NAMD
National Association of Medicaid Directors

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Representative Cheri Bustos
1233 Longworth House Office Building
Washington, DC 20515

Representative Tom Cole
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Washington, DC 20515

Representative G.K. Butterfield
2080 Rayburn House Office Building
Washington, DC 20515

Representative Markwayne Mullin
2421 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Bustos, Cole, Butterfield, and Mullin:

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is pleased to offer comments in response to the Congressional Social Determinants of Health (SDOH) Caucus Request for Information. NAMD supports additional tools and flexibilities for states to address SDOH through their Medicaid programs. We encourage Congress to consider how to account for the cost savings generated by Medicaid investments in other sectors as part of its work in providing these tools to states. We specifically recommend that Congress:

- Allow states to adopt an express lane eligibility option to support standardized eligibility and enrollment across Medicaid and other human services programs
- Remove statutory barriers to inter-agency data sharing, provide funding for states to develop interoperable data systems across health and human services programs, and require federal agencies to issue guidance and best practices to maximize the impact of data sharing for SDOH
- Modify budget neutrality requirements for Medicaid section 1115 demonstration waivers to account for savings in other sectors generated by Medicaid investments
- Allow incorporation of SDOH interventions in the development of capitation rates paid to contracted managed care entities providing Medicaid services
- Lift the prohibition on Medicaid payment of room and board for Medicaid members residing in settings other than a nursing facility
- Promote effective care transitions by allowing Medicaid to cover services for incarcerated individuals within 90 days of release from a correctional setting
- Expand covered services for Medicaid members who are experiencing homelessness or at risk of homelessness to include services such as outreach and engagement
- Allow states to cover the cost of transitional housing for individuals experiencing homelessness and leaving an institutional setting (such as an inpatient psychiatric hospital or a correctional facility) to allow for stabilization prior to a transition to permanent supportive housing

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Key Principles for Navigating Medicaid's Role in SDOH

Social determinants are inherently cross-sectoral. Needs like housing, food security, transportation, school readiness for children, and creating safe environments for families cut across a wide array of existing federal and state programs. Medicaid, as a source of health insurance coverage that is primarily oriented towards payment for medical services and supportive services for subsets of its covered populations, is positioned to serve as a significant platform for targeting SDOH needs and addressing health inequities in partnership and collaboration with these other programs.

However, as a jointly financed program with state and federal dollars and administration by the states under federal rules, Medicaid must also be ever mindful of fiscal pressures within an environment of state-level resource scarcity. Balancing the opportunities within Medicaid to address SDOH with overall program expenditure growth is a key dynamic for state and federal policymakers to navigate. It is with this dynamic in mind that NAMD offers the following principles for Congress to consider in its work to promote effective SDOH interventions:

- **Flexibility:** States must have the flexibility within federal authorities to develop and implement SDOH interventions that reflect the state's populations, strategic goals, and resources to dedicate to the intervention. This flexibility should include the explicit ability for states to incorporate Medicaid-funded SDOH interventions into existing delivery system mechanisms and authority pathways.
- **Evaluation Over Appropriate Time Horizons:** SDOH interventions should be consistently evaluated to assess their cost effectiveness and return on investment for both the Medicaid program and other sectors within state and federal government. Congress should be mindful that some interventions may target outcomes that are not easily measured in the short-term, and support data infrastructure, measurement development, and evaluative frameworks that account for long-term, cross-sector outcomes associated with a given intervention.
- **Acknowledging Cross-Sector Impacts:** Because of the cross-sector nature of SDOH, it is highly likely that investments from one program in one sector will realize more significant savings in a separate program and sector. Medicaid authorities should be modified to account for this dynamic, with the aim of recognizing, supporting, and rewarding state investments within Medicaid that generate savings or improve outcomes in other sectors.

Common Barriers to Addressing SDOH for Medicaid Members

The Medicaid program serves diverse populations across the states, ranging from pregnant women and children, individuals with mental health or substance use disorder treatment needs, to homebound individuals receiving supportive services. Current frameworks for delivering public services and benefits do not necessarily reflect the interconnected nature of SDOH and the initiatives that best serve the varied array of needs across these populations. Barriers that state Medicaid agencies have identified to addressing the SDOH needs of the members they serve include:

- The fragmented and siloed nature of public programs, each with their own complex application processes and varied eligibility criteria. This creates a challenging environment that individuals in need of services must navigate which may result in individuals not receiving services they are entitled to receive.
- The inability for Medicaid to cover many SDOH interventions and receive federal match, which creates budgetary pressures on state general funds to support non-matchable Medicaid expenses. Such pressures call the sustainability of non-matchable initiatives into question.
- Operational challenges with executing on SDOH initiatives, such as establishing necessary contracts and care management mechanisms with community-based organizations (CBOs), ensuring CBOs are familiar with Medicaid policies and procedures and can successfully code and bill for services, establishing reimbursement structures for services like language translation, and a lack of necessary technology and data infrastructure among CBOs to support coding, billing, and service evaluation.
- Lack of sufficient workforce to support consistent SDOH interventions. This is an especially acute challenge in rural areas.
- Frequent gaps in care as members transition across settings and service programs, such as moving from an acute inpatient hospital admission to a long-term care setting, transitioning between pediatric and adult coverage programs with differing service arrays, and leaving a correctional setting to re-enter the community.
- Challenges related to a lack of adequate technology to connect Medicaid members to CBOs, particularly in rural communities.

