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Investing in Health: A Federal Action Plan

Melinda Dutton, Partner,
Kyla Ellis, Manager,
Manatt Health

Rocco Perla, Co-Founder,
Rebecca Onie, Co-Founder,
The Health Initiative



About the Authors

This report was written by Melinda Dutton and Kyla Ellis of Manatt Health, and Rocco Perla and Rebecca Onie of The Health Initiative, with significant contributions from Secretary Mandy Cohen of the North Carolina Department of Health and Human Services, Debbie I. Chang and Richard Thomason of Blue Shield of California Foundation, Melinda K. Abrams of the Commonwealth Fund, and subject matter experts from Manatt Health.

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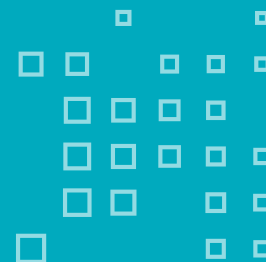


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Executive Summary

In the wake of a pandemic that has pushed our health care system to its limits, crippled the economy, and brought into stark relief longstanding racial inequities, we are faced with both the opportunity and the imperative to rethink the role of federal leadership in creating a healthier America. Over the past decade, policy makers and industry leaders have pursued **significant changes** in the way we deliver and pay for healthcare, moving away from incentivizing volume and high-cost interventions, and linking payment more closely to “value.” To date, these efforts have focused overwhelmingly on **health care**—attempting to change the way medical services are delivered and reimbursed. **Yet improvement in health care is not enough to improve health. An estimated 20 percent of health outcomes are linked to medical care; the remaining 80 percent stem from socioeconomic, environmental and behavioral factors collectively referred to as drivers of health (DOH). A growing evidence base has established that addressing drivers of health can improve health outcomes and do so more cost-effectively and equitably than medical interventions alone.**

Efforts to address drivers of health are growing yet remain diffuse, lacking clear expectations of the appropriate role of health care payors, providers and regulators. **Scalable, sustainable integration of drivers of health into the health care system requires greater alignment of financial incentives, development of shared assets—such as information exchange platforms and community-based social services networks—and new expectations about the role of health care providers and payors as employers, anchor institutions in their communities, and stewards of public funds.** This requires a federal action plan to *Invest in Health*.

The Centers for Medicare & Medicaid Services (CMS) is well positioned to leverage its significant purchasing power, regulatory authority, intra- and interagency partnerships, and bully pulpit to chart a new path toward *Investing in Health*. By making *Investing in Health* its central organizing principle guiding health care policy, financing and operations, CMS can help change the paradigm of what the health system can and should achieve, and better align incentives for states, payors, providers and communities. With these partners, CMS should deploy the following seven federal strategies to *Invest in Health*:

- 1. Address drivers of health in combatting COVID-19;**
- 2. Integrate drivers of health into payment policy for providers and payors;**
- 3. Develop shared assets that enable interventions to address drivers of health;**
- 4. Maximize participation in public programs that address drivers of health;**
- 5. Create new standards for drivers of health quality, utilization and outcome measurement;**
- 6. Make drivers of health central to CMMI’s innovation agenda; and**
- 7. Incentivize community accountability and stewardship** by creating new expectations for federally funded health care providers and payors to address upstream drivers of health, including reducing wage differentials, addressing structural racism, and contributing to multi-generational community wealth creation.

This Federal Action Plan for *Investing in Health* describes these strategies, as well as associated recommended policy and program changes for Medicaid, Medicare, the Marketplace, and CMMI, and specific federal actions to implement those changes under existing legislative authority.

Recognizing the profound impact of DOH on the country's ability to tackle the COVID-19 pandemic and to address the racial and economic inequity it has exacerbated, in the first 100 days of the next federal administration, CMS should announce its intent to engage states, private payors, providers, consumer groups, community-based organizations and other health care stakeholders in a national partnership to *Invest in Health*.

Investing in Health: The Imperative

In the wake of a pandemic that has pushed our health care system to its limits, crippled the economy, and deepened longstanding health and economic inequities, especially for communities of color, we are faced with both the opportunity and the imperative to rethink the role of federal leadership in creating a healthier America.

Over the past decade, policy makers and industry leaders have pursued significant changes in the way we deliver and pay for health care, moving away from incentivizing volume and high-cost interventions and linking payment more closely to “value.” To date, these efforts have focused overwhelmingly on health care, creating greater integration between physical and behavioral health; bolstering the capacity and effectiveness of primary and preventive care; avoiding preventable costs; reducing medical errors; and changing payment models to incentivize these efforts. Today, just **over a third** of health care spending is linked to alternative payment methods, with a growing minority of these payments linked to total cost of care. These efforts, coupled with expanded coverage under the Affordable Care Act, remain critical to creating a more accessible, affordable and equitable health care system.

Yet improvement in *health care* is not enough to improve *health*. An estimated **20 percent** of health outcomes are linked to medical care; the remaining 80 percent stem from socioeconomic, environmental and behavioral factors collectively referred to as social determinants of health or, more simply, drivers of health. Certain of these factors—such as **homelessness, food insecurity, exposure to intimate partner violence, adverse childhood experiences, and racism**—are linked to poorer health. People with these and other social and economic risk factors have **worse health outcomes, lower Merit-based Incentive Payment System (MIPS) scores, increased utilization, significantly higher annual health care expenditures, poorer mental health, and higher rates of racial disparities in health outcomes**. While COVID-19 has compounded economic and social deprivation, even pre-COVID-19, **24 percent** of those with commercial health insurance lacked adequate food or housing, which impacts overall health and drives up **health care costs**.

A **growing evidence base** has established that addressing DOH can improve health outcomes and do so more cost-effectively and equitably than medical interventions alone. At the same time, focusing on traditional measures of value-based care without addressing DOH and health equity may exacerbate access barriers and **worsen racial disparities**. Across race, class, politics and geography, **people agree** that there is a need to invest in what we all need to be healthy—safe homes, healthy food, a stable income. The economic

devastation of the pandemic, and stark racial inequities it has brought to the fore, have broadened this consensus, creating new urgency and alignment among state and federal policy makers and a growing chorus of [providers](#), payors and public health experts about the need to Invest in Health.

What Does It Mean to *Invest in Health*?

Investing in Health requires that **we leverage our country's significant public and private resources to achieve health, not just deliver health care.** It requires direct investment in the drivers of health—decent wages, healthy food, safe housing—and it requires unlocking the **approximately \$11 billion we spend every day on health care** to maximize health. When brought to scale, *Investing in Health* is good for people, good for business and good for government.

Investing in Health aligns with key health care priorities: renewing the federal commitment to Medicaid, revitalizing our public health infrastructure, protecting the solvency of Medicare, strengthening the Marketplace, promoting innovation through CMMI, and accelerating the use and exchange of data and building trusted consumer privacy frameworks. But it also requires us to break new ground—to embrace a broader understanding of health-related conditions and interventions necessary to improve health equity, quality and value.

Efforts by regulators, payors and providers to address DOH are growing. CMMI's [Accountable Health Communities](#) are now operating in 21 states. Over the past two years, Medicare Advantage plans have been given [increasing flexibility](#) to provide benefits to address DOH to targeted populations. The Health Care Payment Learning and Action Network (HCP-LAN) identifies DOH as [a core strategy area](#). **CMS recently released new guidance to support states in addressing DOH in Medicaid and the Children's Health Insurance Program (CHIP), and virtually every state in the nation includes contractual requirements related to DOH in their Medicaid Managed Care contracts.** And a [recent survey of health systems](#) identified 78 unique programs representing \$2.5 billion in health system funds for interventions focused on housing, employment, education, food security, transportation and more.

Yet these and other efforts to address drivers of health remain diffuse, episodic and grossly underfunded, reflecting varying degrees of systematic rigor and impact. Why? Because the sector still lacks clear expectations of the appropriate role of health care payors, providers and regulators in *Investing in Health*. Scalable, sustainable integration of DOH into the health care system requires a paradigm shift. **It requires greater alignment of financial incentives, development of shared assets - such as information exchange platforms and community-based social services networks - and new expectations for health care providers and payors—as employers, anchor institutions in their communities, and stewards of public funds—to address upstream drivers of health, including reducing wage differentials, addressing structural racism, and contributing to multi-generational community wealth creation.**

North Carolina offers a [case study](#) of how to align financial, regulatory and policy levers to *Invest in Health*. Under the banner of **"buying health,"** the state has created a central set of assets and targeted investments aligned to create sustainable strategies to address DOH (see below). Buying health is built into every facet of the state's delivery system—not as a special project or initiative, but as the **central organizing principle**

guiding health care policy, financing and operations. North Carolina's buying health agenda has spurred broad support as a more efficient and effective use of taxpayer dollars, galvanized private payors and physicians, and leveraged existing federal and state dollars toward improving health.

Case Study: North Carolina's Efforts to Address DOH

With a focus on housing stability, food security, transportation access and intimate partner violence, North Carolina developed standardized screening questions to identify and assist patients with unmet health-related resource needs; mandated screening and other DOH-related interventions and investments in the state's Medicaid managed care contracts; built a statewide coordinated care network to electronically connect those with identified needs with community resources—and allow for a feedback loop on the outcome of that connection; secured a Medicaid 1115 waiver allowing the creation of Healthy Opportunities Pilots providing select evidence-based, non-medical interventions to Medicaid enrollees; launched a Community Health Worker Initiative to build a workforce prepared to meet a more diverse set of community needs; created an interactive statewide map of DOH indicators to guide community investment; and sought to maximize enrollment in existing key benefit programs, including Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), linked to improved health outcomes. When COVID-19 hit, the state leveraged this infrastructure to provide supportive services for individuals isolating or quarantining due to COVID-19 and in need of food, relief payments or access to primary medical care to do so.

