NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

June 27, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: CMS-2439-P, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule

Dear Administrator Brooks-LaSure,

The National Alliance to Impact Social Determinants of Health (NASDOH) thanks you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule. The Proposed Rule includes several proposals to improve access to and the quality of care to better meet the needs of Medicaid and CHIP enrollees.

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. 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 efforts to address social determinants of health (SDOH). Additionally, NASDOH is committed to advancing health equity as a critical component to addressing social needs and SDOH and improving the health of individuals and communities.

NASDOH provides the following comments in response to the proposals in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule:

In Lieu of Services and Settings (ILOS):
CMS proposes to revise the regulatory requirements for ILOSs "to specify the nature of the ILOSs that can be offered and ensure appropriate and efficient use of Medicaid and CHIP resources, and that these investments advance the objectives of the Medicaid and CHIP programs."

NASDOH appreciates CMS' intent to ensure the appropriate and efficient use of Medicaid and CHIP resources and to ensure ILOS investments are advancing the objectives of Medicaid and CHIP programs, including to promote health equity. Additionally, in the proposed rule, CMS notes that ILOS can be used to address social determinants of health and health-related social needs, improve population health,

and reduce health disparities. NASDOH supports ILOS as one pathway to address social needs through the Medicaid program and would encourage CMS to avoid placing restrictions or administrative burdens on the pathway that would discourage the use of ILOS to address SDOH.

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. A 2019 survey of Medicaid beneficiaries indicated that around two-thirds of survey respondents reported one or more unmet social needs. The evidence demonstrates that social risk factors combined with related non-medical health needs or social needs, negatively impacts healthcare utilization, costs, and outcomes.[1]

NASDOH strongly supported the CMS letter to state Medicaid directors in January 2023 to provide additional guidance about how ILOS can be used by states and managed care plans to address Medicaid enrollee's HRSNs.[2] We are pleased to see CMS expand upon and codify this guidance through regulation.

Importantly, in this proposed regulation, CMS indicated that these ILOS need to be medically appropriate and cost effective, but not necessarily "budget neutral." We share CMS' view that for certain ILOS that are provided in lieu of a future service, cost effectiveness may not be realized in the short term, and instead a longer view, even over a period of years, may be more appropriate in determining cost effectiveness.

We are also pleased that CMS states in the proposed rule that "We encourage managed care plans to leverage existing State and community level resources, including through contracting with community-based organizations and other providers that are already providing such services and settings and that have expertise working with Medicaid and CHIP enrollees." CBOs are valuable partners to healthcare organizations, and are often best positioned to provide these services due to their history and trust within the community, and we encourage continued conversations about how to meaningfully support CBO infrastructure and how it gets connected with healthcare entities.

We also support CMS' proposal to require states to identify specific codes and modifiers, if needed, for each ILOS and provide that information to its managed care plans to ensure consistent use. We agree with CMS that requiring specific codes to be in states' managed care contracts would make data more easily available in the Transformed Medicaid Statistical Information System (T-MSIS), support program integrity, and ensure information is publicly available. Additionally, we believe this standardization of data will provide plans, states, and researchers more opportunities to assess and build the evidence base about which specific interventions work best and are cost effective for specific populations. CMS indicated that states can use their own HCPCS or CPT codes and encouraged that to the extent possible, they work towards the development of standardized codes. We think this would be very valuable, and encourage standardization, which could include the use of existing data taxonomies and standard outcomes reporting on addressing HRSNs, to increase efficiency and improve the reliability and usability of data generated through this reporting.

[1] Thompson T, McQueen A, Croston M, Luke A, Caito N, Quinn K, Funaro J, Kreuter MW. Social Needs and Health-Related Outcomes Among Medicaid Beneficiaries. Health Educ Behav. 2019 Jun;46(3):436-444. doi: 10.1177/1090198118822724. Epub 2019 Jan 17. PMID: 30654655. Retrieved from https://pubmed.ncbi.nlm.nih.gov/30654655/.

[2] Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care. (2023, June 4) https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf

Finally, NASDOH encourages CMS to ensure additional requirements will not unnecessarily limit or discourage the use of ILOS to provide social supports and provide information to CMS on the effectiveness of these interventions.

Medical Loss Ratio (MLR):
CMS proposes to make several changes to MLR in order to better align with Marketplace standards for Qualified Health Plans (QHPs) and Medicare Advantage standards for Medicare Advantage organizations (MAOs). CMS proposes revisions to the requirements for clinical or quality improvement standards for provider incentive arrangements, prohibited administrative costs in quality improvement activity (QIA) reporting, and additional requirements for expense allocation methodology reporting.

NASDOH requests CMS conduct a Medicaid learning collaborative for states and CMS to consider and provide clarity about how to appropriately count social needs interventions, and particularly investments in infrastructure to coordinate social care, in the numerator of the MLR. NASDOH appreciates the ILOS guidance which supports this work and while it is our understanding that social care can be counted as an incurred medical expense, 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. These allowances should be made clear to states and CMS should encourage states to address them when contracting with MCOs. This would ensure effective social needs services are sustainable and scalable, and meet beneficiary needs.

NASDOH appreciates the opportunity to comment on this proposed rule. For more information on NASDOH and our members, 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