NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

April 18, 2022

Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
7500 Security Boulevard,
Baltimore, MD 21244

Re: Response to "Request for Information: Access to Coverage and Care in Medicaid & CHIP"

Dear Administrator Brooks-LaSure,

The National Alliance to Impact the Social Determinants of Health (NASDOH) is pleased to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information on "Access to Coverage and Care in Medicaid & CHIP".

Federal health and social programs have a profound effect on the wellbeing of individuals and families. NASDOH believes this RFI can inform a comprehensive access strategy for Medicaid and the Children's Health Insurance Program (CHIP). We commend CMS for seeking input on how to ensure equitable access to these essential health care programs.

About NASDOH

NASDOH is a group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement. We seek to make a material improvement in the health of individuals and communities and, through multi-sector partnerships, advance holistic, value-based, person-centered health care that can successfully impact the social determinants of health.

NASDOH brings together health care, public health and social services expertise, local community experience, community-convening competence, business and financial insight, technology innovation, data and analytics competencies, and policy and advocacy acumen to assess and address current regulatory frameworks, funding environments and opportunities, and practical challenges to implementing and sustaining social determinants of health efforts.

Response to Specific Questions

NASDOH appreciates the detailed and thoughtful questions posed in the RFI. NASDOH offers the following comments in response to specific questions posed:

What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations? In your response, consider both eligibility determinations and

redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable

CMS can support states in achieving timely eligibility determinations, enrollment, and redeterminations by leveraging administrative flexibility to waive requirements that while well intended, often pose barriers to individual's enrollment. These include waiving in-person contact requirements, allowing presumptive eligibility, streamlining paperwork through means such as self-attestation, and verifying income based on state data sources.

Further, we encourage CMS to evaluate other eligibility and enrollment flexibilities allowed during the COVID-19 Public Health Emergency (PHE). Those flexibilities that led to greater efficiency and impact and reduced burden for individuals without high cost or error should be made permanent and expanded to other programs that would benefit.

What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?

We encourage CMS to promote and facilitate IT integration across federal and state health and social service programs so that states can verify eligibility without requiring individuals to complete redundant paperwork and repeatedly prove their eligibility. In addition to reducing burden on individuals, IT system integration can facilitate individuals' enrollment in health and social service programs – for example, those that address nutrition, unemployment, and more - which would support efforts to address social need and positively impact their health and well-being.

How could CMS consider the concepts of whole person care or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? *For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?*

Medicaid programs are the primary provider of health care benefits to tens of millions of Americans with limited incomes and resources, many of whom are vulnerable to adverse social determinants of health (SDOH) and as a result, are more likely to have unmet health-related social needs. We applaud CMS efforts to include access to services to address social needs and believe it is an essential component of whole person and coordinated care.

To facilitate access to whole person care, CMS can provide greater clarity on which services addressing social needs ("social care") are allowable and their classifications. Additionally, CMS could provide clarity about how to appropriately count investments in infrastructure to coordinate social care in the numerator of the Medicaid medical loss ratio (MLR). It is our understanding that social care can be counted as an incurred medical expense in the Medical Loss Ratio (MLR) but we see that confusion still exists. Some are still unclear that the provision of social care can be counted in the MLR, and for others who believe it is allowable, they still struggle with how to classify non-traditional services. Lack of clarity

limits inclusion in Medicaid managed care contracts and plan confidence or willingness to provide non-medical services designed to address social needs, to invest in essential infrastructure – like technology systems to facilitate referrals, and subjects plans to potential penalties for failing to reach the minimum MLR threshold.

We encourage CMS to consider how social risk factors and SDOH can be appropriately included in Medicaid rate setting process. Adequately accounting for these health-related social drivers would enable plans to improve access, intervene, and mitigate their impacts on health.