A Federal Action Plan to Invest in Health

A federal strategy to *Invest in Health* can help fundamentally change expectations of our health system. CMS is well positioned to help catalyze this change, accelerating market-wide integration of drivers of health into coverage, payment reform and delivery system transformation on a national scale. CMS administers programs serving more than 145 million people, including Medicare, Medicaid, CHIP and the Marketplaces, and operates with a budget of approximately \$1 trillion. It is also well positioned for intra-agency cooperation within the Department of Health and Human Services (HHS), collaboration across federal departments, and partnerships with states and other public and private stakeholders. By making *Investing in Health* its central organizing principle, CMS can leverage its purchasing power, regulatory authority, intra- and interagency partnerships, and bully pulpit to help change the paradigm of what the health system can and should achieve. The following **seven federal strategies**, if deployed by CMS and its partners, provide a path forward to **Invest in Health**: (1) address DOH in combating COVID-19; (2) enable payor and provider payments for DOH; (3) support the development of shared assets to enable DOH interventions; (4) maximize participation in public programs the address DOH; (5) create new standards for DOH quality, utilization and outcome measurement;

(6) make DOH central to CMMI’s innovation agenda; and (7) **incentivize community accountability and stewardship by creating new expectations for federally funded health care providers and payors to address upstream drivers of health.**

Below is a summary chart of each of the strategies and recommended policy/program changes for Medicaid, Medicare and the Marketplaces, as well as changes applicable across these public programs and the private sector, and to CMMI. Recommendations for policy and program changes to be implemented in the first 100 days of the new federal administration are shaded. The appendices below provide detailed information on each recommended policy and program change, including a description of federal action necessary to implement it under existing legislative authority.

Table 1: Federal Strategies to Invest in Health

| Federal Strategies to Invest in Health | |
|--|---|
| <i>Shaded rows to be implemented in first 100 days</i> | |
| 1. Address Drivers of Health in Combating COVID-19 | |
| Cross-Sector | Provide funding to address DOH-related barriers to isolation and quarantine. |
| | Ensure DOH are considered during the distribution of COVID-19 vaccines. |
| | In response to COVID-19, test a new model with a focus on identifying gaps and coordinating public and private investments in DOH. |
| | Develop new Provider Relief Fund distribution methodologies for any future appropriations and disbursements that recognize providers’ investments in DOH. |
| | Repurpose Provider Relief Funds allocated to the Health Resources and Services Administration (HRSA)-administered “uninsured fund” to more effectively support health care providers serving uninsured and vulnerable patients who are more likely to struggle to meet basic needs. |
| 2. Integrate Drivers of Health into Payment Policy for Providers and Payors | |
| Cross-Sector | Build DOH into standardized CMS risk scoring and risk adjustment methods. |
| | Update medical loss ratio (MLR) calculation requirements across programs to account for DOH investments. |
| | Issue an Request for Information (RFI) to Medicaid, Medicare and Marketplace stakeholders seeking best practices and recommendations for eliminating barriers to addressing DOH in current coverage and payment models. |
| | Integrate DOH into alternative payment models by updating the (HCP-LAN) annual measurement effort to include more DOH indicators. |
| | Create financial incentives for reporting race and ethnicity data in all CMS payment models. |
| | Encourage use of and tie provider reimbursement to ICD-10Z codes. |
| | Establish/quantify baseline spending on DOH-related expenditures and develop goals for future spending growth. |
| Medicaid | Encourage states to hold managed care organizations (MCOs) harmless for “premium slide” attributed to DOH investments during rate setting. |
| | Encourage states to include DOH interventions as a covered service. |
| Medicare | Broaden definitions of allowable supplemental benefits in Medicare Advantage. |
| | Pay for DOH screening and navigation to community resources by Medicare providers beyond the current Medicare reimbursement codes for psychosocial elements of chronic care management. |
| | Recalibrate county benchmarks to account for differences in socioeconomic status (SES) in ways that increase benchmarks in low-SES counties and encourage Medicare Advantage participation. |

| Federal Strategies to Invest in Health <i>Shaded rows to be implemented in first 100 days</i> | |
|---|---|
| Marketplace | <p>Include specific references to DOH-related services in the definition of essential health benefits (EHBs), such as enhanced care management, social service referral/navigation and community coordinators (peer support, community health workers, doulas).</p> <p>Include DOH interventions in standardized qualified health plans (QHPs) and promote these plans on the Marketplaces.</p> <p>Encourage insurers to voluntarily cover DOH interventions, or permit states to require coverage.</p> <p>Design a model for wellness programs that addresses DOH without discriminating by health risk.</p> |
| 3. Develop Shared Assets to Enable Interventions Addressing Drivers of Health | |
| Cross-Sector | <p>Support the development of networks of community-based organizations and providers with the capacity to sustainably address DOH.</p> <p>Advance state and regional efforts to connect DOH data by (1) enhancing existing health information exchange capacity and protocols and (2) tying payment to new performance measures of whole-person care and cross-sector outcomes.</p> <p>Update federal privacy standards and consent requirements to facilitate cross-sector information sharing between health care providers and payors, and community-based social service providers.</p> <p>Establish federal technical standards to govern the sharing and use of cross-sector data.</p> |
| Medicaid | <p>Encourage the use of community health workers (CHWs) as part of integrated care teams.</p> <p>Seed development and deepening of DOH information technology infrastructure and capacity.</p> |
| 4. Maximize Participation in Public Programs that Address Drivers of Health | |
| Medicaid | <p>Encourage states to maximize enrollment in public programs that impact health.</p> <p>Encourage Medicaid expansion in non-expansion states and expansion of postpartum coverage.</p> <p>Remove barriers to Medicaid coverage/care that decrease access, and encourage policies that promote coverage/care to improve health outcomes and access.</p> |
| 5. Create New Standards for DOH Quality, Utilization and Outcome Measurement | |
| Cross-Sector | Establish comprehensive nationwide standards for drivers of health (DOH) data, collection and measurement focused on both process and outcomes measures. |
| Medicaid | <p>Update the Medicaid core measures set to include DOH measures.</p> <p>Add DOH to state quality strategy under Medicaid Managed Care.</p> |
| Medicare | Build DOH into the Quality Payment Program (QPP) via the Center for Clinical Standards and Quality (CCSQ). |
| Marketplace | Build DOH into the health insurance exchange Quality Ratings System (QRS). |
| 6. Make Drivers of Health Central to CMMI's Innovation Agenda | |
| CMMI | <p>Develop and test a social services fee schedule to be used by health care payers and providers to pay for DOH interventions.</p> <p>Integrate the Accountable Health Communities Model DOH-related components, such as screening and navigation, into other existing models and new CMMI payment models.</p> <p>Direct CMMI to incorporate DOH into all payment and care delivery models.</p> <p>Restructure CMMI models to promote participation among providers serving middle/low-income and marginalized groups.</p> <p>Increase use of Quality Improvement Organizations (QIOs) in Medicare to support efforts to address DOH.</p> |
| 7. Incentivize Community Accountability and Stewardship | |
| Medicaid | <p>Encourage or require states to direct managed care organizations to contribute to locally governed community wellness and equity organizations.</p> <p>Tie certain supplemental payments to DOH expectations for community stewardship.</p> <p>Incentivize healthy living wages, particularly for the long-term care (LTC) workforce.</p> |
| Medicare | <p>Update the Medicare wage index to incentivize healthy living wage compensation for hospital workers.</p> <p>Provide rate increases for critical access hospitals (CAHs) that invest in healthy living wage compensation.</p> |

Getting Started

Recognizing the profound impact of DOH on the country's ability to tackle the COVID-19 pandemic and to address the racial and economic inequity it has exacerbated, in the first 100 days of the next federal administration CMS should announce its intent to engage states, private payors, providers, consumer groups, community-based organizations and other health care stakeholders in a national partnership to *Invest in Health*. While CMS is a critical catalyst, it will be important to reach across HHS and into other federal agencies to forge the partnerships required to implement change. Potential priorities are highlighted in Table 1, above, and summarized in Table 2, below.

Table 2: Summary of Potential Priorities in the First 100 Days

Summary of Potential Priorities in the First 100 Days

- Implement COVID-19-related DOH recommendations.
- Issue an RFI to Medicare, Medicaid and Marketplace plans and providers and other stakeholders seeking best practices and recommendations for eliminating barriers to addressing DOH in current coverage and payment models.
- Develop tools and templates to assist state Medicaid programs.
- Develop a Medicaid Managed Care contracting toolkit for states including strategies to combat premium slide.
- Launch an effort to establish comprehensive nationwide standards for DOH data, collection and measurement focused on both process and outcomes measures.
- Direct CMMI to incorporate DOH into all payment and care delivery models.
- Launch multiagency data privacy and technical standards work groups.

While many of the proposed policy/program changes would benefit consumers across payor and provider types, with a broad range of needs and inclusive of all demographics, to yield greatest impact, CMS should focus initially on a defined set of DOH domains and interventions (see examples in Table 3, below) that address the most prevalent individual and community DOH needs (especially in light of COVID-19), promote health equity and have a strong track record for efficacy. CMS should work with internal and external stakeholders to expedite identification of target DOH domains and interventions that are ready, with appropriately aligned incentives and structural supports, to be brought to scale; develop additional policy/program changes that align incentives around these interventions and support the development of shared assets necessary for their deployment; and drive efforts to gather data and seed and assess innovation as we continue to build the evidence base for sustainable change.

