Health Care Without Harm

the campaign for environmentally responsible health care

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September 6, 2022
Re: **proposed CY2023 Physician Fee Schedule**

On behalf of Health Care Without Harm and our hospital member network of over 1,400 hospitals across the country, **we applaud CMS for adopting the "*SDOH Screening Measure*" in the Hospital Inpatient Quality Reporting Program (HIQR), and offer our support for CMS to adopt the same "*SDOH Screening Measure*" via the Merit-Based Incentive Payment System (MIPS), for which 90% of doctors are eligible**. This measure would incentivize doctors to screen their patients for five SDOH domains: food insecurity, housing instability, utilities difficulties, transportation needs, and interpersonal safety. *(see Health Care without Harm's letter of support for these SDOH screening measures, dated 6/17/22, below)*

Health Care Without Harm also pledges our support for CMS to **adopt the *"SDOH Screen Positive Rate Measure"*** (% of patients who screen positive for 1+ of the five SDOH domains) for doctors via MIPS and the implementation of the **same SDOH screening and screen positive measures for** Accountable Care Organizations serving 11 million patients (via the Medicare Shared Savings Program).

Together, changes to these two rules alone – the HIQR and the Physician Fee Schedule – cover nearly all of the hospitals and doctors in our country, representing an unprecedented opportunity to make SDOH an integral part of our healthcare delivery system. The absence of standard drivers of health data or measures in federal healthcare quality or payment programs has impeded efforts to achieve racial equity in health outcomes, given their disproportionate and profound impact on communities of color, especially in COVID's wake**. CMS should apply the same screening measures it has adopted for the HIQR program to MIPS to align measures and allow CMS to achieve its stated goals (p.1178-79)**, including "meaningful collaboration among clinicians and community-based organizations" and "reporting quality measure results stratified by patient social risk factors" (p.1178).

Health Care Without Harm also strongly recommends that CMS implement its proposed Advanced Investment Payments (AIPs), as a critical step in enabling clinical practices to partner with communities in acting on the SDOH identified in its patient population (p. 617). The Center for Medicare and Medicaid Innovation's Accountable Health Communities pilot evaluation found that 74% of eligible beneficiaries screened with these same DOH measures requested resource navigation. Barriers to successful resource navigation included insufficient community resources; difficulty maintaining an up-to-date resource inventory; and large caseloads impeding high-quality navigation. In proposing these AIPs, CMS recognizes these barriers; that "it is important for health providers who may not have expertise in providing social services to work with those community-based organizations that do have such expertise" (p. 645); and the importance of financial resources for these clinic-community partnerships to be successful.

We urge CMS to make these necessary changes to the health care delivery system in this country, and Health Care Without Harm stands ready to offer our support within the health care sector and through our national network of hospitals, health care systems, clinicians, community-based organizations, and allied partners to

disseminate and operationalize these important measures. With the increasing impacts of a changing climate on peoples' health in our communities - from increased and prolonged heat events, extreme storm events, wildfires and excessive drought, and increased healthy food and clean water insecurity, the social determinants of health are becoming even more critical factors that must be part of health care delivery in this country, towards more positive and equitable health outcomes.

Signed by:

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Health Care Without Harm letter of support for MUC 2021-136, and MUC 2021-134
Submitted to CMS on June 17, 2022

On behalf of Health Care Without Harm, which maintains a hospital member network of over 1,400 hospitals across the country, we strongly support the National Quality Forum Measure Applications Program (NQF MAP) working groups in recommending the following two Drivers of Health (DOH) measures under consideration:

MUC 2021-136; Driver of Health Screening Rate *- Percentage of patients (18+ years old) who are screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during a hospital inpatient stay,* ***and***

MUC 2021-134; Driver of Health Screen Positive Rate *- Percentage of patients (18+ years old) admitted for a hospital stay who screen positive for 1+ of the following: food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety (reported as five separate rates).*

Health Care Without Harm is founded on the belief that: As the only sector with healing as its mission, health care has an opportunity, indeed a responsibility, to use its ethical, economic and political influence to create ecologically sustainable, equitable and healthy communities. Founded over 25 years ago, Health Care Without Harm seeks to transform health care worldwide so that it reduces its environmental footprint, becomes a community anchor for sustainability and a leader in the global movement for environmental health and justice. We conduct research, model strategic interventions and provide guidance and resources to spread and accelerate best practice in the field – with programs focused on climate and health, safer chemicals, and healthy food.

Health Care Without Harm has long recognized the impact that DOH have had on increasing rates of poor health outcomes, chronic disease and death. Climate change, the COVID-19 pandemic and increasing economic and social inequities in our communities that are the result of decades of systemic racism only serve to exacerbate the situation.

