Investing in Health:
Integrating DOH into Systems of Measurement and Accountability

I. The Charge

Department of Health & Human Services (HHS) Secretary Xavier Becerra has pledged to "take a department-wide approach to the advancement of equity," including "examination of ways to address the social determinants of health." Health disparities exist independently from, but are substantially compounded by, drivers of health (DOH) – the socioeconomic, environmental, and behavioral factors that drive 80% of health outcomes. Addressing DOH is central to efforts to improve health, advance health equity, and reduce health care costs.

Investing in Health: A Federal Action Plan outlines seven strategies to accelerate scalable, sustainable integration of DOH into the health care system. This brief is the second in a series of three which draws from the Federal Action Plan and subsequent discussions with state and federal policymakers and thought leaders describing specific policy changes that could be deployed by the Centers for Medicare & Medicaid Services (CMS) under existing authority within the next one to two years.

The focus of this document is on integrating DOH into systems of measurement and accountability, building on a prior document focused on alignment of financial incentives to invest in health. A subsequent document will focus on investment in the community, human, and technological capacity required to integrate DOH across the health/health care continuum.

II. The Strategy: Integrate DOH into Standard Federal Measurement Frameworks

Standard DOH measures are critical to effectively quantifying and addressing the impact of DOH factors on health disparities, outcomes, and costs. A growing set of constituencies have called on CMS to lead in measuring and addressing DOH, recognizing that what we measure is a reflection of both what and whom we value. Health care experts have recognized that addressing DOH is necessary (though not sufficient) to achieve equity, calling for CMS to "build DOH measures into [the] Merit-based Incentive Payment System (MIPS) and all alternative payment models (APMs)." The Health Care Payment Learning & Action Network (LAN) – a group of public and private health care leaders providing thought leadership, strategic direction, and ongoing support to accelerate adoption of APMs – has identified promoting equity and addressing DOH as key facets of APM resiliency.

Likewise, physicians and other providers have called on CMS to create standard patient-level DOH measures – beyond socioeconomic status (SES), hierarchical condition category (HCC) score, or dual status – recognizing that these risk factors transcend specific subpopulations, drive demand for health care services, escalate physician burnout, and penalize physicians caring for those patients via worse MIPS scores.

CMS itself has recognized the importance of making DOH measures standard across programs, identifying the development and implementation of "measures that reflect social and economic

determinants" as a key priority and measurement gap to be addressed through Meaningful Measures 2.0. Likewise, CMS' February 2021 Technical Expert Panel to inform its Quality Measure Development Plan called for a concerted effort to collect information on social risk factors.

Further, a number of Center for Medicare & Medicaid Innovation (CMMI) models have functionally incorporated DOH screening and navigation data into their quality frameworks and care management plans for beneficiaries. CMMI's Comprehensive Primary Care Plus (CPC+) model reported in 2020 that 86% of ~1,500 Track 1 practices and 99% of ~1,500 Track 2 practices (together serving ~2.4 million beneficiaries) are implementing DOH screening. Participants in the State Innovation Model (SIM) and Next Generation Accountable Care Organizations (ACOs) are investing in staffing and infrastructure to conduct DOH screening and navigation. The 2021 Comprehensive End-Stage Renal Disease (ESRD) Care Model evaluation reported ESRD Seamless Care Organizations have begun to monitor food insecurity and provide food gift cards to address beneficiaries' non-adherence to nutritional guidelines and reduce the risk of increased utilization and costs.

Finally, CMS has the opportunity to leverage and apply CMMI's five-plus years of data and experience with the AHC Model. Launched in 2016, the AHC Model was the first federal pilot to address DOH, by testing whether systematically screening eligible Medicare and Medicaid beneficiaries for health-related social needs (HRSN) and navigating them to community resources will impact health care costs and reduce health care utilization. Using a standard, validated screening tool, the AHC Model has screened nearly one million beneficiaries for HRSN in 21 states, with 33% of beneficiaries screened having at least one HRSN.