Potential high-priority DOH domains could include housing stability, food insecurity, and interpersonal safety and toxic stress. Within these domains, priority DOH interventions should have a strong or emerging evidence base for improved health outcomes and/or reduced costs and cost-effectiveness; be inclusive of populations disproportionately impacted by DOH (e.g., children, pregnant women, low-wage parents, dual-eligibles, individuals with chronic health needs or behavioral health comorbidities, communities of color); and allow for longer time horizons and account for “wrong pocket” savings that might otherwise disincentivize investment. For example, investments in children—half of whom have publicly funded health insurance and who research shows are both particularly vulnerable to DOH and particularly responsive to interventions—often take a longer time horizon to show their full value, and cost savings often accrue beyond the health plan or payor making the investment. New models are needed to ensure this reality does not create barriers to investment.

Table 3: Examples of High-Value Services Approved by CMS in North Carolina’s 1115 Waiver

| Housing Services | Food/Nutrition Services | Services to Address Adverse Childhood Experiences (ACEs)/Toxic Stress |
|--|--|--|
| <ul style="list-style-type: none"> • Housing navigation, support and sustaining wraparound services • Essential utility setup • Home remediation services • Short-term post-hospitalization housing • One-time payment for security deposit and/or first month’s rent | <ul style="list-style-type: none"> • Food and nutrition access case management services • Group nutrition classes • Healthy food boxes • Food pantry prescription • Medically tailored home-delivered meals | <ul style="list-style-type: none"> • Dyadic/family therapy • Evidence-based parenting curriculum • Home visiting services • Violence intervention services • Intimate partner violence (IPV) case management services |

Over time, as experience and evidence grow, the number and diversity of domains and interventions addressed by CMS should expand, with an eye to the compounding effects of certain drivers—for example, pervasive linkages between intimate partner violence and homelessness—and test interventions addressing the unique needs of specific populations, such as former foster youth or formerly incarcerated adults.

To ensure this vision is sustained, CMS should build it into multi-year strategic planning processes and annual objectives; create messaging to ensure the vision is disseminated and internalized within the agency and among its partners in a consistent way through its stakeholder engagement function and Office of Communications; define specific goals around market and agency progress and provide transparent tracking against those goals; establish targeted work groups to foster interagency collaboration; leverage existing mechanisms, such as standing calls, open-door forums, learning collaboratives and robust regional office infrastructure, to engage with state partners; and use CMS’s bully pulpit with providers, plans and patients to align the market around *Investing in Health*.

DOH Strategies and Related Policy and Program Changes

- Strategy 1. [Address Drivers of Health in Combating COVID-19](#)
- Strategy 2. [Integrate Drivers of Health into Payment Policy for Providers and Payors](#)
- Strategy 3. [Develop Shared Assets to Enable Interventions Addressing Drivers of Health](#)
- Strategy 4. [Maximize Participation in Public Programs that Address Drivers of Health](#)
- Strategy 5. [Create New Standards for DOH Quality, Utilization and Outcome Measurement](#)
- Strategy 6. [Make Drivers of Health Central to CMMI's Innovation Agenda](#)
- Strategy 7. [Incentivize Community Accountability and Stewardship](#)

Strategy 1. Address Drivers of Health in Combating COVID-19

| Strategy 1: Address Drivers of Health in Combating COVID-19 | | | |
|---|---|---|---|
| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Cross-Sector | Fund efforts to address drivers of health (DOH)-related barriers to isolation and quarantine. | Despite the emergence of vaccines, COVID-19 continues to spread across the nation at an alarming rate. State efforts to test and trace disease spread remain critical, but DOH can create barriers to isolation and quarantine for those at risk of transmitting the virus. Multiple states (e.g., Michigan , Oregon and North Carolina) have recognized the importance of interventions to address DOH in containing disease spread and have prioritized the use of Coronavirus Relief Funds for DOH-related isolation supports—including housing and nutrition supports. Additional federal support and resources would enable states to increase the utilization of these programs. | <ul style="list-style-type: none"> • Clarify in guidance/notice of awards that states may use the Consolidated Appropriations Act, 2021 testing and tracing funding for expenses that support social distancing and isolation for individuals with suspected or confirmed cases of COVID-19 (or for members of such individuals’ households). For example, expense types include temporary housing for individuals who are unable to isolate in their homes (or do not have homes),¹ meal/grocery delivery, internet/phone access to ensure access to telehealth services as needed, among others.² • Distribute informational bulletin to states describing interventions that leader states have implemented and encourage other states to consider similar approaches. • (Legislative) Provide additional Coronavirus Relief Fund dollars in future COVID-19 relief and stimulus legislation. |

¹ CDC [recommends](#) that individuals with COVID-19 should isolate for up to 20 days after symptom onset (10 days is the general standard; however, some people with severe illness may produce replication-competent virus beyond the 10 days). Individuals who never develop symptoms should isolate for 10 days after the date of their first positive RT-PCR test. [Isolation](#) includes staying in a separate room from other household members, using a separate bathroom, and avoiding sharing personal household items like cups, towels, and utensils.

² The Consolidated Appropriations Act, 2021 allocated \$21.61 billion, to be awarded to states, localities, and territories, according to the formula that applies to the PHEP cooperative agreement in FY 2020, for “necessary expenses for testing, contact tracing, surveillance, containment, and mitigation to monitor and suppress COVID-19...” \$2.5 billion must be used for strategies to improve testing capabilities and related expenses in high-risk and underserved populations, including racial and ethnic minority populations in rural communities.

| Strategy 1: Address Drivers of Health in Combating COVID-19 | | | |
|---|---|--|--|
| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Cross-Sector | Ensure DOH is considered during the distribution of COVID-19 vaccine. | The distribution of the COVID-19 vaccine will require a substantial operational effort by states to ensure residents have access to the vaccine. Vaccines and/or people will need to be transported to the last mile and states must include considerations of DOH, particularly transportation access and the need to take time off work, during distribution planning. | <ul style="list-style-type: none"> Allocate more than \$4.5 billion of the \$8.75 billion in CDC vaccine funding authorized by the Consolidated Appropriations Act, 2021 to states, localities, territories, and tribes,³ increasing their ability to address needs of this nature (note: the legislation provides \$8.75 billion to CDC, \$4.5 billion of which must be distributed to states, localities, territories, and tribes).⁴ Distribute state funding by the end of the first quarter of CY 2021 (note: the statute requires CDC to distribute \$1 billion of the \$4.5 billion minimum allocation for states, localities, territories, and tribes within 21 days of enactment). Clarify in guidance/notice of awards that states may use the Consolidated Appropriations Act, 2021 vaccine funding for transportation expenses for vaccine access purposes.⁵ Issue guidance to remind states of their obligations to provide non-emergency medical transportation to Medicaid beneficiaries and clarify that transportation to vaccination sites is allowable if no other mode of transportation is available to the beneficiary; CMS also could clarify the degree to which other insurers (commercial carriers) may cover such services. (Legislative) Provide additional state funds in future COVID-19 relief and stimulus legislation. |

³ This includes tribal organizations, urban health organizations, and health service providers to tribes.

⁴ \$210 million must be transferred to IHS.

⁵ The statute allows the funds to be used to “plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage.” Additionally, the statute requires that not less than \$300 million is allocated for “high-risk and underserved populations, including racial and ethnic minority populations and rural communities.”

| Strategy 1: Address Drivers of Health in Combating COVID-19 | | | |
|---|---|--|---|
| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Cross-Sector | In response to COVID-19, test a new model with a focus on coordinating public and private investments in DOH. | No current health reform model exists with the explicit purpose of improving the resource landscape in communities where beneficiaries live and receive care. This first-of-its-kind model would focus on enabling public, corporate and private sector actors to understand the promising strategies that exist to address key DOH associated with COVID-19 and increased health care costs (e.g., food or housing) and quantify the capital investment required to implement those strategies at scale. This is intended to ensure that the resource landscape is sufficiently robust to support all the DOH screening and navigation described elsewhere, including closed referrals from the community resource data described below. Recent CMMI models have identified significant gaps in the resource landscape that may explain why many models have failed to demonstrate anticipated costs savings. | CMMI should issue a Letter of Intent to gauge interest in the model and fast-track the approval process and the Innovation Center Investment Plan (ICIP). |

| Strategy 1: Address Drivers of Health in Combating COVID-19 | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Cross-Sector | Develop new Provider Relief Fund distribution methodologies that recognize the investments of providers supporting DOH interventions. | HHS has significant authority to distribute funds to reimburse providers for expenses or lost revenues that are attributable to efforts to prevent, prepare for and respond to COVID-19. Provider Relief Fund distributions to date have generally benefited providers with a larger share of Medicare and commercial patients relative to those with high volumes of Medicaid and uninsured patients, because most distributions have been based on patient revenues. With a portion of the remaining funds available for distribution, ⁶ HHS could consider additional targeted distributions geared toward community-based providers making DOH-focused investments geared at serving particularly vulnerable populations at this time (e.g., isolation supports). | Direct future rounds of Provider Relief Funding to providers that can document expenditures for DOH interventions for particularly vulnerable populations. |
| Cross-Sector | Repurpose Provider Relief Funds allocated to the HRSA-administered “uninsured fund” to more effectively support providers serving uninsured and vulnerable patients who are more likely to struggle to meet basic needs, such as access to adequate housing, healthy and nutritious foods, and stable employment. | The HRSA-administered “Uninsured Fund” (funded by Provider Relief Fund dollars) has been underutilized for a variety of reasons (provider burden/complexity, concerns about claiming for undocumented immigrants or others in unsatisfactory immigrant status); HHS has the authority to revisit this claims-based distribution methodology. | Revisit Provider Relief Fund methodologies to target additional payments to providers that serve a high volume of Medicaid and uninsured patients. |

⁶ Note that the FY 2021 year-end spending package legislation specifies that HHS must distribute not less than 85% of the unallocated balance of the Provider Relief Fund and any funds that HHS recovers from healthcare providers to eligible healthcare providers based on their financial losses and changes in expenses that occurred in the third and fourth calendar-year quarters of 2020, or the first quarter of 2021. Even within this new parameter, HHS has flexibility to target funds to community providers.

