MUC2024-052 Social Need Screening and Intervention

American Academy of Family Physicians (AAFP) comments

Recommendation: Do not support

The AAFP supports CMS' goal of reducing health inequities and believes family physicians, along with others, play an important role in helping to identify and alleviate the health-related social needs of patients. However, we do not support the addition of this measure for use in the CMS Medicare Advantage Star Rating Program. We would like to note the following concerns:

- As stated in our previous comments about the appropriate application of HEDIS measures, we do not support the implementation of this measure for health plans.
    - There is another social needs screening and intervention measure on this year's MUC list that is proposed for use in MIPS and is specified for use at the individual clinician and group level (MUC2024-072).
    - If both the health plan AND the patient's primary care or other clinician are screening for social needs and trying to provide interventions (when needed), then there is a significant duplication of services. This will likely lead to patient confusion, hesitancy, frustration, and survey fatigue. If further fragments care.
- This measure is not digital, nor is it an eCQM.
- It has not been endorsed by a consensus-based entity (was never even submitted).
- The measure does meet reliability testing requirements. In fact, the developer did not even perform reliability testing.
- The community-based organizations (CBOs) who can help patients alleviate social needs are often overwhelmed and do not have the capacity for a mass influx of referrals.
- The lack of data sharing and interoperability across the health ecosystem presents a tremendous problem and challenge.

In addition to the above concerns specific to this proposed measure, we would like to reiterate comments we have previously shared with CMS about proposed performance measures for social needs screening and intervention:

It is important for family and other primary care physicians to be connected to social and community-based organizations that can help to address patients' social needs using an efficient, centralized approach. These are core tenants of comprehensive, longitudinal primary care, though we note that these types of services are often not billable under the MPFS. Moving to APMs that include comprehensive prospective payment must be prioritized if we are to sufficiently and sustainably support primary care's role in improving health equity. Further, **physicians and other clinicians cannot be held accountable for providing resources to address individual health-related social needs when those resources do not exist in the community.**

The overarching goal should be to drive improved health for historically marginalized and medically underserved populations. Addressing health equity and social drivers of health are community issues that require community solutions. Many communities simply do not have adequate social resources and community-based organizations available to help meet patients' diverse social needs. Even when those resources exist at the community level, community-based organizations

are not typically resourced with the funding, skills, or staff to accept referrals from the health care system. CMS should incentivize the development and use of community care hubs or other payer and provider agnostic centralized referral systems to ease the burden on all parties, including the community-based organizations best equipped to address patients' social needs

The AAFP is very supportive of screening for health-related social needs and has equipped its members with the tools to engage in this important aspect of whole-person care through the EveryONE Project. As screening patients for unmet health-related social needs is increasingly common for many provider types and at many points of entry for patients into the health care and health insurance systems, there is increased interest in measurement of these efforts. The AAFP agrees with CMS that the insights gained through these screenings provide important patient and community level insights but urges caution when considering measurement of this activity as an indicator of care quality in a single health care setting.

The ultimate goal should be to build the infrastructure and capabilities necessary to share these patient-level insights across provider types in a secure and timely fashion with the patient's permission to do so, just as is done with clinical information. This will ensure that all of a patient's caregivers are aware of their unique needs while not overburdening patients or their physicians and other clinicians with unnecessary, repetitive assessment efforts. Overwhelming patients with different screening mechanisms at different points along the health care spectrum could be counter-productive to building trust with patients. It is important to recognize that there are challenges and important considerations to address before new measure requirements are introduced. Most importantly, the measure should address those factors or circumstances within the control of the individuals or organizations being measured. CMS' measurement strategy should account for these challenges and ensure quality measurement does not negatively impact underserved patients or the clinicians caring for them.