December 20, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Administrator Brooks-LaSure:

We appreciate the opportunity to comment on the North Carolina Department of Health and Human Services Division of Health Benefits "(NC DHHS)", North Carolina Medicaid Reform Section 1115 Waiver Demonstration Renewal Request "(Waiver)". We comment on NC DHHS for the work it has done during the first waiver period and seeking to both extend and expand its efforts of enhancing whole-person and well-coordinated care addressing medical and non-medical drivers of health and advancing health access by removing disparities. We further applaud NC DHHS for aggressively seeking to expand services and particularly note the innovation concerning the request to pay for firearm safety and re-entry interventions. The primary focus of this comment letter will surround the Healthy Opportunity Pilot section of the Waiver request.

Founded in 2010, findhelp (formerly Aunt Bertha), a Public Benefit Corporation, runs the largest social care network in the United States and has served more than 35 million Americans. Our mission is to connect all people in need with the programs that serve them with dignity and ease. As part of fulfilling our mission, we will always maintain findhelp.org, a free and anonymous search tool for self-navigation to free and reduced cost programs in every U.S. Zip Code. Our network is used by over 550 customers, including 250 health systems, 130 health plans, community health centers, and health departments in the U.S. to manage social care referrals, as well as tens of thousands of community based organizations. With a network that includes at least 1,500 program locations in every U.S. county, findhelp's interoperable social care technology works with electronic health records (EHRs) and other Systems of Record (SoRs) to help clinicians and navigators seamlessly connect individuals with free and reduced cost social care services.

The findhelp network in North Carolina brings together 9,788 community programs and 16 customers to address social care needs. Through customer platforms and our free public site, findhelp.org, our network reaches more than 35 million users across the country (including over 1 million North Carolina users), connecting people with local programs and tracking outcomes. Since January 2020, more than 811,418 connections have been made via the findhelp network between North Carolinians looking for help and community organizations providing services for their health related social needs (HRSNs). Our robust North Carolina network spans each region of the state, and includes partners across the healthcare spectrum, including MCOs, providers, and community based organizations.

While we generally support North Carolina's request to expand the Health Opportunities Pilot statewide, a review of the Rapid Cycle Assessment Report (dated March 24, 2023) of the Pilot suggest that the current closed loop referral system platform (NCCares360) serving as the foundation of the Pilot may be holding the Pilot back from maximizing its success in the three current regions of the program. Therefore, as indicated below in more detail, we strongly suggest that CMS require NC DHHS to open the closed loop referral system to more vendors than just UniteUs to see if systems with more user friendliness (for the HSOs, providers, and members using the system), more functionality, and additional transparency and accountability will accelerate NC DHHS's success under the renewed waiver.

With increased focus on addressing the upstream factors that influence health and wellbeing, state Medicaid programs across the country are working to develop effective and sustainable approaches to better integrate the delivery of healthcare and social services. As the leading social care or Social Determinants of Health (SDOH) technology platform in the country, we are proud to be at the forefront of supporting effective technology approaches to connect members with services to address HRSNs. In partnership with MCOs, providers, health information exchanges, and an extensive network of community based organizations, we are committed to a sustainable approach that leverages existing technology infrastructure with a focus on interoperability. To this end, we believe that as the Health Opportunities Pilot expands statewide, the state could benefit greatly from added assistance through our findhelp platform.

We have also observed in other states attempts similar to that of North Carolina's to mandate health care plans and providers exclusively use a single vendor (and, in some cases) require HSOs sign exclusivity contracts as a condition of funding. This type of single vendor approach seems to be less successful in practice, and we believe CMS can play a leadership role by providing guidance that shapes a more sustainable and equity-driven path forward. In recent months, states including New York and Washington have moved away from procurement of a single, statewide referral platform within their 1115 waiver requests in favor of a more interoperable approach, focusing on standards development and alignment with federal interoperability initiatives. This shift is largely due to significant stakeholder input that an approach founded on technology choice and interoperability would lead to better adoption and sustainability beyond the life of this waiver.

As CMS considers this request and other state waivers requesting flexibility related to the integration of services to address HRSNs, policy guidance on interoperability and data privacy can facilitate a more successful and sustainable path and be consistent with the CMS strategic vision for advancing equity and whole-person care in the Medicaid program.