Strategy 2. Integrate Drivers of Health into Payment Policy for Providers and Payors

| Strategy 2: Integrate Drivers of Health into Payment Policy for Providers and Payors | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact/Notes | Federal Action |
| Cross-Sector | Build DOH into standardized CMS risk scoring and risk adjustment methods. | <p>There is growing pressure on CMS and the health care sector to incorporate social risk factors into risk adjustment models to more accurately predict cost and utilization, deliver better care to beneficiaries, and establish more precise cost benchmarks for advanced payment models (APMs) that go beyond HCC score (based on hierarchical condition categories, disability, demographics and Medicaid status). Select states have pursued risk adjustment models that include social risk factors:</p> <p>Massachusetts' Medicaid model, for example, includes data elements such as transportation, employment status and housing instability.</p> <p>The Minnesota Integrated Health Partnerships social risk adjustment methodology includes a set of social risk factor measures for children and for adults (e.g., homelessness, deep poverty (<50% of the federal poverty level), substance use disorder and/or serious mental illness diagnosis) that are used to enhance the medically based risk adjustment methodology obtained from administrative and claims data.</p> | <ul style="list-style-type: none"> • Develop and test a Medicare Advantage risk adjustment model that incorporates patient-level DOH risk factors into the Hierarchical Condition Category score (e.g., adding specified ICD-10 Z codes). • Validate and implement for Medicare Advantage. • Encourage states to implement the model in Medicaid Managed Care. • Explore use for Marketplace risk adjustment methodology. |

| Strategy 2: Integrate Drivers of Health into Payment Policy for Providers and Payors | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact/Notes | Federal Action |
| Cross-Sector | Update the medical loss ratio (MLR) calculation across programs to account for investments in DOH | <p>The Affordable Care Act (ACA) requires insurers to provide a rebate to enrollees if a plan’s MLR is less than 80% for individual market products (i.e., if the insurer does not spend at least 80% of the premium on “medical” expenses and keep “administrative” expenses and profits under 20%). While quality improvement activities are included in the numerator of this calculation, it is unclear whether, under current guidance, DOH interventions would qualify. This uncertainty disincentivizes investments in health, leaving carriers at risk if DOH costs are considered administrative expenses rather than medical expenses. For example, an insurer can buy a diabetic medicine, but if it buys her healthy food to manage her disease, that may be treated as an administrative cost. MLR rebates have consistently increased in the individual market since 2017, signaling an opportunity to repurpose unspent premium dollars on DOH interventions.</p> <p>One state, North Carolina, currently encourages its Medicaid Managed Care plans to voluntarily contribute to high-impact DOH-related initiatives within the communities it serves and allows those contributions to count toward the numerator of its MLR.</p> | <ul style="list-style-type: none"> • Provide guidance clarifying that DOH interventions that improve health may be counted as quality improvement activities and provide examples of the types of DOH interventions that meet 45 CFR §158.150 definition of “quality improvement activities.” • Disseminate guidance through the Marketplace, Medicaid, and Medicare programs. |
| Cross-Sector | Issue a Request for Information (RFI) to Medicare, Medicaid and Marketplace plans, state officials, providers, and community stakeholders seeking best practices and recommendations for eliminating common barriers to addressing DOH in current coverage and payment models. | An RFI will signal CMS’ commitment to future investments in DOH intervention and interest in partnering across the health care sector. Dissemination of best practices will accelerate market adoption. | <ul style="list-style-type: none"> • Issue a cross-program RFI on the Federal Register asking cross-cutting and program-specific questions (Medicaid, Medicare, and Marketplace). • Develop a comprehensive compendium of best practices based on the findings from the RFI, including guidance on legal authorities and key implementation strategies • Update this resource regularly |

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| Sector/Program | Policy and Program Changes | Description/Impact/Notes | Federal Action |
| Cross-Sector | Integrate DOH in alternative payment models (APMs)/ value-based payment (VBP) initiatives by updating Health Care Payment Learning & Action Network (LAN)'s annual measurement effort to include DOH indicators. | <p>Designing and implementing VBP initiatives and rewards improved health outcomes and cost-efficiency by moving away from reimbursing providers based on the volume of care they provide and moving toward reimbursing them for improving outcomes and reducing costs. Payment incentives (or withholds) can be also be designed to promote DOH interventions that have been proven to improve health outcomes.</p> <p>The LAN is a public-private effort to create a common framework for classifying APMs. DOH are a strategic focus for the LAN yet the LAN measurement framework does not include DOH cost or quality measures.</p> | <ul style="list-style-type: none"> Charge the LAN stakeholders to build DOH measures into the alternative payment model (APM) measurement framework that account for DOH-related expenditures, which could include, for example, consideration of ICD-10 Z codes, supplemental benefits or in-lieu-of services as part of Category 4 (population-based payments) to establish a baseline investment in health. Build upon payment guidance encouraging Value-Based Care Opportunities in Medicaid to promote additional innovation across programs. |
| Cross-Sector | Create financial incentives for reporting race and ethnicity data in all CMS payment models, including fee-for-service and alternative payment models. | <p>The link between racial disparities and DOH is clear and is only becoming more acute given COVID-19. As of 2012, section 4302 of the ACA requires population health surveys in federal health programs, including Medicare and Medicaid, to collect and report race, ethnicity, language, and other data to understand and help reduce health and health care disparities. Nonetheless, recent studies confirm that Medicare, Medicaid and commercial plans have largely incomplete data on race and ethnicity, though some positive outliers exist. Recent delivery reform recommendations call for public and private payers to require the collection, use, and application of race and ethnicity data, as essential to identifying and improving disparities.</p> | <ul style="list-style-type: none"> Leverage CMS's authority under Section 4302 of the ACA to require Medicare, Medicare Advantage and Medicaid payments be tied to specific performance levels for reporting race and ethnicity data (e.g., >95% complete reporting equals 100% financial reward, adjusted downward for lower rates of complete reporting). Encourage states to include analogous requirements and financial incentives in their Medicaid managed care organization contracting and performance metrics tied to reimbursement. |

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| Sector/Program | Policy and Program Changes | Description/Impact/Notes | Federal Action |
| Cross-Sector | Encourage use of and tie provider reimbursement adjustments to ICD-10 Z codes for potential socioeconomic and psychosocial circumstances (Z55-Z65). | Encouraging and standardizing the widespread use/adoption of Z-codes across payors will enable changes in provider reimbursement, support DOH data collection, inform future research on DOH impacts, and strengthen the case for increased payment for DOH services as a value driver. | <ul style="list-style-type: none"> Weight Medicare provider payment for services when Z-codes are reported via annual fee-schedule rulemaking: <ul style="list-style-type: none"> Link Z-codes to reimbursement in the Physician Fee Schedule Reweight Diagnosis-related groups (DGRs) to treat DOH factors as co-morbidities via annual Hospital Inpatient Prospective Payment Systems rulemaking. Encourage states to require use of Z-codes in Medicaid billing and encounter reporting, and to update Medicaid reimbursements to align with Medicare changes incorporating Z-codes. |
| Cross-Sector | Establish/quantify baseline spending on DOH-related expenditures (e.g., spending on supplemental benefits, in-lieu-of services (ILOS), non-medical allowable services) to understand the federal investment in health overall and by market segment (Medicare, Medicaid/CHIP and individual) and develop goals for future spending growth. | <p>The CMS value agenda and national payment goals now include a strong focus on increased investments in DOH. Unlike with value, the country has a limited line of sight into current DOH expenditures. Beginning to quantify this investment is necessary to:</p> <ul style="list-style-type: none"> Understand how much of our national health expenditure (NHE) is aimed at DOH, which drives 80% of variation in health outcomes and costs. Study and model the impact of any shift in DOH expenditures. Inform future regulatory and legislative action. Design delivery and payment models via Center for Medicare & Medicaid Innovation (CMMI) that are person centered. Inform Trust Fund projections. Set future spending targets aimed at improving health. <p>This analysis could be done at the federal, state and commercial levels to guide decision-making in the wake of COVID-19-related economic challenges that will likely have impact on health outcomes and cost.</p> | <ul style="list-style-type: none"> Establish a DOH-related expenditure category through OACT that is reported annually as outlined in HHS leadership priorities, or a part of a larger quality-focused Executive Order. (Legislative) Include this spending analysis as part of Medicare Payment Advisory Commission (MedPAC)'s and Medicaid and CHIP Payment and Access Commission (MACPAC)'s Report to Congress. |

