technology. The Office of the National Coordinator for Health Information Technology Health IT Playbook. https://www.healthit.gov/playbook/population-public-health/. Updated 2013. Accessed February 24, 2023

[v] American Health Information Management Association, National Opinion Research Center. Social Determinants of Health Data: Survey Results on the Collection, Integration, and Use. 2023

[vi] The Pew Charitable Trusts. Patients Seek Better Exchange of Health Data Among Their Care Providers. 2020

[vii] Association of State and Territorial Health Officials. Alexander Billioux: Public Health's Role in Screening for Health-Related Social Needs. ASTHO Web site. https://www.astho.org/communications/blog/alexander-billioux-ph-role-screening-health-related-social-needs/. Updated 2019. Accessed February 15, 2023

[viii] Health Management Associates. Calling All Sectors Evaluation Final Report. *Health Management Associates.* 2022

[ix] U.S. Centers for Disease Control and Prevention. Data Integration Improves Public Health Surveillance. https://www.cdc.gov/nssp/partners/Data-Integration-Improves-Public-Health.html. Updated 2022. Accessed February 24, 2023

[x] U.S. Centers for Disease Control and Prevention. CDC Approach to Evaluation. U.S. Centers for Disease Control and Prevention Web site. https://www.cdc.gov/evaluation/approach/index.htm. Updated 2021. Accessed February 15, 2023

[xi] U.S. Centers for Disease Control and Prevention. ACD Meeting Information. U.S. Centers for Disease Control and Prevention Web site. https://www.cdc.gov/about/advisory-committee-director/meetings/index.html. Updated 2023. Accessed February 15, 2023

[xii] Dieterele R. The Gravity Project: HITAC ISP TF Presentation. *The Gravity Project.* 2021

[xiii] Office of the National Coordinator for Health Information Technology, (ONC). Interoperability Standards Workgroup. HealthIt.gov Web site. https://www.healthit.gov/hitac/committees/interoperability-standards-workgroup. Updated 2023. Accessed February 15, 2023

[xiv] Drake P, Rudowitz R. Tracking Social Determinants of Health During the COVID-19 Pandemic. *Kaiser Family Foundation.* April 21, 2022. Accessed February 24, 2023. https://www.kff.org/coronavirus-covid-19/issue-brief/tracking-social-determinants-of-health-during-the-covid-19-pandemic/