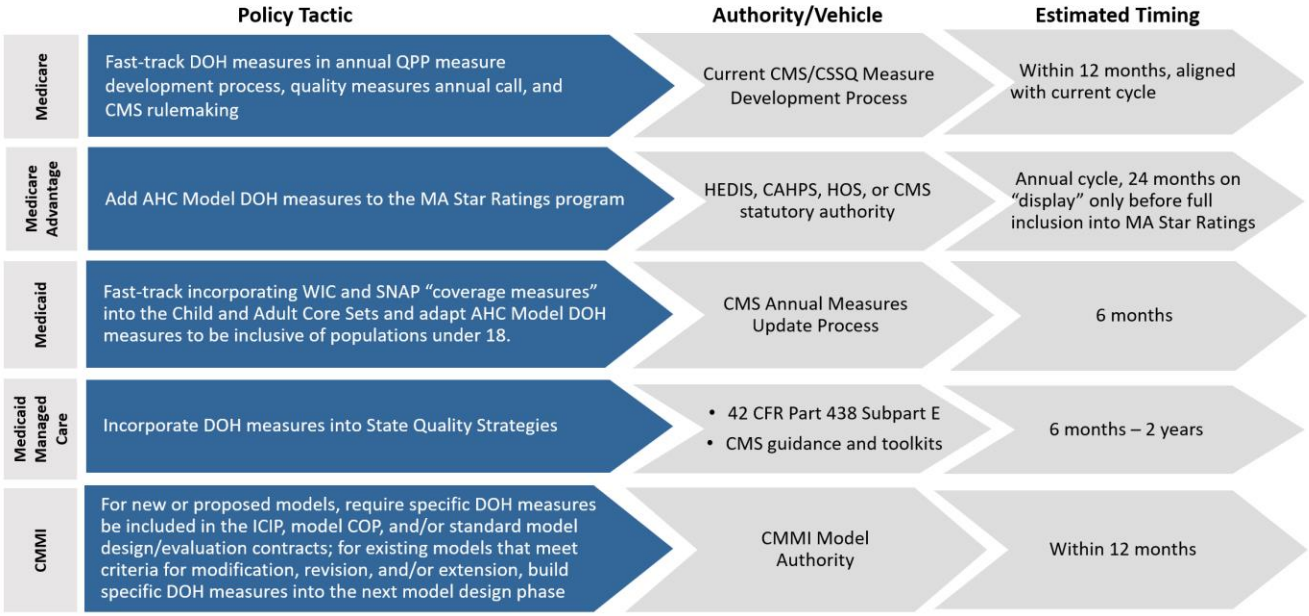
While CMS has been field-testing DOH data collection and measurement for a long time – and despite the market demand to address DOH – it has not yet instituted any beneficiary-level DOH measures in any of the major federal payment programs or quality measurement frameworks, as shown in Table 1.

Table 1. CMS programs and DOH measures

CMS Program	# of Measures	# of DOH Measures
Medicare Share Savings ACO	29	**0**
Merit-based Incentive Payment System (MIPS)	208	**0**
Medicare Advantage Star Ratings	46	**0**
Home Health Quality Reporting Program (HH QRP)	41	**0**
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	13	**0**
Hospital Inpatient Quality Reporting Program	42	**0**
Hospital Outpatient Quality Reporting Program	13	**0**
2021 Medicaid Core Measure Sets (Adult)	32	**0**

In the wake of a pandemic that has pushed our health care system to its limits – and has both exposed and exacerbated the interrelated inequities of health, race, and class – CMS has a crucial imperative to "put a 1 on the board" by integrating DOH measures into its measurement frameworks and programs. Figure 1 outlines a set of five specific recommendations that CMS could take to integrate DOH into systems of measurement and accountability within its current regulatory authority within the next two years.