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| Sector/Program | Policy and Program Changes | Description/Impact/Notes | Federal Action |
| Medicaid | Encourage states to hold managed care organizations (MCOs) harmless for “premium slide” attributed to DOH investments during rate setting. | Currently, when health care utilization falls, it is reflected within a few years as lower capitation payments for plans. If there were a DOH-related value-added service that led to a reduction in utilization, that plan would see lower payments in the future and would no longer have the dollars to fund the successful DOH intervention. The purpose of this recommended intervention is to preserve funding for successful DOH investments that reduce health care utilization. | <ul style="list-style-type: none"> • Educate states on strategies to address premium slide and offer technical support in implementing strategies including: <ul style="list-style-type: none"> – Incorporating social risk scores in risk adjustment. For example, Massachusetts includes housing instability, neighborhood stress scores, and an additional measure of disability as part of its risk adjustment methodology—in effect, redistributing capitation dollars among plans based on the socioeconomic status of each plan’s beneficiaries. – Integrating ILOS costs into capitation rates to fund interventions. – Offering enhanced care management payments for members with social needs/high social risk scores to cover, for example, screening and navigation assistance and assistance with enrollment in other public programs. – Leveraging existing authority under federal Medicaid managed care regulations to provide incentive payments up to 5% of capitation payments when plans meet goals consistent with the state’s quality strategy. – Providing kick payments for targeted populations, which are permissible under current regulations, outside of rate, and can be held constant over time. • Refining managed care rate setting to permit delinking of capitation payments from utilization. Under such a model, a base capitation rate would be trended forward, taking into account changes in population health and medical inflation, but would not rebase rates relying on utilization. This is similar to applying the hospital global budgets seen in Maryland and Pennsylvania to a managed care environment. |

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| Medicaid | Encourage states to include DOH interventions as a covered service. | <p>CMS recently issued guidance describing opportunities for state Medicaid and CHIP programs to better address DOH, including outlining legal authorities that permit the provision of DOH-related services for specific populations under Medicaid, along with examples of existing state initiatives.</p> <p>CMS also has approved through North Carolina’s 1115 waiver a set of evidence-based, high-value interventions addressing DOH. These services are illustrative of the types of services states should be encouraged to include as a covered service under Medicaid.</p> <p>Some services, such as housing navigation services, can be covered under existing federal law as a standalone fee-for-service benefit or under the rubric of targeted case management. Others, such as healthy food boxes can be provided by Medicaid managed care plans under quality initiatives, or as a value-added or in-lieu-of service. Still others, including services not offered statewide, could be offered through waiver. The recent CMS guidance reiterates previous guidance prohibiting the use of Medicaid funds to pay for room and board except in certain medical institutions. CMS defines “board” as three meals a day or any other full nutritional regimen.</p> | <ul style="list-style-type: none"> • Build upon this guidance to create new template and tools to assist states in leveraging this authority and to create greater clarity on the full range of services that can be made available under Medicaid. • For services offered under managed care, create learning collaboratives and tools including model contract language to support states as they implement DOH screening and navigation services, ILOS or other payment mechanisms (value-added services, quality incentive payments, withholds, etc.), and rate-setting options in the Medicaid Managed Care rule to account for DOH-related services. • For services offered via fee-for-service, create a State Plan Amendment (SPA) template for coverable services. • For services requiring a waiver: <ul style="list-style-type: none"> – Create an 1115 template for coverable services. – Include explicit focus on DOH interventions in Section 1115 demonstration monitoring and evaluations and develop tools to support states in monitoring and evaluating DOH 1115 demonstrations, such as templates and guidance for implementation plans, monitoring protocols and reports, and evaluations designs. – Issue guidance clarifying that short-term posthospitalization, transitional housing, such as the service approved in the NC waiver, can be covered under Medicaid. |

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| Sector/Program | Policy and Program Changes | Description/Impact/Notes | Federal Action |
| Medicare | Broaden Medicare Advantage coverage of DOH services and ability to target benefits to individuals based on social need. | Recent legislation and CMS guidance have begun to broaden the ability of Medicare Advantage plans to offer some supplemental benefits that might address DOH, within limited parameters. Plans have begun to offer DOH benefits to the extent allowed. The remaining constraints on these benefits have in some cases prevented plans from offering some DOH benefits because the benefits are not primarily health-related (even under a broader CMS reinterpretation) or from allocating some of these benefits strictly on the basis of the beneficiary’s social, rather than medical needs. Financial constraints also prevent plans from offering these benefits, as plans must pay for them from rebate dollars or premiums, potentially crowding out other benefits. | <p>Expand Medicare Advantage plans’ ability to offer DOH-related supplemental benefits in annual Medicare Advantage rulemaking.</p> <ul style="list-style-type: none"> • Allow allocation of all supplemental DOH benefits based solely on beneficiary’s social need. • Further broaden the types of DOH benefits allowed beyond those that are “primarily health related” by interpreting the term “supplemental health care benefits” to include all benefits with a plausible nexus to improving health or wellness, even if their primary purpose is to address DOH. • Remove requirement that DOH benefits be recommended by a licensed medical professional as part of a health care plan. • Improve financial incentives for Medicare Advantage plans to offer DOH-related supplemental benefits treating them as basic benefits for bid purposes through a CMMI model test. |
| Medicare | Pay for DOH screening and navigation to community resources by Medicare providers beyond the current Medicare reimbursement codes for psychosocial elements of chronic care management. | The lack of reliable and consistent documentation of health-related social needs makes it challenging to identify and invest in sustainable interventions that reduce health care costs. Screening for and documenting health-related social needs will provide crucial data to inform actuarial analyses, risk adjustment, rate setting, investment of public and private funding (including community benefit dollars), and strategies to address racial inequities, and to identify evidence-based interventions. | <ul style="list-style-type: none"> • Broaden definitions of covered services in Medicare fee-for-service by expanding chronic care management codes and code definitions that include DOH. • Establish care management codes for standalone psychosocial evaluation and referral. • Leverage the Accountable Health Communities (AHC) pilot and its screening tool to require health plans and delivery systems to screen patients for health-related social needs like any other vital sign and to navigate them to relevant community resources. • Leverage CMMI waiver authority to expand covered benefits. • Interpret “treatment of illness or injury” in Social Security Act 1862(a)(1)(A) to include purely DOH-related activities when related to diagnosis or treatment of illness or injury. • (Legislative) Amend Social Security Act 1862(a)(1)(A) to permit coverage of DOH-related activities for prevention of illness or injury. |

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| Sector/Program | Policy and Program Changes | Description/Impact/Notes | Federal Action |
| Medicare | Recalibrate county benchmarks to account for differences in socioeconomic status (SES) in ways that increase benchmarks in low-SES counties and encourage Medicare Advantage participation. | The CMS OACT currently uses its discretion and adjusts benchmarks in Puerto Rico upward to account for underserved beneficiaries based on the territory’s high rate of beneficiaries with no Medicare claims. OACT could identify other underserved counties within the United States with similar rates of no- or low-utilization beneficiaries and make similar adjustments. | Propose this methodological change via OACT’s annual Medicare Advantage and Part D Rate Announcement and Final Call Letter . |
| Marketplace | Include specific references to DOH-related services in the definition of essential health benefits (EHB), such as enhanced care management, social service referral/navigation and community coordinators (peer support, community health workers, doulas). | <p>Non-grandfathered individual and small-group health insurance coverage is required to cover EHBs (ACA § 1302, Public Health Service Act (PHSA) § 2707), which include preventive services. These preventive services include, at minimum, the following (which also apply to non-grandfathered group health plans, PHSA § 2713):</p> <ul style="list-style-type: none"> • U.S. Preventive Services Task Force (USPSTF) rated A and B preventive services. • Health Resources and Services Administration (HRSA) recommended preventive services for women and children. • CDC Advisory Committee on Immunization Practices-recommended vaccines. <p>If DOH interventions are not included in the section 2713 preventive services, they could still be included in the definition of EHB. Existing regulations defer to states to define the particular items and services covered within each EHB category (by defining a benchmark plan). Federal regulation could require or encourage EHB to include DOH interventions, subject to the statutory limits on EHB, including that HHS determine the EHB package is “equal to the scope of benefits provided under a typical employer plan.” ACA § 1302(b)(2)(A).</p> | <ul style="list-style-type: none"> • Work with HRSA to update its recommendations for preventive services for women and children. • Amend EHB regulations to encourage/require coverage of DOH interventions (after analysis of typical employer plans to demonstrate equivalence). • Encourage states to use flexibility granted under the 2019 NBPP⁷ to add DOH services to the state benchmark plan used to calculate federal tax credits. <p><i>Note: Services must fall under the definition of “amounts received through accident or health insurance (or through an arrangement having the effect of accident or health insurance) for personal injuries or sickness,” 26 USC 104(a)(3), to avoid a tax liability for beneficiaries.</i></p> |

⁷ Five states—Illinois, Michigan, New Mexico, Oregon, and South Dakota—recently added services to increase the generosity of the state EHB benchmarks relying on flexibilities in the [2019 NBPP](#) that allows new services to be added to the benchmark based on a gap between the state’s current benchmark and the most generous of the ten benchmark options available in that state. This pathway provides a safe harbor against the state having to pay for newly mandated services and could be used to add DOH services to the extent the state proposal meets pathway requirements. A new administration could also restrict states from using the similar pathways to select a less generous benchmark plan in future rulemaking. For more information, see [Updating the Essential Health Benefit Benchmark Plan: An Unexpected Path to Fill Coverage Gaps?](#).

