NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

November 4, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW Washington, DC 20201

Re: Request for information: Make your voice heard—Promoting efficiency and equity within CMS programs

On behalf of the National Alliance to impact the Social Determinants of Health (NASDOH), we submit these comments in response to the request for information (RFI), Make your voice heard—Promoting efficiency and equity within Centers for Medicare & Medicaid Services (CMS) programs (CMS 2022a). We appreciate the opportunity to comment and offer responses to each of the four buckets CMS outlined below.

Accessing Healthcare and Related Challenges

Provide more clarity on addressing social needs in Medicaid: NASDOH was pleased that CMS recently approved Medicaid waivers in Massachusetts, Oregon, and Arizona to address health related social needs in those states. Additional clarity for states that do not currently have a waiver but are interested in doing this work, could help these states prepare and submit waiver applications. To facilitate access to and payment for services that provide 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 the human, physical, and technical infrastructure needed 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 social determinants of health (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.

Use CMMI models to test SDOH interventions: 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.

Use learning collaboratives to share strategies for addressing SDOH: Lastly, NASDOH requests that CMS facilitate information sharing between states and among providers 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 regions 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.
- Allowable services for addressing social needs and their classification. In a learning collaborative environment, CMS could work with states, MCOs and providers 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.

Effectively use Community Health Workers: Additionally, NASDOH members note the importance of 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 allow 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 to train and recruit thousands more CHWs, so we anticipate this workforce will grow in the future. 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.

Understanding Provider Experiences

Provider role in screening for health-related social needs: While NASDOH strongly supports screening for social needs, we recognize that providers, who are most often responsible for screening for and collecting SDOH information, are managing multiple and often competing programmatic requirements. This burden can be disruptive to effective and efficient operations. Importantly, this can also impact enrollees, who are then asked to share their social risks and needs, data which we know is sensitive, multiple times to meet provider programmatic requirements. The use of a consistent screening tool and a standardized process can help alleviate this burden.

NASDOH believes it is important to encourage meaningful collaboration between health care providers and community-based organizations to screen and connect patients to the resources they need to be healthy. NASDOH notes that many clinicians are not trained nor comfortable conducting social risk screening and instead delegate screening and assessment to community-based organizations (CBOs). This should be permitted and encouraged and allowed to be paid for, and guidance and training for clinicians should also be made available. In some cases, CBOs are best positioned to conduct this screening due to their history and trust within the community. NASDOH encourages CMS to ensure any quality measures on clinician referrals to community-based services upon screening positive for a social driver of health do not discourage clinicians from partnering with CBOs to conduct the screening where appropriate.

Advancing Health Equity

Stratification of measures: To identify health disparities across groups and advance health equity, it is essential that information can be stratified by factors such as race and ethnicity. NASDOH encourages CMS to consider developing guidance on methods to collect information stratified by demographic factors. We recommend the prioritization of demographic factors identifying race, ethnicity, sexual orientation, and gender identity as a starting point. We know health care outcomes vary by these demographic factors and studies show that belonging to a racial or ethnic minority group or being a member of the LGBTQ+ community is often associated with receiving lower quality of care, having a worse experience of care, and having worse health outcomes even after accounting for social risk factors. Further, because of systemic and institutionalized racism and discrimination, these groups are also more likely to experience adverse SDOH which influence health risks and healthcare outcomes. Additionally, NASDOH recommends that CMS consider food security, housing security, transportation access and reliability, interpersonal violence, and social isolation to stratify performance by social risk.

Screening for social needs and SDOH is a first step in identifying health disparities across groups and addressing health inequities. NASDOH was grateful to see the proposal of social needs screening measures in CMS' annual Medicare payment proposed rules and the inclusion of those measures in the finalized CY 2023 Medicare Physician Fee Schedule (PFS) Rule. We encourage CMS to issue guidance for SDOH screening across all of its programs using a standardized set of common

screening elements, such as the Screening for Social Drivers of Health measure included in the PFS rule, which includes screening for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. Considering the particular challenges in screening for interpersonal violence, including the necessary privacy required to disclose this information and the threat to individuals in disclosing this information, it is imperative that CMS be explicit about the complexities of carrying out screening in this domain and require providers to be sensitive of these complexities when designing and implementing the screening process around interpersonal violence.

Role of CBOs in screening: To this end, CMS should allow entities outside of health care to screen for the five domains, including community-based organizations in the social service sector. Often, community-based organizations are best positioned to conduct this screening due to their history and trust within the community. NASDOH encourages CMS to allow providers under federal health care programs to partner with, and ideally contract with, community-based organizations, to conduct screening on the five domains above. We also note that it is important that there continues to be flexibility for providers to pursue assessment in the clinical setting as they deem appropriate. There are clinical reasons for tailoring questions or conducting more in-depth screening; for example, screening that is tailored to a pediatric or adult population, and the ability to conduct a more in-depth screening once need is identified to inform interventions or care plans.