Figure 1. Recommendations for integrating DOH into systems of measurement and accountability



As CMS implements these initiatives, it is critical to:

- **Center on equity.** A growing evidence base has established that addressing DOH can improve health outcomes and reduce health disparities, and can do so more cost-effectively and equitably than medical interventions alone. Focusing on traditional quality measures without addressing DOH may exacerbate access barriers and worsen racial disparities. Efforts to address DOH must be anchored in the broader effort to achieve health equity, with a focus on communities of color that are disproportionately impacted by DOH. For this reason, it is crucial that CMS collect – and use – both DOH data and race and ethnicity data. In particular, any DOH measure reporting requirements should be stratified by race and ethnicity so that they may be evaluated and adapted to ensure they advance health equity goals.

- **Use available data to develop and improve payment models.** Public and private health and health care entities, including the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), Patient-Centered Outcomes Research Institute (PCORI), Office of the Assistant Secretary for Planning and Evaluation (ASPE), and Agency for Healthcare Research and Quality (AHRQ), have begun to incorporate DOH into their national priority frameworks. Yet the nation still lacks standard DOH measure sets and reporting requirements, and where they do exist, they are not broadly deployed. Waiting for their scaled adoption leaves us stuck in an

endless loop: we cannot tie DOH to reimbursement without measurement, but measurement will not proliferate without payment. Massachusetts' risk adjustment model illustrates that using available data to incorporate DOH into payment models is possible today *and* triggers increased reporting, allowing for further refinement of models over time.

- **Align DOH measures across programs.** To avoid fragmentation or divergent approaches and enable cross-agency and market alignment, the recommendations below call on CMS to integrate standard DOH measures (stratified by race and ethnicity) across all its programs, starting with the percentage of beneficiaries who are screened for DOH and who screen positive for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. Further, in recognition of ongoing efforts to address providers' administrative burden, we recommend that for each DOH measure added, CMS eliminate one or more administrative or other measures.

III. The Policy Changes

❖ *Medicare:* Fast-track DOH measures in annual Quality Payment Program (QPP) measure development process, quality measures annual call, and CMS rulemaking.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to implement the Quality Payment Program (QPP), a program that links payment increases to high-quality and high-value providers based on performance standards and quality measures. The most significant opportunity to incorporate existing DOH measures from the AHC Model into federal health reform is through the QPP, which sets measures for the MIPS and APMs. DOH are 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. To date, the QPP has not accounted for DOH in its quality measures, financial incentives, category weights, or performance pathways.

In May 2021, the following DOH measures used in the AHC Model evaluation were submitted by The Physicians Foundation, which represents 21 state and county medical societies, to the CMS Measures Under Consideration (MUC) list:

- DOH Screening Rate: Percentage of beneficiaries ≥18 years screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety
- DOH Screen Positive Rate: Percentage of beneficiaries ≥18 years who screen positive for food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety

In July 2021, under the leadership of the Center for Clinical Standards and Quality (CCSQ), CMS officially accepted these measures onto the MUC list for the MIPS program and the Hospital Inpatient Quality Reporting Program. Between 2013 and 2020, 2,864 measures were submitted for consideration in the MUC process – *not a single one addressing food, housing, or other DOH.* Should these DOH measures become official, they would represent the first such measures in the history of the U.S. health care system. As with any DOH measure adopted by CMS, reporting requirements should require that these

measures be stratified by race and ethnicity. CMS will review and publish the MUC list by December 2021. The next critical steps in the process include:

- The Measurement Applications Partnership (MAP) will convene multi-stakeholder workgroups through the National Quality Forum to provide pre-rulemaking input to CMS/HHS on measures under consideration for payment and reporting programs. The MAP assesses each candidate measure and issues one of the following recommendations: (1) support, (2) do not support, (3) conditionally support, or (4) refine and resubmit. *(November 2021 – January 2022)*
- The MAP provides the measure recommendations to HHS for the QPP and other CMS payment and reporting programs. *(February 2022)*
- HHS then reviews the MAP's guidance and makes final decisions regarding measure selection. CMS leadership should flag for HHS leadership the imperative to embed DOH measures into the federal framework this cycle to address the stated CMS measurement gap and priority on social and economic determinants.
- Final measures are published as proposed rules in the *Federal Register* and, following an open comment period, are finalized.