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| Sector/Program | Policy and Program Changes | Description/Impact/Notes | Federal Action |
| Marketplace | Include DOH interventions in standardized qualified health plans (QHP) and promote these plans on the Marketplaces. | There is growing evidence that high deductibles (often over \$5,000 for silver-level plans) are not affordable, especially for low- and moderate-income consumers, deter people from seeking needed care, and disproportionately impact minority populations. To address affordability, some state-based Marketplaces (SBMs) require insurers to provide standardized plans with more services covered pre-deductible. Standardized plans that include DOH services pre-deductible could be implemented on the federally-facilitated Marketplace and required/encouraged for SBM states. An important constraint on standardized plans is limited flexibility to add services to metal level plans without eliminating other services in order to comply with actuarial value rules. CMS would also have to determine whether to allow non-standardized plan offerings to participate alongside standardized plans in the Marketplaces (e.g., California allows only standardized plans, whereas New York, and other states) allow a limited number of additional plans alongside standardized plans). | <ul style="list-style-type: none"> Reinstate standardized plan design in the Notice of Benefit and Payment Parameters (NBPP, first introduced in the 2017 NBPP). Provide a template for carriers to include DOH services in plan design. Further encourage the use of standardized plans/enhanced benefit plans by adopting an “active purchaser” model for Healthcare.gov, similar to California’s strategy to only contract with carriers that meet specified standards. Encourage states to adopt standardized plans in the absence of a federal requirement. |
| Marketplace | Encourage insurers to voluntarily cover DOH interventions, or permit states to require coverage. | ACA § 1311(d)(3) requires states to defray the cost of benefits they mandate in excess of EHBs. If DOH interventions are not EHBs, a state could mandate them if (1) DOH interventions are considered mandated benefits and the state defrays the cost or (2) DOH are not considered mandated benefits (and instead are considered, for example, part of the plan’s required care management program). Plans could voluntarily cover these services as well. | <ul style="list-style-type: none"> Provide guidance on section 1311(d)(3) on state flexibility to include DOH interventions without it being considered a mandated benefit. Provide states flexibility to add DOH interventions to their EHB benchmark by allowing them to select a benchmark plan from another state that has a higher actuarial value (AV) than the 10 in-state benchmark options. |

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| Sector/Program | Policy and Program Changes | Description/Impact/Notes | Federal Action |
| Marketplace | Design a model for wellness programs that addresses DOH without discriminating by health risk. | Wellness program, while popular with employers, are controversial for the lack of evidence of effectiveness and their significant potential to discriminate against people with poorer health. Health-contingent wellness programs are allowed under certain restrictions for employer-based coverage; they are not permitted in the individual market outside of a demonstration projects pursuant to PHSA § 2705(l) . Creating models for states and carriers to address DOH through wellness programs (e.g., supporting access to healthy foods) could improve health outcomes, while protecting against discriminatory effects. | <ul style="list-style-type: none"> • Provide toolkits to the health insurance industry regarding how wellness incentives can promote DOH interventions • Promote individual market wellness program pilots (pursuant to PHSA § 2705(l)) that further DOH interventions while protecting against discriminatory effects, through the release of a bulletin updating existing guidance. |

Strategy 3. Develop Shared Assets to Enable Interventions Addressing Drivers of Health

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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Cross-Sector | Support the development of networks of community-based organizations and providers with the capacity to sustainably address DOH. | <p>Community-based providers of services have the expertise and authentic community relationships required to address social service needs, but lack experience contracting with payors and providers of health services. Too often, DOH initiatives are funded through one-off charitable grants, without an eye to sustainability. CBO networks can bring DOH interventions to scale by:</p> <ul style="list-style-type: none"> • Serving as integrators who look systematically across multiple sectors to identify DOH priorities, service gaps and system and policy changes necessary to impact populations within the targeted region • Convening and collaborating with community around planning, training and information sharing • Developing and executing multi-payor sustainability plans • Tracking and submitting performance data • Supporting CBO contracting/billing • Supporting CBO capacity building and performance improvement • Distributing seed funding to contracted CBOs (if available) <p>New Jersey recently created Regional Health Hubs with this purpose in mind, providing health care data infrastructure and analysis, supporting care management, and convening community stakeholders in close coordination with the state's Office of Medicaid Innovation. Additional examples include "lead entities" in the California Whole Person Care Pilots, Washington State's Accountable Community of Health model, and North Carolina's Lead Pilot Entity program.</p> | <p>Provide models and best practices for network development and functions, and for funding these networks, including through:</p> <ul style="list-style-type: none"> • 1115 waivers (North Carolina, Washington) • MLR remissions (e.g., North Carolina) • Profit contributions (e.g., Arizona) • CMMI funding/initiatives (e.g., Michigan) • Medicaid managed care contract requirements (e.g., Oregon) |

| Strategy 3: Develop Shared Assets to Enable Interventions Addressing Drivers of Health | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Cross-Sector | Advance state and regional efforts to connect DOH data by (1) enhancing existing health information exchange capacity and protocols and (2) tying payment to new performance measures of whole-person care and cross-sector outcomes. | In most communities, technical capacity and infrastructure to support the sharing of physical health, behavioral health and DOH information between providers, public agencies and community-based organizations is limited. Capacity within state and regional health information exchanges and other institutions could be expanded to broker and link community and regional data assets, matching data against a common identifier to create “community health records” for individuals while minimizing individual system/organization burden. “Community information exchanges” are underway in North Carolina’s NCCare 360 , and the concept is being piloted in Washington State (e.g., Healthier Here CIE) and California (e.g., Alameda County Care Connect). | <ul style="list-style-type: none"> • Provide guidance and tools to support state Medicaid requests for enhanced federal funding to expand DOH data exchange capacity and provide additional state guidance on ways to leverage Medicaid managed care and 1115 waivers to support data exchange capacity. • Expand CMMI funding to support DOH information exchange infrastructure and capacity through its Regional Budget Payment and other funded programs. • Incentivize or require cross-sector data exchange through existing state/regional Health Information Exchanges (HIEs) in CMMI-funded initiatives. • Refine the MIPS program to incorporate DOH data sharing incentives. • Provide standardized template Medicaid, Medicare and Marketplace managed care contracting language requirements for provider data-sharing participation. • (Legislative) Extend HITECH beyond 2021 and expand applicable uses of funding to include building cross-sector information exchange. |
| Cross-Sector | Update federal privacy standards and consent requirements to facilitate cross-sector information sharing between health care providers and payors, and community-based social service providers. | Administrative, physical, behavioral and social service data are governed by different, and often conflicting, federal data-sharing and privacy laws, making it difficult for stakeholders to acquire, connect and use these data. The harmonization of federal laws and regulations governing drivers of health data will be essential to enabling states and health systems to provide whole-person care while earning patient trust and ensuring sensitive patient information is used for appropriate purposes. | <ul style="list-style-type: none"> • Convene a multiagency workgroup, including Department of Housing and Urban Development (HUD), Substance Abuse and Mental Health Services Administration (SAMHSA), Office for Civil Rights (OCR), Office of the National Coordinator for Health Information Technology (ONC) and others to identify regulations governing the sharing and use of DOH data and recommend and implement regulatory actions needed to eliminate data-sharing barriers. • Engage with HUD to develop new guidance to its funded “Continuum of Care (CoC) Program” participants to enable the secure sharing of housing and homelessness data with medical provider partners. |

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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Cross-Sector | Establish <i>federal technical standards</i> to govern the sharing and use of cross-sector data. | The consumption, linking, sharing and use of cross-sector and cross-federal-agency data to support whole-person health will require new technical standards for how these data are curated (e.g., adding new fields and classifications), compiled for distribution (e.g., maintaining common identifiers), and transmitted (e.g., using Fast Health Care Interoperability Resources (FHIR) Application programming interfaces (APIs)). Processes governing how such standards will be maintained will also be needed. | <ul style="list-style-type: none"> Establish a multiagency workgroup in coordination with public-sector initiatives (e.g., ONC/Sequoia Project and Trusted Exchange Framework and Common Agreement) and private-sector initiatives (e.g., HL7 Gravity Project) to identify data, definitions (e.g., provider/service nomenclature and terminology), transmission protocols (e.g., FHIR), processes (e.g., closed-loop referrals) and forms (e.g., care plans) that require standardization for integration and use, and establish several targeted cross-agency and cross-industry tactical teams to propose new standards for implementation. Release guidance and standards based on feedback received from the December 2020 RFI on barriers to adopting standards, and opportunities to accelerate adoption of standards, related to social risk data in the Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information proposed rule that called for accelerated adoption of standards related to social risk data. |
| Medicaid | Encourage the use of community health workers (CHWs) as part of integrated care teams to conduct DOH screening, navigate patients to community resources, enroll them in DOH programs and document closed resource referrals. | <p>Building on shared experiences and familiarity with the community, community health workers can create trusted relationships with patients and engage in critical health education and promotion activities. Community health workers can be a vital resource for patients and providers, creating linkages to health and social services that providers may lack either the time or knowledge to facilitate.</p> <p>Other community-based providers could also be incorporated into integrated care teams, such as housing specialists (e.g., New Jersey), employment specialists (e.g., New Hampshire), access to medical legal professionals (e.g., North Carolina), using similar policy mechanisms.</p> | <ul style="list-style-type: none"> Issue guidance that reinforces and elevates current opportunities to leverage Medicaid to finance CHWs (i.e., Medicaid managed care contract opportunities, State Plan Amendment and 1115 demonstrations). Issue guidance that clarifies availability of Medicaid IT funds to support infrastructure that connects CHWs to patients, providers, and community resources and “close the loop” between visits (e.g., integrating CHWs with provider electronic health records (EHRs) and community resource platforms). |

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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Medicaid | Seed development and deepening of DOH information technology (IT) infrastructure and capacity through Medicaid. | Under the current statutory and regulatory framework, state Medicaid agencies are authorized to receive federal funding for Medicaid IT and associated activities, including an array of Medicaid program management and administration functions and health information exchange. Much of the federal funding is available at an enhanced federal matching level of 90% or 75%. | <ul style="list-style-type: none"> • Provide guidance and resources on Medicaid IT enhanced funding to support DOH technology, such as the development of shared platforms and standards for data exchange to support care management, social service screening and navigation, oversight and evaluation, and payment. • Provide exception to federal cost allocation requirements (OMB Circular A-87) to allow technology developed and supported by Medicaid and/or CHIP to be used by other health and human services programs (e.g., Marketplaces, Temporary Assistance for Needy Families (TANF), SNAP, HUD).⁸ |

⁸ Precedent exists in ACA guidance: [2011 USDA-HHS Letter](#), [2012 USDA-HHS Letter](#), and [2015 USDA-HHS Letter](#).