Accountability mechanisms: Importantly, stratifying by demographic factors and screening for social needs and SDOH is not enough to address the identified health disparities. NASDOH strongly encourages CMS to consider how it will move beyond screening and related quality measures to what is done with this information. While this information can be useful for administrative use and payment adjustment, information about an individual's social risk and needs has been shown to be sensitive, and individuals are often hesitant to disclose this information for fear of bias, misuse, or discrimination. Asking beneficiaries to disclose this information without also offering them services and supports to address identified needs may lead to increased distrust, impact reliability of data overtime, and worsen disparities. It is essential that we quickly move beyond assessing structures to assessing action taken and impact to ensure that our efforts are achieving the health equity and disparities reduction goals to which CMS is committed. To advance health equity, CMS must develop accountability mechanisms that link the identified health-related social needs to allowable interventions. That is, beneficiaries should be asked about needs that can actually be met within program authorities or through partnerships.

Meeting the Social Care Needs of Beneficiaries with Additional Resources: In addition to CMS reimbursement where available, NASDOH encourages CMS to consider how funding can be leveraged through braiding, blending, and pooling with other sources to maximize the services that community-based organizations (CBOs) and others are able to provide when needs are identified through screening and assessment. Aggregating funding – including via braiding, blending, and pooling – from multiple sources can reduce the financial barriers to addressing social needs. In the SDOH context, pooling acts as a mechanism to align incentives to collaborate across sectors and aggregate resources from different stakeholders and sectors over time.

Commitment to health equity measure: Finally, NASDOH strongly encourages CMS to require that all federal programs that receive payment from CMS adopt a commitment to health equity. We were grateful to see the inclusion of the new health equity measure in the CY 23 PFS rule, and we recommend that CMS apply this requirement more broadly to all programs.

Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

Coordination of Medicaid and other non-CMS waivers and flexibilities: Federal health and social programs have a profound effect on the wellbeing of individuals and families. The importance of these programs is amplified in any health emergency, and likewise in an economic downturn, where they serve as lifelines and provide counter-cyclical stimulus for the economy. The COVID-19 pandemic is unprecedented in that it was simultaneously a public health and an economic emergency, underscoring the importance of programs addressing both health and underlying social and economic determinants of health. The magnitude of the COVID-19 pandemic provided clear motivation for agencies to use any and all existing flexibilities, and for Congress to enact new authorities. These steps included pushing existing administrative flexibilities to the limits, using authorities to grant temporary waivers, legislative enactment of new program rules, and new programs designed specifically for the COVID-19 environment (e.g., the Paycheck Protection Program)

The COVID-19 experience suggests that waivers and program flexibilities, applied appropriately, can help overcome some of the limitations of federal health and social services programs that persist even when we are not in a national pandemic. We encourage CMS to explore how Medicaid waivers can be coordinated with other agency and department flexibilities to deliver social care services without compromising the intent or allowances of each program. Providing flexibility to adapt to emergencies and to promote greater program integration, such as more integrated enrollment or data sharing across programs, may involve addressing cross-agency jurisdictional issues, and require coordinated efforts of multiple Congressional committees of jurisdiction.

We believe that many of the program changes made from waiver and flexibilities that allowed additional ease at addressing health-related social needs should be extended for further evaluation, or should be retained permanently. We encourage CMS to evaluate and make permanent eligibility and enrollment flexibilities allowed during the COVID-19 Public Health Emergency (PHE), such as waiving in-person contact requirements, allowing presumptive eligibility, streamlining paperwork through means such as self-attestation, and verifying income based on state data sources. However, it is important that CMS study and inventory states' use of waivers, consider who the appropriate federal decision-makers are to contemplate extension of flexibilities, ensure appropriate guardrails to maintain program integrity, and balance effectiveness and accountability.

Strengthening data and tech: Finally, we encourage CMS to allow the specific use of COVID-19 related flexibilities to develop and strengthen data and tech systems to meet the needs and capacity limitations of community-based organizations and promote information sharing across health care,

public health, and social services to improve community health. When COVID-19 first spread, the public health data systems in many states and localities were poorly equipped to capture and transmit basic information essential to surveil and manage the accelerating pandemic. Even fewer public health data systems were able to collect and use data on social risk and social needs, which limited their ability to fully capture and respond to inequities and deploy essential interventions to support individuals in the community, or coordinate between essential partners in the community, including health care and social services. These capacities could have extended important advantages; for example, connecting individuals to essential social supports needed to quarantine could have slowed or stopped transmission, and connecting essential sectors like public health, health care, and social care organizations would have helped cross sector partnerships to develop shared solutions to meet community needs. Data on social needs and circumstances continues to be important to identifying priority populations for vaccination outreach, along with connections to social service providers that may be important partners in vaccinating hard to reach populations.

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