In our comment, we highlight three areas that will be critical for guiding successful implementation. We believe these areas complement NC DHHS's broader themes throughout the waiver extension request: 1) supporting a truly interoperable approach that maintains organizations' choice of technology systems; 2) fostering an open and focused network; and 3) protecting individual data privacy.

About findhelp

Founded in 2010, **findhelp** is a Public Benefit Corporation that runs the largest social care network in the United States and has served more than 35 million Americans, now growing at a pace of nearly 1 million new users every three weeks. Our network and interoperable e-referral technology is used by over 550 customers, including 250 health systems, health plans, community health centers, and health departments in the United States, to manage social care referrals. With a network that includes tens of thousands of community based organizations (CBOs) and social services

organizations (together referred to as HSOs by NC DHHS), and at least 1,600 program locations available to serve residents of every county nationwide, findhelp's interoperable social care technology works with electronic health records (EHRs) and other platforms to help clinicians and navigators address the social needs of individuals in a seamless fashion. Our mission is to connect people in need with the programs that serve them, with dignity and ease.

Our data and analytics capabilities are facilitating efficacy and value to regionally driven SDOH approaches, and through our referral and reimbursement workflows, we enable our customers to see, in real time, how people are accessing care. In addition, our network partners are able to track covered HRSN utilization and additional analytics for assessing CBO capacity. Our network is available to anyone who needs help, and we offer a free suite of tools, technical support, and guidance to CBOs, who best understand and are equipped to meet the needs of their communities' most vulnerable populations. With our technology being made available across the country, we empower our partners (CBOs, local health departments, MCOs, and others) to collaborate to address health disparities and improve wellbeing.

As Value Based Payment (VBP) models and outcome measurement practices mature, we are dedicated to providing continued support to our MCO and other healthcare partners in their work to improve health equity and wellbeing across the country. In Massachusetts, we are supporting ACO and hospital customers to implement Mass Flex pilots, a waiver initiative providing housing and nutrition support. In California, we are working with MCO partners under CalAIM to connect members with housing support, medically tailored meals, and other community support benefits. Further, we are supporting Medicaid plans to facilitate claims and payments to the CBOs that provide covered HRSN services. Through our Marketplace program, navigators can send groceries or diapers, set up rides to healthcare appointments, and much more. Marketplace also supports eligibility screening, authorization, and payment for orders under 1115 Medicaid Waivers.

We commend NC DHHS on its thoughtful approach to expanding its service offerings to Medicaid members in North Carolina. In particular, we believe the expansion of the Healthy Opportunities Pilot, with the changes we articulate below, will build research and evidence to support scaling of medically appropriate HRSN interventions within Medicaid programs across the country, and spur innovative ways of blending and braiding funding the supports goals of CMS and the Biden-Harris administration.

Comments on the NC DHHS Medicaid Reform Section 1115 Waiver Demonstration's Request to Expand the Healthy Opportunities Pilot Statewide

Through the requested extension and expansion of the Medicaid Reform Section 1115 Waiver Demonstration, NC DHHS is requesting to expand the current three-region Healthy Opportunities Pilot statewide. We applaud this request and encourage CMS to approve this request. However, upon review of the evaluation of the previous period of the waiver, including quotes from various stakeholders, we note that the cost of the program compared the number of Medicaid members served reveals potentially missed opportunities even within the limited three region area it served. Based upon the comments included in the evaluation, we also note that there appears to be concern about the usability, flexibility, administrative burden, and costs of the UniteUs platform. As discussed in more detail below, we believe opening up the CLRS platform options beyond the current state-mandated platform will accelerate the speed at which NC DHHS can scale the Healthy Opportunities Pilot from its current regions across the state. Undoubtedly, there are providers and HSOs in these new regions of the state that are already working with other, non-UniteUs CLRS platforms. By allowing those stakeholders the opportunity to leverage their existing systems workflows, they will be able to immediately begin participating in the Healthy Opportunities Pilot as it comes to their region, and NC DHHS can avoid

the delays it seemingly experienced during the previous waiver period thereby driving significantly more help to the Medicaid members NC DHHS is attempting to target with this expanded waiver program. In fact, we believe the only way to ensure that NC DHHS maximizes the opportunities to address health disparities and health equity across the state is for CMS to require NC DHHS to open the Healthy Opportunities Pilot to all CLRS platforms that comply with the safety, security, and interoperability expectations CMS has articulated in both regulation and guidance documents. Doing so will minimize provider and HSO administrative burden and generate significant momentum for those served by the Pilot in North Carolina.