❖ *Medicare Advantage (MA)*: Add AHC Model DOH measures to the MA Star Ratings program.

Since 2007, CMS has evaluated Medicare Advantage (MA) plans using the Star Ratings program based on each plan's performance across a number of measures. More than 24 million Americans are currently enrolled in an MA plan, and the number is expected to rise significantly by 2030. In 2020, the majority (78%) of MA enrollees are in plans with quality ratings of four or more stars. A recent study found that five-star ratings are only modestly associated with the quality of the health care experience for racial/ethnic minorities and socioeconomically disadvantaged enrollees in plans. None of the 32 MA or 14 Part D measures in place today incorporate DOH or are adjusted beyond an overall adjustment for low-income status/dual eligibility and disability.

CMS should use its authority to add the existing AHC Model DOH measures (see above) to the MA Star Ratings program. To add DOH measures to the MA Star Ratings program, CMS can use the Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers & Systems (CAHPS), or Health Outcomes Survey (HOS) as sources, or can use its statutory authority to propose and add new measures. Next steps include:

- CMS previews MA Star Ratings measures and methodology for plan comment. (*November)*
- CMS proposes final MA Star Ratings measures and methodology with a 30-day comment period. *(February)*
- CMS finalizes MA Star Ratings measures and methodology via subregulatory guidance. (*April)*
- New measures are for "display" purposes only, for a period of two years while undergoing testing before inclusion in the MA Star Ratings program.

❖ *Medicaid:* (1) Adapt AHC Model DOH measures to be inclusive of populations under 18, and/or (2) fast-track incorporating WIC and SNAP "coverage measures" into the Child and Adult Core Sets.

The Medicaid and Children's Health Insurance Program (CHIP) Child Core Set and Adult Core Set consist of quality measures collected at the state level that can be used to estimate the overall national quality of health care for Medicaid and CHIP beneficiaries, monitor performance of state Medicaid and CHIP programs, and identify where improvements in care delivery and/or outcomes are needed. By statute, reporting of the Core Sets is currently voluntary for states. Beginning in 2024, reporting on the Child Core Set and on the behavioral health measures of the Adult Core Set will become mandatory.

Quality measures included on the Core Sets must satisfy six criteria aimed at estimating the quality of health care in Medicaid and CHIP, ensuring feasibility of measurement across states, and providing useful and actionable results to drive improvement. Measures must go through the annual Core Set review process.

The Center for Medicaid & CHIP Services (CMCS) has issued guidance encouraging states to incorporate DOH measures into Medicaid and CHIP. Further, the 2021 *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP* specifically cites three cross-cutting gap areas in the measures: (1) social determinants of health, including housing insecurity, social isolation, and poverty status; (2) stratification of new and existing measures by race, ethnicity, language, and disability; and (3) integration and data linkages across sectors and settings, particularly for beneficiaries with complex needs and social risk factors. Yet CMCS itself has included *no* DOH measures in the 2021 Medicaid Adult or Child Core Set or in the recently recommended 2022 Core Sets. CMCS should incorporate DOH measures via one of two potential pathways.

CMCS should adapt the DOH measures used by the AHC Model (as described above) for use as standard measures in the Medicaid program for populations under 18 (and stratified by race and ethnicity), consistent with CMS' commitment to "promote alignment across quality initiatives and programs" across Medicare and Medicaid.

Alternatively, CMCS should fast-track the following WIC and SNAP "coverage measures" to the Child Core Set and Adult Core Set as a first step toward integration of standard DOH measures:

- Percentage of SNAP-eligible Medicaid beneficiaries enrolled in SNAP
- Percentage of WIC-eligible Medicaid beneficiaries enrolled in WIC

These measures are responsive to the Core Sets criteria:

- Recent studies demonstrate that Medicaid beneficiaries who are SNAP-eligible but not enrolled in SNAP have health care costs that are ~$2,544 more per member per year compared with those who are SNAP-eligible and enrolled in SNAP.
- Many other Adult and Child Core Set measures specified for the seven target domains listed above are significantly impacted by access to healthy food (e.g., low birth weight, hemoglobin A1c, readmissions).