For example, some sobering statistics regarding diet-related diseases and how food insecurity is impacting our nation's health, published in The Washington Post (November 30, 2021):

- *More than 100 million Americans — nearly half of all adults — suffer from diabetes or prediabetes.*
- *About 122 million Americans have cardiovascular disease, which kills roughly 840,000 people each year.*

● More Americans are sick or suffer from major medical conditions than are healthy, and much of this is related to diet-related illness.
● If you are a Black person, those numbers mean you probably will have an even worse outcome. 49.6 percent of Black adults are considered overweight if not obese. Black people are also 60 percent more likely to be diagnosed with diabetes than White people.
● Americans who suffer from diet-related conditions such as heart disease, diabetes, cancer, and obesity are 12 times as likely to die after a COVID infection. 2
● And in 2020, the year COVID-19 hit the United States, African Americans were disproportionately impacted by the virus, many due to those same underlying diseases of obesity and diabetes. In total, Black people experienced a 2.9 year decrease in life expectancy, causing the Black-White life expectancy gap to widen from 3.6 to 5 years. In a single year.

Statistics similarly alarming can be found regarding the health impacts of poor indoor air quality, air pollution, climate change, poor access to public transportation or living close to a freeway or port, housing instability, and exposure to toxic chemicals in the air, land and water. And they are disproportionately affecting under-resourced communities of color. The frightening question is, how big and bad do the numbers have to get? What is the final tipping point before the federal government will declare a state of public health emergency and prioritize addressing the DOH with a systemic strategy? A coordinated, aligned national standards measurement process to screen for DOH as part of basic primary health care is absolutely critical to moving forward, and these two measures are a positive start.

The Physicians Foundation, which is directed by 21 state and county medical societies across the country, submitted these first-ever measures focused on screening patients for food insecurity, housing instability, transportation, utility needs, and interpersonal safety, including intimate partner violence. Their adoption would represent a crucial milestone as the first standardized federal measures to assess social need in the history of the U.S. health care system.

Despite the well-documented impact of DOH on health outcomes and costs and their impact on people of color, there are still no approved, standardized DOH measures in any Centers for Medicare and Medicaid Services' (CMS) programs. The impact of DOH interventions remain fairly invisible in federal health care policymaking, and the absence of standard DOH data or measures impedes efforts to achieve racial equity in health outcomes, given their profound impact on people and communities of color, especially in COVID's wake.

In enacting these first federal DOH measures, CMS could send a powerful signal to the health care sector and the communities they serve that there should be acknowledgement of how DOH impact peoples' health outcomes and an intention to address them in a coordinated strategy across the country. These initial DOH measures for screening could lay the foundation for additional measures focused on navigating beneficiaries to resources and connecting beneficiaries to the resources they need to be healthy. If implemented together, these two measures will:

- *Advance health equity by addressing the health disparities that underlie the country's health system, a key Biden-Harris Administration priority;*
- *Make visible to the healthcare system the impact of food insecurity and other drivers of health on patients;*
- *Support hospitals and health systems in actualizing their commitment to address disparities and implement associated equity measures to track progress;*
- *Encourage meaningful collaboration between healthcare providers and community-based organizations to connect patients to the resources they need to be healthy; and*
- *Guide future public and private resource allocation to promote collaboration between hospitals and health systems and invest in leveraging assets and addressing capacity and other gaps in the community resource landscape.*

We urge the Coordinating Committee to recommend both DOH measures (screening and screen positive rate) for the Hospital Inpatient Quality Reporting program (HIQRP), and include screening for all five of the drivers of health domains – food insecurity, housing instability, utilities difficulties, transportation 3 needs, and interpersonal safety. All five of these factors have a profound impact on health outcomes and disparities.

Additionally, the federal government pays for much of healthcare through billing codes. Healthcare providers use these codes to record – and get paid for – their patients' clinical diagnosis (ex. diabetes) and the clinical services/procedures they provide to patients. "Z codes" are a type of diagnosis code. Some Z codes are related to social determinants of health (SDOH), including Z59.4 (lack of adequate food) and Z59.41 (food insecurity). Currently, healthcare providers are not required or incentivized to use SDOH Z codes, resulting in underreporting of food insecurity and other drivers of health among patients. By requiring providers to report SDOH Z codes, CMS would begin to lay the foundation for payment for relevant resources (ex. produce prescriptions). We recommend that CMS require a subset of SDOH Z codes that:

- *align with the five core domains from the proposed SDOH measures – food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety – which are linked to adverse health outcomes and increased utilization; and*
- *are specific and actionable (e.g., Z59.4 - lack of adequate food and Z59.41 - food insecurity).*

When addressing issues such as food insecurity, housing instability, climate change, lack of transportation, and exposure to toxics in our air, land and water, we cannot settle on solving for acute, short-term health impacts alone. We must devise long term solutions for these long term and entrenched challenges that require equitable investment and attention. Our collective environmental and economic health need to be prioritized, with regenerative systems that are protective of our environmental health and natural resources, and substantial investment in fair labor practices and living wage mandates.

It is our hope that CMS will do the right thing and approve these measures, creating a federal, standardized system to incorporate DOH factors into primary health care and begin to set the stage for long term effective intervention.

Signed by:

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