As CMS considers this 1115 Waiver Demonstration Extension Request, we would like to highlight three critical areas related to social care navigation that appear to be lacking during the previous period of this waiver but that can easily be remedied with the right intervention and continued oversight of CMS, all of which complement not only NC DHHS's approach but also the broader CMS Health Equity Framework: 1) supporting a truly interoperable approach that maintains organizations' choice of technology systems; 2) fostering an open and focused network; and 3) protecting individual data privacy.

Interoperability

A truly interoperable approach is founded on agreed upon data standards and incentivizes vendors to support consistent data reporting. In North Carolina, interoperability is the best way to ensure that taxpayer dollars – both state and federal – are maximally leveraged to create the most return for the Medicaid members being served by the Health Opportunities Pilot. Unfortunately, interoperability has not been a core component of the NC DHHS Health Opportunities Pilot thus far as it has attempted to mandate, through a single vendor, all non-medical needs assessments, identifications, referrals and the tracking of closure of those referrals. By mandating the usage of the UniteUs platform, NC DHHS has hamstrung the success of the program's scale and efficiency, both of which were noted in the state's Rapid Cycle Assessment (dated March 24, 2023) and in its waiver renewal application submitted by NC DHHS. Examples include stakeholder concerns related to technical glitches and lack of unified/standard templates for use and reporting in NCCARE360 as well as the concerns listed over the required use of multiples systems and reports (e.g., Salesforce, Google, NCCARE360, etc.) because of lacking functionality of the current NCCARE360 platform. Without CMS instructing NC DHHS to open up the Healthy Opportunities Pilot to additional CLRS vendors, these costs and programmatic inefficiencies will only multiply as the NC DHHS scales the Health Opportunities Pilot from its current regions across the state under this pending waiver renewal request.

As part of North Carolina's efforts to scale the Health Opportunities Pilot statewide while simultaneously building HSO capacity, it is critical that NC DHHS bring in additional CLRS vendors (or allow the MCOs, HSOs, and providers to leverage the CLRS of their respective choice) to bring about more efficiency and lower priced services through competition. Our experience across the country shows that doing so – while maintaining documentation and reporting standards that will provide consistency and transparency across multiple CLRS vendors as is required in the Accountable Health Communities Grant Model – will enable NC DHHS to build robust data sharing infrastructure that will ultimately inure to the benefit of the Medicaid members served under the Healthy Opportunities Pilot. Doing so will not only ease the administrative and, potentially financial, burden of the participating providers and HSOs, but it also allow CMS to more easily synthesize the best practices regarding how to leverage federal financial participation to reduce health disparities and enhance the health statuses of historically marginalized populations through the Section 1115 Medicaid Demonstration Waiver paradigm. Findhelp continues to focus our efforts in building a robust data sharing infrastructure and programs to incentivize vendors to develop integrations that allow existing systems (whether

at providers, MCOs, HSOs, etc) to communicate with each other and NC DHHS. CMS has taken the first steps towards establishing interoperability on a nationwide scale through the United States Core Data for Interoperability (USCDI) Version 1 dataset. Further iterations of USCDI have included SDOH elements, and in 2023, ONC announced the rollout of USCDI+ to support federal agency partners' interoperability efforts through program specific datasets operating as extensions to the existing USCDI. We are proud participants of regional and national interoperability efforts. Through the **MiHIN Interoperability Pledge**, we have committed to advancing interoperability standards across organizations, and through the White House **Sync for Social Needs Initiative**, we have pledged to work with agencies, technology vendors and healthcare organizations to standardize the collection of patient data on SDOH. It is time for CMS to ensure that NC DHHS show the same level of commitment in this next waiver period to interoperability as that demonstrated by CMS as outlined above.

