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Ms. Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

September 11, 2023

Dear Administrator Brooks-LaSure,

On the part of Michigan Multipayer Initiatives (MMI) and its Steering Committee, and the Michigan Health Information Network (MiHIN) are grateful for the CMS' leadership and hard work to improve the well-being of Medicare beneficiaries.

MMI works to align payer policy to promote evidence-based approaches that improve outcomes of care in a provider-informed manner. MMI represents both the leading health plan payers and physician organizations in Michigan and has served to convene four state-wide multipayer CMMI demonstrations. Our member health plans are among the first nationally to incent providers and physician organizations to screen and service social care needs and to utilize health information exchange (HIE) for SDoH and referral submission.

MiHIN is the state's designated HIE and a leading force in the national work with Gravity, the Partnership for Aligned Social Care, and others to advance the standardization and interoperability of cross-sector social care. MiHIN also operationalizes use cases for data transmission statewide for more than 13 million patients and MiHIN is evolving to an integrated technology platform that is positioned to take advantage of HL7® FHIR®.

We are thankful for the opportunity to respond to CMS' call for comments on the proposed 2024 Physician Fee Schedule (PFS). We applaud your inclusion of an add-on code for complex primary care patient care, the addition of codes for Community Health Integration services, and Social Determinants of Health (SDoH) screening and assessment.

We are also appreciative of the limitations of authority that are clearly delineated in the proposed policy and think that you did an artful job of creatively working within the limitations to catalyze needed change. For example, though you do not have the statutory authority to waive beneficiary copays, you point out that SDoH screenings conducted in conjunction with Annual Wellness Visits would not bear a screening copay.

We feel strongly, however, that the following modifications to the proposed language are required to better achieve progress on the CMS Framework for Health Equity and to establish consistency with national standard-setting organizations such as Gravity and NCQA.

1. ***Section d. - Social Determinants of Health (SDOH) –Proposal to Establish a Stand-Alone G Code) (page 251-259)***

   A. **Recommendation: Use of "Social Need Screening" rather than " SDoH Risk Assessment"** - We recommend substituting the preferred language of "Proposed Social Need Screening Code" for the current language of "Proposed SDoH Risk Assessment Code".

   Rationale: Consistency on key terms and the concepts is important to advancing a shared understanding among the many partners (e.g., health providers, community-based organizations, etc.) that must cooperate to service the unmet social needs of Medicare beneficiaries. The new NCQA HEDIS measure is called the "Social *Needs Screening* and Intervention (SNS-E)" measure[1]. Further, the Accountable Health Communities tool focuses on "health-related social needs" screening[2]. The CMS Inpatient Prospective Payment System rule for 2024 further, focuses on "SDoH Screening". As well, leading researchers[3,4] have emphasized the importance of consistency in social care terminology. The adoption of "social need screening" in the final rule not only is consistent with national and international experts, but it also positions CMS well for evolution in later years to also address social need interventions.

   B. **Recommendation: Documentation via LOINC observation code -** We recommend that SDOH screening instrument responses be documented in the medical record using available LOINC observation codes, and that use of the set of ICD-CM codes known as "Z codes" (Z55-Z65) be limited to document confirmed social problems.

   Rationale: Current recommendations call for medical practices to conduct SDOH risk assessment using SDOH screening instruments. Positive responses to questions on screening instruments indicate a possible active social need, but as is the case for other types of screening (example: use of the PHQ-2 to screen for the presence of depression) they do not confirm the presence of an active social problem. Additional assessment is usually required to confirm the presence of active social needs. That can be done at the time of screening in a medical practice, but in many cases medical practices will conduct screening, then refer patients with positive

[1] https://www.ncqa.org/wp-content/uploads/2022/02/04.-SNS-E.pdf
2 https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
[3] Garg A, LeBlanc A, Raphael JL. Inadequacy of Current Screening Measures for Health-Related Social Needs. *JAMA.* Published online August 21, 2023. doi:10.1001/jama.2023.13948
[4] Alderwick H, Gottlieb LM. Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems. Milbank Q. 2019 Jun;97(2):407-419. doi: 10.1111/1468-0009.12390. Epub 2019 May 8. PMID: 31069864; PMCID: PMC6554506.