Challenges in Sharing SDOH Data Across State Agencies

Actionable data is a critical component for successful SDOH interventions. However, because SDOH factors are so varied and addressed through so many different programs, the data that is collected is often not able to be easily shared across sectors. Programs have their own evaluation approaches, data collection requirements, and timelines for data collection, with limited overarching data strategies specific to SDOH.

This patchwork data approach across siloes and systems creates significant hurdles to building out an interoperable data environment that supports tracking individuals as they interact with specific programs to meet specific needs. The data that is captured by the health care system via electronic health records or claims information looks very different from data collected by social service providers. In some instances, laws or regulations may prohibit sharing certain data, such as substance use disorder diagnoses, or some data may not be collected at all out of concern for stigma or personal safety associated with individuals accessing certain services. These challenges can be further amplified by the inconsistent data infrastructure available across CBOs and other community partners to gather and share SDOH data.
States are taking actions to address some of these barriers to data sharing. Some states are building out online platforms to promote care coordination across partners and develop closed-loop referral systems to improve access to services. Others are pioneering interoperable health information exchange (HIE) platforms to connect health and social service providers, which leverages existing investments in innovative ways to broaden their reach.

Federal Policy Opportunities to Enhance Medicaid's Ability to Address SDOH

There are numerous opportunities for Congress to enhance Medicaid's ability to address SDOH. We see significant value in Congress directing federal agencies to develop joint guidance and policies on how Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Housing Choice Voucher Program, and other social service programs can mutually support each other and the members they serve. Areas for focus could include:

- Broad program alignment on health and social goals, with a specific focus on addressing health inequities across populations served by these programs
- Standardize and simplify application processes across programs
- Allow the adoption of express lane eligibility options across programs and support auto-enrollment options, while ensuring member choice
- Remove statutory barriers to inter-agency data sharing, provide funding for states to develop interoperable data systems across health and human services programs, and require federal agencies to issue guidance and best practices to maximize the impact of data sharing for SDOH

Congress should specifically call on federal agencies to develop guidance on braided or parallel funding opportunities that states may leverage to address SDOH. Such guidance should focus on administrative simplification for states leveraging these funding strategies (such as standardized reporting requirements across programs) and ensure that existing funding opportunities are preserved and expanded. Braided funding strategies should also not create any new burdens on current recipients of SDOH

supports, and ideally should result in simplified pathways for members served by these programs.

In addition to the opportunities to promote cross-section collaboration discussed above, Congress can make specific modifications to Medicaid statute to enhance the program's ability to directly address SDOH factors. These include, but are not limited to:

- Lifting the prohibition on Medicaid paying directly for room and board and other affordable housing initiatives. Currently Medicaid is only able to pay for room and board in institutional settings, primarily nursing facilities. This creates significant challenges for supporting Medicaid members who wish to receive services in their homes or communities, but may not be able to afford housing on limited incomes. Allowing Medicaid to pay for room and board in additional settings will correct the institutional bias that has existed in Medicaid statute since the program's inception in 1965.
- Modify budget neutrality requirements for Medicaid section 1115 demonstration waivers to account for savings in other sectors generated by Medicaid investments. The 1115 demonstration waiver is a flexible authority that many states are looking to in their SDOH initiatives. However, current federal rules that require Medicaid spending in an 1115 demonstration to be budget neutral to the federal government can inhibit Medicaid making investments that achieve savings in other sectors of federal spending. By accounting for these cross-sector savings in budget neutrality caps, Congress can promote more innovative Medicaid SDOH initiatives.
- Allow incorporation of SDOH interventions in the development of capitation rates paid to contracted managed care entities providing Medicaid services. Specifically, managed care SDOH spending should be considered a service rather than an administrative expense. Current rules require SDOH spending to come from administrative budgets of managed care entities, which creates disincentives for this spending in the medical loss ratio calculation and in the development of future capitation rates.
- Create new authorities or modify existing authorities to allow fee-for-service Medicaid delivery systems to target SDOH in a manner that reflects the flexibilities afforded under managed care, particularly in the area of performance-based payment.
- Allow states to provide Medicaid compensable services to incarcerated individuals within 90 days of release. Pre-release coverage allows states to initiate care coordination and ensure linkage to services in the community, which is critical to preventing recidivism and promoting positive outcomes for this population.

- Expand covered services for Medicaid members who are experiencing homelessness or at risk of homelessness to include services such as outreach and engagement.
- Allow states to cover the cost of transitional housing for individuals experiencing homelessness and leaving an institutional setting (such as an inpatient psychiatric hospital or a correctional facility) to allow for stabilization prior to a transition to permanent supportive housing.

NAMD appreciates the opportunity to provide these comments to the Congressional SDOH Caucus. We look forward to working with the caucus to promote innovative and effective strategies to improve health outcomes for the diverse populations Medicaid serves.

Sincerely,

Jami Snyder
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