Strategy 4. Maximize Participation in Public Programs that Address Drivers of Health

| Strategy 4: Maximize Participation in Public Programs that Address Drivers of Health | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Medicaid | Encourage states to maximize enrollment in public programs that impact health outcomes and access (Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), etc.) | Patients eligible for, but not enrolled in, SNAP have higher health care costs than those enrolled . Further, Black Americans have the highest rates of food insecurity and diabetes. States are hiring contact tracers and community health workers, even as insurers and health care delivery systems are firing or furloughing employees. All these workforces could enroll SNAP-eligible patients. One major commercial payor, for example, is deploying its employees (who would otherwise be furloughed due to COVID-19) to enroll members in SNAP, after calculating that it carries approximately \$60 million in excess medical costs in one state for those members struggling to feed their families. | <ul style="list-style-type: none"> • Create toolkits and learning collaboratives for state Medicaid to showcase best practices connecting beneficiaries to other programs that impact health, including: <ul style="list-style-type: none"> – Requiring MCOs to assist with cross-program enrollment as part of their care management responsibilities. – Making the percentage of patients or members who are SNAP-eligible and enrolled a standard quality measure for insurers and/or providers, with associated financial incentives/penalties. – Allowing health insurers to include the costs of enrolling members in SNAP as a care management cost attributable to the numerator of the MLR. • Clarify the ability of states to share information with MCOs to identify and enroll those potentially eligible for SNAP, WIC, etc. • Release an annual report card of comparative state participation rates in targeted public programs (Medicaid, SNAP, WIC, etc.). |
| Medicaid | Encourage Medicaid expansion in non-expansion states and expansion of postpartum coverage. | During the COVID-19 pandemic and related recession, expansion offers states the potential to offset state health spending , reduce unnecessary utilization , improve health outcomes and increase revenues . Further, access to Medicaid effectively increases household income, a key DOH. | <ul style="list-style-type: none"> • Clarify existing guidance to restrict uncompensated care waiver pools to care that is not attributable to a state's failure to expand Medicaid. • Expand Medicaid's postpartum coverage from 60 days to one year. • (Legislative) Increase Federal Medical Assistance Percentages (FMAP) for late adopters. |

| Strategy 4: Maximize Participation in Public Programs that Address Drivers of Health | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Medicaid | <p>Remove barriers to coverage/care that decrease access, particularly for marginalized and under-resourced groups:</p> <ul style="list-style-type: none"> • Prohibit work requirements as a condition of eligibility. • Limit premiums as a condition of eligibility. • Restrict lockouts. <p>Encourage policies that promote coverage/care to improve health outcomes and access:</p> <ul style="list-style-type: none"> • Encourage/allow continuous coverage. • Encourage more widespread use of presumptive eligibility state plan options. • Encourage streamlined and technology-supported eligibility and enrollment processes. | <p>Continuity of coverage is a prerequisite to efforts to manage care and control costs. Barriers to coverage disrupt access to services and impede states' ability to hold plans and providers accountable for improving health outcomes.</p> | <ul style="list-style-type: none"> • Rescind existing guidance encouraging states to take up work requirements and reject related pending 1115 waivers. • Revisit policy on premiums and lockouts, which create barriers to coverage. • Encourage states that do not already have continuous coverage for children to adopt it; encourage waivers to permit continuous coverage for adults. • Provide simplified SPA or waiver application, including tools for continuous eligibility in Medicaid. • Continue to work with states to ensure compliance with Medicaid eligibility rules intended to help maintain coverage and encourage states to adopt existing state plan options to facilitate enrollment where possible (e.g., expand the list of qualified entities to conduct presumptive eligibility and support necessary systems investments to encourage coordination). • Identify opportunities for enhanced funding for design, development, implementation and ongoing operations of improved application, enrollment and retention processes. • Provide toolkits supporting implementation of these and other best practices. |

Strategy 5. Create New Standards for DOH Quality, Utilization and Outcome Measurement

| Strategy 5: Develop DOH Quality Measures | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Cross-Sector | Establish comprehensive nationwide standards for drivers of health data, collection and measurement focused on both process and outcomes measures. | Public and private health and healthcare organizations and government leads such as NQF , NCQA , PCORI , ASPE , AHRQ , RWJF and others have long since begun to incorporate DOH into their national priority frameworks, resources guides and reports to Congress, and measure development processes. Yet the nation still lacks standard DOH measure sets that can be incorporated into delivery system reform . | <ul style="list-style-type: none"> • Convene a measurement group with DOH experts from within and outside government to establish the first DOH measurement standards to be applied across all CMS programs • Develop common standards for the collection and use of social risk data (e.g., expanding the use of Accountable Health Communities (AHC) screening tools). |
| Medicaid | Update the Medicaid core measures set to include DOH measures. | The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Social Security Act (Section 1139B) require the Secretary of the Department of Health and Human Services (HHS) to identify and publish a core set of health care quality measures for children and adult Medicaid enrollees. State reporting measures are currently voluntary, and measures generally must be able to be reported by at least 25 states. The current measure sets lack DOH indicators. | Include DOH in Annual Core Set update (published in annual Center Informational Bulletin after a multistakeholder process to evaluate new and existing measures). |

| Strategy 5: Develop DOH Quality Measures | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Medicaid | Add DOH to state quality strategy under Medicaid Managed Care. | Federal regulations at 42 CFR Part 438, subpart E (Quality Assessment and Performance Improvement) lay the groundwork for the development and maintenance of a quality strategy to assess and improve the quality of managed care services offered within a state. This quality strategy is intended to serve as a blueprint for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as in setting forth measurable goals and targets for improvement. Each state contracting with a managed care organization must develop and maintain a quality strategy. CMS has begun to work with states to broaden the scope of the quality strategy beyond managed care. While some states have incorporated DOH into their quality measure sets—for example, North Carolina and Rhode Island require DOH screening as part of state quality reporting requirements—most states lack DOH indicators. | <ul style="list-style-type: none"> Amend 42 CFR Part 438 Subpart D to include addressing DOH as a minimum quality requirement. Update the November 2013 State Health Official Letter (SHO) titled “Quality Considerations for Medicaid and CHIP Programs” to encourage/implement this requirement. Encourage states and plans to work with public health and social services entities in developing and executing the minimum quality requirement strategy. |
| Medicare | Build DOH into the Quality Payment Program (QPP) via the Center for Clinical Standards and Quality (CCSQ). | Through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS eliminated the Sustainable Growth Rate to determine spending by Medicare on clinician services in favor of linking payment increases to high-quality and high-value providers based on performance standards and quality measures. The Quality Payment Program (QPP) is the regulatory mechanism required to implement this part of the MACRA legislation, which it does through two participation tracks: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models. To date, the QPP has not accounted for DOH in its quality measures, financial incentives, category weights or performance pathways. Preliminary data from the CMS Accountable Health Communities (AHC) pilot has identified food, housing and transportation as the most pressing needs for 33% of the first 750,000 beneficiaries screened for health-related social needs (pre-COVID-19). | <ul style="list-style-type: none"> Prioritize DOH-related measures in the annual QPP measure development process and measure development plan, the annual call for quality measures, and the preliminary and final rule-making process. Work with ASPE, as noted in the CY 2021 QPP Final Rule, to build off the second social risk report to Congress and establish DOH measures to be integrated into value-based purchasing. Leverage the AHC validated screening tool and data to develop DOH measures. |

| Strategy 5: Develop DOH Quality Measures | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Marketplace | Build DOH into the health insurance exchange Quality Ratings System (QRS) . | The QRS consists of 38 quality measures, including 28 clinical quality measures that assess general performance and the quality of health care services provided and 10 survey measures that assess enrollees' experiences with their health plans. Other than income, DOH measures are not included in the data file or survey. | <ul style="list-style-type: none"> Identify potential measures in collaboration with nationwide DOH data and measure process (above). Issue a Draft Call Letter for the QRS and Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey) for public comment. Issue a Final Call Letter and supporting materials. |