- Every state currently has access to this data at the aggregate level, with the USDA providing: SNAP and WIC participation data monthly at the beneficiary and household levels; SNAP and WIC coverage data; and, the ability to cross-walk enrollment data at the individual level.
- States could leverage these SNAP and WIC coverage measures by requiring managed care organizations (MCOs) to focus on them as part of their Quality Assessment and Performance Improvement requirements, as some states have already begun to do.

Next steps include:

- The Core Set Review Workgroup develops recommended changes, which are posted for public comment. *(May 2022)*
- The Core Set Review Workgroup posts its recommendations for public comment. CMCS should specifically elicit public comment on the proposed DOH measures above. *(July 2022)*
- CMCS issues a final report to review with state partners for feedback. CMCS then reviews the recommendations in the final report, along with feedback from state partners, internally within CMS and with key federal partners. CMCS should engage its state and federal partners on the SNAP and WIC coverage measures proposed above. *(August 2022)*
- The final 2022 Core Sets will be released by the end of the calendar year and published in a CMS informational bulletin. *(December 2022)*

❖ *Medicaid Managed Care:* Incorporate DOH measures into State Quality Strategies.

42 CFR Part 438 Subpart E (Quality Assessment and Performance Improvement) lays the groundwork for the development and maintenance of a quality strategy to assess and improve the quality of managed care services offered within a state. The quality strategy is intended to serve as a blueprint for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as in setting forth measurable goals and targets for improvement. Each state contracting with an MCO must develop and maintain a quality strategy, and CMS has begun to work with states to broaden the scope of the quality strategy beyond managed care. While some states have incorporated DOH into their quality measure sets (for example, North Carolina and Rhode Island require DOH screening as part of state quality reporting requirements), most states lack standardized DOH indicators.

CMS should add DOH to state quality strategies under Medicaid managed care by:

- Issuing new guidance, building off the November 2013 State Health Official Letter (SHO) titled "Quality Considerations for Medicaid and CHIP Programs," *requiring the integration of DOH into state quality strategies* in the context of Medicaid managed care and value-based purchasing arrangements. *(Six to nine months to develop and clear policy)*
- Working with states to develop *standardized use cases*, *implementation tools*, and *templates* to support integration of DOH standards into (1) state quality strategies, (2) health plan comprehensive quality assessment and performance improvement program contractual requirements, and (3) approaches for linking these standards to financial incentives. *(Nine*

months to convene a learning collaborative to identify promising practices from states and develop toolkits/guidance to share findings with other states)

- Amending 42 CFR Part 438 Subpart E to include addressing DOH as a minimum quality requirement. *(One to two years to develop policy, draft and clear notice of proposed rulemaking, and issue final rule)*

❖ *CMMI:* Require specific DOH measures in new models and in current models that meet the criteria for modification, revision, and/or extension.

Drawing on its experience and data from implementing DOH measures with almost one million AHC Model beneficiaries (as well as other CMMI models that have functionally implemented DOH screening and navigation), CMMI should require the integration of a core set of AHC Model DOH measures (as discussed above) into all models – and most immediately into new or proposed primary care or population health payment models. Acting within its current legislative authority, CMMI should:

- For *new* or *proposed* models, or for models *under development*, require that specific DOH measures be included in the:
  - Innovation Center Investment Plan (ICIP) used to guide all models through the clearance process, including as part of any required equity impact assessment
  - Conditions of participation for model awardees
  - Standard model design/evaluation contracts
- For *existing* models meeting the criteria for modification, revision, and/or extension, build specific DOH measures into the next model design phase based on learning from model evaluations.