responses to a social care organization for further assessment to confirm problems and provide interventions. Therefore, we suggest that practices document screening results using LOINC codes. When further assessment and problem identification is completed in the medical practice, clinicians may then document confirmed problems using ICD-10-CM Z codes in the medical record. When further assessment and problem identification is delayed or carried out by external social care providers after referral, we recommend that the medical practice defer documentation of ICD-10-CM Z-code diagnoses until problem identification is confirmed. This will minimize the risk of 'overdiagnosis' of social problems which can occur with false-positive SDOH screening results. For this reason, we also recommend against the use of automated algorithms to directly convert SDOH screening results into ICD-10-CM Z-codes.

C. **Recommendation**: **Conformance with NCQA HEDIS SNS-e Measure** - We applaud CMS' focus on validated, evidence-based social need screening instruments. This strengthens the structure and usefulness of data collection and is feasible given the number of excellent tools such as the Accountable Health Communities and PRAPARE instruments. Some providers use a variety of validated, evidence-based screening tools to assess the domains of focus identified by CMS (food insecurity, housing insecurity, transportation needs, and utility difficulties). We recommend that CMS clarify that screening questions may be combined from various instruments, so long as screening requirements for all identified domains are met.

Rationale: The NCQA SNS-e measure permits use of multiple accepted tools, all of whom have been tested for validity and have LOINC mapping. For consistency with the NCQA HEDIS SNS-e measure, it is reasonable that CMS also permit the use of multiple, accepted tools.

2. Section b. – Community Health Integration Services (pages 236-251)

A. Recommendation: **Inclusion of TCM and AWV codes as initiating visits -** We recommend the inclusion of Transitional Care Management (TCM) and Annual Wellness Visit (AWV) codes as permissible initiating visits for CHI services and for social need screening and assessment.

Rationale: TCM and AWV services represent unique opportunities to engage with patients at a point when they are activated to partner with providers on health status improvement. This makes it all the more important to include attention to addressing social needs via community health integration.

B. Recommendation: **Permit CHI servicing via audio-only** - We strongly recommend that CMS allow audio-only servicing as a permissible modality for providing Community Health Integration services.

Rationale: We are concerned that some of the patients most in need of CHI services also are also those least likely to be able to have broadband capability. The Pew Research Center quantified this gap in 2021 and found that "About four-in-ten adults with lower incomes do not have home broadband services (43%) or a desktop or laptop computer (41%). And a majority of Americans with lower incomes are not tablet owners."[5]

In addition, though not incorporated in this year's proposed language, we encourage CMS to incorporate primary care hybrid payment in 2025. The evidence supporting the National Academy of Medicine's call for primary care hybrid is strong[6] and recent literature has thoughtfully addressed ways to overcome some of the thornier operational and modeling aspects of implementing hybrid primary care payment in Medicare FFS.[7]

We are thankful for the opportunity to provide comments and recommendations on the 2024 PFS and urge your careful consideration of our recommendations. Without the changes proposed above, we risk compromising very promising efforts underway in the HIE transmission of social care data including social needs screening and interoperable referral secure data exchange.

We appreciate the opportunity to provide feedback. We are happy to discuss any of the concerns identified above further. Questions regarding these comments can be directed to Diane Marriott at dbechel@umich.edu or Angie Bass at Angie.Bass@mihin.org.

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[5] https://www.pewresearch.org/short-reads/2021/06/22/digital-divide-persists-even-as-americans-with-lower-incomes-make-gains-in-tech-adoption/
[6] https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care
[7] Robert A Berenson and others, Beyond demonstrations: implementing a primary care hybrid payment model in Medicare, Health Affairs Scholar, Volume 1, Issue 2, August 2023, qxad024, https://doi.org/10.1093/haschl/qxad024