Strategy 6. Make Drivers of Health Central to CMMI’s Innovation Agenda

| Strategy 6: Integrate DOH Into CMMI’s Innovation Agenda | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| CMMI | Develop and test a social services fee schedule to be used by health care payers and providers to pay for DOH interventions. | A primary barrier to scaling sustainable interventions is a lack of common understanding of how to quantify the costs of interventions that address DOH. A social services fee schedule provides a common starting point for forging new partnerships between health care payors and providers and the community-based organizations best equipped to provide social services impacting health. A fee schedule also provides baseline information necessary for measuring the impact of DOH in the context of cost and risk modelling. CMS has approved one such fee schedule as part of North Carolina’s 1115 waiver. Multipayor models, such as SIM or CPC+, are ideally suited to test the development of such a fee schedule. | <ul style="list-style-type: none"> • Select five SIM states to develop and test an initial social services fee schedule. • Test the social services fee schedule through Medicare Advantage chronically ill populations that already have flexibility in non-medically related spending. • Build a Community Based Organizations (CBO) fee schedule into State Innovation Model (SIM) states in partnerships with CBOs and Medicaid offices. |
| CMMI | Integrate the Accountable Health Communities Model DOH-related components, such as screening and navigation, into other existing models and new CMMI payment models. | <p>Integrating AHC learning, tools and data across all models will provide data on how these mechanisms interact with other care delivery interventions, and make them available to more participants. Some of the major CMMI models (e.g., Accountable Care Organization (ACOs) do not address DOH).</p> <p>To the extent CMS lacks administrative authority to implement changes to the Medicare fee schedules directly for coverage of DOH-related services, CMMI could use its authority to test the implementation of these services.</p> | <ul style="list-style-type: none"> • Require new models to integrate AHC screening and navigation of social needs processes through the Innovation Center Investment Plans. • Require existing models to consider adding AHC program elements in annual contract renewals or contract extensions with grantees/contractors. |

| Strategy 6: Integrate DOH Into CMMI's Innovation Agenda | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| CMMI | Direct CMMI to incorporate standard DOH considerations into all payment and care delivery models. | AHC and Comprehensive Primary Care Plus (CPC+), are models designed specifically to account for DOH. It is possible that many other CMMI models languish or fail to produce predicted savings and quality outcomes because they fail to fully account for DOH factors that impact health outcomes and cost. | <ul style="list-style-type: none"> • Include DOH-related measures as part of the standard CMMI measure framework maintained by the Rapid Cycle Evaluation Group at CMMI. • Require DOH standards/criteria be applied to every Innovation Center Investment Plan required for every model. • Require DOH commitments/attestation as part of award applications. • Build DOH into terms and conditions of participation. • Build standard DOH measures into the core CMMI measure framework and contracted model evaluations. • Add social need performance metrics to reporting requirements (e.g., screen/closed loop referrals). |
| CMMI | Restructure CMMI models to promote participation among providers serving middle/low-income and marginalized groups. | Currently the application processes alone for model participation can require substantial financial and administrative resources, which may be a participation deterrent for less-resourced practices that serve marginalized groups. CMMI can take steps to promote participation among these providers, providing opportunities to benefit from DOH-related demonstrations. | <ul style="list-style-type: none"> • Implement tiered/sliding payment scales for providers in these categories. • Set targets for awards given to providers in these groups (e.g., 15% of all awards). • Offer application support services for under-resourced practices. |
| Medicare | Increase use of Quality Improvement Organizations (QIOs) in Medicare to support efforts to address DOH. | The QIO Program is one of the largest federal programs and networks dedicated to improving health quality for Medicare beneficiaries. By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries. The QIOs could be highly leveraged to provide DOH-related support to health systems across the country, especially given the impact of COVID-19 on beneficiaries' basic health needs. | Build DOH task orders into the future QIO Scope of Work, including for the Quality Innovation Network (QIN)-QIOs, and add DOH perspective as a contract modification to the existing scopes of work. |

Strategy 7. Incentivize Community Accountability and Stewardship

| Strategy 7: Incentivize Community Accountability and Stewardship | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Medicaid | Encourage or require states to direct managed care organizations to contribute to locally-governed community wellness and equity organizations. | <p>Requiring Medicaid managed care organizations to make investments in community-based organizations can catalyze DOH interventions not just through providing direct services, but also through broader community collaboration and development. These organizations focus on improving health at a community scale (not just for individual plan members), addressing a set of priority health and social issues (trauma, resilience, housing stability, economic opportunity), and supporting an enduring platform for better coordination and alignment of resources across sectors.</p> <p>Some states already require community investments.</p> <ul style="list-style-type: none"> • Arizona requires MCOs to contribute 6% of their annual profits to community reinvestment and produce an annual Community Reinvestment Report. • Beginning in 2021, Oregon's Coordinated Care Organizations are required to participate in the Supporting Health for All through Reinvestment (SHARE) initiative by reinvesting a portion of the prior year's excess net income or reserves to address DOH and health disparities. • Through its managed care contracting process, California requires an MCO serving Imperial County to make a per member per month payment into a local Wellness Fund intended to pool, manage, and align funds from various sources (including from the California Accountable Communities for Health Initiative) to address community health priorities. | Provide guidance, models and best practices for implementing community investment requirements for managed care contracting and for future 1115 waiver demonstrations. |

| Strategy 7: Incentivize Community Accountability and Stewardship | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Medicaid | Tie certain supplemental payments to DOH expectations for community stewardship. | Many providers, particularly hospitals, receive a significant portion of their reimbursement through supplemental payments, including Medicaid Disproportionate Share Hospital (DSH) , upper payment limit payments and, in managed care, directed payments. CMS has more discretion with respect to approving directed payments, especially those in excess of Medicare payment levels. CMS could condition approval of directed payments, and possibly other types of supplemental payments, on requiring that qualifying providers meet defined metrics related to community stewardship. | <ul style="list-style-type: none"> • Develop standards for providers related to healthy living wage expectations and community benefit obligations. • Issue a State Medicaid Director Letter (SMDL) outlining expectations. • Require attestation of healthy living wage for employees as a condition to receiving funding from waiver pools. • Require community benefits plans to meet standards for contributing to the development of community assets to address DOH. |
| Medicaid | Incentivize healthy living wages, particularly for the long-term care (LTC) workforce. | <p>COVID-19 revealed the vulnerability of our nation’s LTC system—and the LTC workforce that supports it. Long-term care workers are often paid low wages, requiring them to work multiple jobs. Workers are overwhelmingly women of color, many with wages so low they may themselves be Medicaid eligible. Increasing wages for the LTC workforce will improve recruitment and retention of LTC workers, thereby improving the quality of care for beneficiaries and the integrity of our LTC infrastructure. Further, a healthy living wage will better enable LTC workers to address DOH, such as having secure housing or access to food.</p> <p>While focused here on LTC workers, this approach could be applied to any Medicaid provider.</p> | <ul style="list-style-type: none"> • Revise budget neutrality policy to account for state-mandated changes in the minimum wage—for example, zeroing out minimum wage increases in budget neutrality calculations (e.g., New York and Washington State). • Publish subregulatory guidance educating states on how to use tools like incentive payments to promote healthy living wages for LTC workers. • Encourage states to continue to transition enhanced payments such as hazard pay under COVID-19 flexibilities into the permanent payment base. • Encourage Medicaid managed care incentive payments (capped at 5% of capitation) linked to entering into contracts with LTC providers under which employees are paid a healthy living wage. • (Legislative) Amend Section 1902(a)(30)(A) of the Social Security Act to add a new subsection to require rate setting to incorporate a healthy living wage calculation for all Medicaid providers. |

| Strategy 7: Incentivize Community Accountability and Stewardship | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Medicare | Update the Medicare wage index to incentivize healthy living wage compensation for hospital workers. | <p>Changes to the wage index that increase payment rates would enable hospitals to ensure that their employees are paid a healthy living wage. A recent HHS Office of Inspector General (OIG) report highlighted the challenges for hospitals with low wage index values to raise wages under the current payment methodology.</p> <p>A wage index increase incorporated into the Medicare payment methodology would require several key considerations:</p> <ul style="list-style-type: none"> • Defining a “healthy living wage” in each geographic region. • Potentially providing additional federal funding to prevent cost-shifting from other program elements, therefore requiring a federal budget impact analysis. • Potentially developing an approach to target wage adjustments to providers to protect safety net providers from disproportionate impacts. <p>CMS has asserted the authority to remove aberrant wage index data from the inpatient prospective payment wage index calculation, including those with extraordinarily high or low wages. (80 Fed. Reg. 49325 at 49491). CMS recently proposed, but did not adopt, a plan to use this authority to remove collectively bargained hospitals from the data mix. (84 Fed. Reg. 19158, 19376). In this proposal, CMS would use the authority and discretion to the opposite end.</p> | <ul style="list-style-type: none"> • Use secretarial discretion to discard data for facilities not paying a healthy living wage from the wage index as invalid. • Include and heavily weight facilities that collectively bargain in wage indices. • Create upward/downward adjustments to wages where providers pay/fail to pay healthy living wages, with some protections for safety net providers. • Recommend MedPAC/MACPAC evaluate/recommend healthy living wage considerations and Medicare wage index changes. <p><i>Note: There may also be an opportunity to raise rates in Medicaid that are pegged to changes in the Medicare rate.</i></p> |

| Strategy 7: Incentivize Community Accountability and Stewardship | | | |
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| Sector/Program | Policy and Program Changes | Description/Impact | Federal Action |
| Medicare | Provide rate increases for critical access hospitals (CAHs) that invest in healthy living wage compensation. | CAHs are currently reimbursed on a cost basis (allowable costs + 1%). There is a significant lag, however, between when the cost increase occurs and when the payments increase. An adjustment to the reimbursement methodology to provide an interim payment, subject to reconciliation, to account for wage increases before they are reflected in audited cost reports would better enable hospitals with limited cash flow to increase wages for workers. | (Legislative) Amend § 1814(l) of the Social Security Act to establish an interim payment for CAHs to increase wages to a healthy living wage standard. Interim payments would be subject to reconciliation when final cost reports are filed. |

