Addressing Social Needs under the Medicaid and CHIP Learning Collaboratives

Background

As NASDOH described in our 2021 issue brief, the federal government has made it clear that addressing social needs is within the purview of the Medicaid program and consistent with the program's aims. The Medicaid program has a record of addressing non-medical needs, as seen through the provision of long-term services and supports and personal care services. We are encouraged to see certain flexibilities, such as Section 1915 Home and Community-Based Services (HCBS) waivers and Section 1115 Demonstration waivers used to address social needs under Medicaid. That said, states and health plans continue to seek guidance from CMS on how they can use program authorities and waivers to address social needs, and NASDOH encourages CMS to empower states to identify ways in which they can leverage existing authorities under the state Medicaid programs to address social needs. This is especially important given that the majority of states (35 states in 2020) have implemented managed care organization (MCO) procurement and contracting strategies which require states to, for example, screen for social needs.[1]

NASDOH was pleased to see that in early 2021, CMS released guidance to state health officials designed to drive the adoption of strategies that address the social determinants of health (SDOH) in Medicaid and the Children's Health Insurance Program (CHIP) so states can further improve beneficiary health outcomes, reduce health disparities, and lower overall costs in Medicaid and CHIP in early 2021. While that guidance was helpful in offering a list of waiver opportunities, it reflected the state of play at that point in time and left considerable unclarity regarding aspects of social care that can be provided and to whom. NASDOH members serve populations in multiple states, and they note considerable differences across states in the knowledge and uptake of CMS-approved approaches. We are aware that many prior and ongoing learning collaboratives include an element of addressing social needs as a part of quality improvement projects, but this has not necessarily translated into broader learnings for the diverse array of beneficiaries served across states.

NASDOH strongly encourages the enhancement of CMS efforts to promote cross-state learning, including the creation of a learning collaborative focused specifically on strategies to address social needs in Medicaid. Given our members' on-the-ground experience, NASDOH offers itself as a resource to CMS to assist in the development and/or implementation of a social needs-related learning collaborative and welcome follow-up discussion.

Goals

While the term "Learning Collaborative" is frequently used, we encourage CMS to take a broad view that goes beyond periodic meetings or networking of interested parties. Rather, we encourage CMS to intensify efforts for more systematic cross-state information sharing that can advance the goals of the Medicaid program and improve the health of beneficiaries. The goals of this multi-faceted learning initiative could include:

- Sharing innovative practices and approaches as they are being considered and developed;
- Sharing solutions related to challenges that multiple states face in common;
- Providing a protected forum for discussion of approaches, successes, failures;

[1] https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/

- Providing support to states for documenting their experience;
- Serving as a cross-state clearinghouse for evidence on outcomes, costs and benefits, and other elements that would aid decision-making in other states;
- Compiling, in real-time, documentation of interventions/approaches that CMS has approved through guidance, waivers or other administrative action; this provides states with useful information as they make decisions, rather than waiting for a periodic compilation or guidance letter;
- Providing feedback to CMS on priority areas for considering additional guidance or clarification of Medicaid policy; and,
- Promoting the uptake of approved, effective interventions addressing social needs and determinants in the Medicaid population.

Mechanisms and Participants

In our view, this effort would be most effective if it involved traditional convening of state program officials, but also included a more intensive effort to compile success stories, document interventions, gather and share evidence, and apply the learning to CMS guidance and assistance.

NASDOH recognizes that addressing social needs involves a range of participants outside the health care delivery system. Accordingly, we recommend that a learning model include not only Medicaid agencies and providers, but also their critical partners. A learning network could include:

- State Medicaid agencies;
- Medicaid managed care organizations;
- Medicaid beneficiaries and community residents;
- Community-based social service organizations that deliver services or conduct screening;
- Relevant health services providers, including Federally qualified health centers, and mental health authorities/providers;
- Public health organizations; and
- State or local agencies that administer Federal social programs such as SNAP, WIC, housing assistance, and LIHEAP so that opportunities for braiding and blending of funding can be addressed.

Priority Topics to Address

NASDOH encourages CMS to use 1115 Demonstration waivers as compelling case studies to examine and socialize among states as effective mechanisms for shared learnings. Giving states an understanding of what other states have done and how is a key opportunity for providing the additional detail that sometimes hampers adoption in new states.

Furthermore, NASDOH offers several key areas which members have raised as topics that could especially use further guidance and clarity from CMS, which include:

- Best practices and allowable funding for alignment of eligibility, enrollment, and outreach across Federally funded benefits programs;
- Best practices and allowable funding to integrate Medicaid with other funding sources addressing social needs of beneficiaries (i.e., approaches to braiding and blending funding);
- Specifically which social needs interventions are allowed for which populations as covered medical expenses under the medical loss ratio (MLR) (i.e., CBO reimbursement- like Network lead entities in North Carolina, CalAIM;

- Best practices for building Community Health Workers into service delivery models, including training, and reimbursement;
- Data sharing approaches that maximize patient privacy and effective care delivery, including the appropriate use of SDOH Z codes, information sharing with social service providers, and sharing across Federally funded service providers for eligibility and enrollment. Health Information Exchanges (HIEs) may be considered as a model of successful data sharing across organizations and sectors;
- Practical guidance on how health care organizations can interpret safe harbor regulations, specifically for patient/member inducement or recruitment regulations, intended to facilitate relationships between health care providers and organizations that may provide services related to social needs. These regulations are complex and remain a perceived barrier to developing meaningful relationships that would allow beneficiary needs to be efficiently and effectively met;
- Technical assistance about how to braid and blend funding sources from across existing programs to address social needs and SDOH. We are mindful that while a health care provider may identify the health-related needs of a Medicaid beneficiary, those needs may be better addressed by linking or working with other programs. It is a practical challenge for states and their partners to understand how funds can be braided and blended to provide person-centered care, especially for beneficiaries who have multiple, complex, and inter-related needs;
- The role of states (and Medicaid funding) in building and supporting infrastructure needed to establish mechanisms and partnerships with social service organizations for addressing social needs;
- Training and assistance for HIPAA Covered Entities with understanding HIPAA rules regarding patient consent for sharing PHI in referrals to community-based assistance providers;
- Approaches to measuring the impact of social care interventions, including effective study design and identification of appropriate outcome measures, and how such measures can be incorporated into rate setting and reimbursement; and
- Best practices in developing, measuring, and evaluating strategies for addressing health equity.