In addition, we ask that CMS test more innovation models which improve access to social care and address health-related social needs in the Medicaid and CHIP program through the CMS Innovation Center (CMMI). Due to their impact on access to care and health outcomes for all people, addressing adverse SDOH and unmet social needs are an important part of a health equity strategy – which aligns with CMMI's recent strategy refresh. Many of the CMMI models which incorporate social needs screening and social care provision are being tested in the Medicare program. CMS should prioritize testing innovation models in the Medicaid program as well, and incorporate efforts which address social needs into these models. Further, successful strategies identified in CMMI models, particularly those that improve access, care coordination, and whole person care, should be rapidly adopted in the broader Medicaid and CHIP program.

Finally, we encourage CMS to coordinate across agencies to ensure that program waivers and flexibilities which have proven successful can be extended. The COVID-19 Public Health Emergency demonstrated program flexibilities could be used, and coordinated, to ensure effective and efficient approaches to address social needs. NASDOH believes these same flexibilities would improve health during non-pandemic times too. NASDOH has previously called on the federal government to focus on program integration, and pathways to coordinate parallel waiver authorities across federal programs to allow states or other implementing organizations to optimize social needs interventions. CMS should explore how Medicaid waivers can be coordinated with other agency and department flexibilities to deliver social needs services without compromising the intent or allowances of each program. As others have called for, we encourage CMS to create pathways allowing state Medicaid agencies to coordinate with and request cross-department or cross-agency waivers to provide social need services with other state agencies, while establishing appropriate guardrails to ensure that the fundamental goals of those programs are maintained.

In addition to existing legal obligations, how should CMS address cultural competency and language preferences in establishing minimum access standards? *What activities have states and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?*

NASDOH appreciates CMS question on how to improve access to culturally and linguistically competent care in the Medicaid program, as it is an essential factor in making care accessible. NASDOH members note the importance in utilizing community health worker (CHWs) as one strategy to ensure care is culturally and linguistically congruent. Previously, CMS has made it clear that states can require MCOs to include community health workers (CHWs) in care teams; CMS notes that CHWs promote patient-centered care and provide needed linkages between beneficiaries and services.

The American Rescue Plan Act of 2021 provided funding for CHWs, and states should use that funding to recruit and train CHWs. We encourage CMS to ensure that Medicaid funding can be used to sustain CHW programs over time and ensure that care is accessible to all.

How can CMS assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?

States and MCOs continue to seek guidance from CMS on how they can use program authorities and waivers to address social needs, and to learn about the effects of efforts in other regions. CMS should facilitate information sharing between states by establishing a CMS-led learning collaborative. A learning collaborative would provide states the opportunity to discuss ongoing initiatives, learn from each other's successes, and create an environment where CMS could more readily assess what is working and offer more detailed technical support to states, MCOs, and other important stakeholders, like beneficiaries, community-based organizations, and other human service agencies, who are instrumental in providing whole person care in the Medicaid program. For example, CMS could facilitate discussion and learning within or across geographic reason on:

- Supporting states' capacity to develop and utilize flexibilities and allowances by providing educational training opportunities and professional development for staff. CMS can provide or support the development of training modules and educational resources for state Medicaid staff to help them understand what's allowable, when and how it should be deployed, and what resources are available to them to address social needs. Educational training opportunities, virtual learning modules, and other such professional development opportunities are important to grow the capacity of the state program staff to use the tools made available to address social needs.
- Provide Medicaid MCOs greater clarity on allowable services addressing social needs and their classification. In a learning collaborative environment, CMS could work with states and MCOs to address questions about specific services, and how they may be classified. This would assure states and MCOs they can take advantage of the flexibilities intended in current law, and spur innovation. For now, many MCOs are investing in social needs services using reserves or other funds because of lack of clarity. This could impact their long-term accessibility, sustainability, and scalability.

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We appreciate the opportunity to provide NASDOH's views and recommendations on advancing equity and support for underserved communities through government. We are happy to discuss any of the information outlined above or provide further assistance that would be valuable. For more information on NASDOH, please visit our website at www.nasdoh.org or contact Sara Singleton at Sara.Singleton@leavittpartners.com

Sincerely,

Sara Singleton

Sara Singleton
Principal, Leavitt Partners and Advisor to NASDOH