In recent years, we have seen Medicaid agencies adopt models that attempt to mandate health care plans and providers exclusively use a single vendor to facilitate social care referrals, and have required HSOs to sign exclusivity contracts as a condition of funding. In fact, North Carolina has mandated MCOs, providers, and HSOs use a single technology vendor (UniteUs) as a condition of participation in the Healthy Opportunities pilot. From our perspective, this approach often results in limited adoption by the healthcare and social care partners who are needed to facilitate a successful social care network. And this appears to have been borne out in North Carolina based on the summary interim evaluation points included in the waiver renewal application and in the state's Rapid Cycle Assessment Report (dated March 24, 2023). Our fundamental belief (as described in more detail in the section titled "Open and Focused Network" below) is that true interoperability and open networks that facilitate multiple closed loop referral platforms will allow NC DHHS's waiver to flourish and drive significant health disparity reduction in the populations NC DHHS is attempting to assist with this waiver. More competition and more options can result in less administrative burden for both the members served and all of the other stakeholders (*e.g.*, providers, HSOs, and even MCOs). Notably, while the state has attempted to mandate UniteUs as the region-wide closed loop referral system vendor for the Healthy Opportunities Pilot regions, we nonetheless continue to work with MCOs , providers, HSOs in North Carolina who repeatedly relay discouragement about the lack of momentum and missed opportunities with the Health Opportunities Pilot over the last five years.

In contrast, other Medicaid agencies, including those in Massachusetts and California, have taken an interoperable approach, and, rather than mandating one platform, building upon the infrastructure and investments that have already been made by healthcare plans, providers, and HSOs. A truly interoperable approach maintains organizational choice for social care referral technology, relies on integrations into the existing systems of record used by health and social care providers, and requires investments in governance structures, data standards, and data exchange. We believe that the latter approach, one that maintains organizational choice of technology and builds upon the existing infrastructure, is the approach that will be most successful for achieving HSF's objectives related to advancing health equity through a more integrated delivery system. Not only do we believe that North Carolina will be best positioned to achieve the vision cast in the extension/expansion request of this innovative waiver, but it is even more imperative now that NC DHHS is asking for authority to extend the Health Opportunities Pilot statewide. Doing so will ensure total community participation while also guaranteeing consumer-directed privacy protections.

Open and Focused Network

An open network ensures that members have access to a broad array of services, including services that are trusted in their community and are culturally competent. An open network can also be focused and include preferred providers, meaning that health plans and providers have targeted, and sometimes contractual, relationships with specific HSOs to

target specific member needs. Health equity advancement requires an active open and focused network of service providers, to meet the needs of all communities. In addition, members should be empowered and afforded the opportunity to seek services through self-navigation, without being required to have someone else do it for them. It is, therefore, notable that the first challenge identified in the state's Rapid Cycle Assessment Report (dated March 24, 2023) was a quote from a stakeholder saying the "biggest challenge [of the Healthy Opportunities Pilot] so far has been NCCARE360 and helping HSOs learn how to navigate that system." This could be avoided altogether if HSOs (and other users/stakeholders in the Healthy Opportunities Pilot) were able to use the closed loop referral system of choice. Allowing stakeholder/participant choices in closed loop referral systems (particularly because many are already using another platform) may also lead to significantly more social needs screenings and referral closures, both of which appear to be significant needs for NC DHHS based upon the limited data included in both the waiver renewal application and the Rapid Cycle Assessment Report (dated March 24, 2023).

We are excited to see CMS encourage efforts for states to address HRSNs and other services aimed at addressing SDOH, and we recognize and applaud both NC DHHS and CMS for creating a lot of this momentum with the original approval of the NC DHHS waiver in 2018. We also recognize that the addition of these types of services to the Medicaid service array results in a new way of doing business for MCOs, medical providers, and HSOs. Consequently, these historical health care industry participants attempting to build meaningful (and, in some cases, financial) partnerships with a new, non-medical provider base can be a challenge. We urge CMS to carefully consider technology approaches to ensure that we do not add to existing barriers to uptake for these new HSO, non-medical providers, especially given that NC DHHS is requesting a statewide expansion/roll-out of the Healthy Opportunities Pilot.

Through requiring use of a single platform, financially strapped organizations might choose to opt out of the initiative, or will be required to expend already stretched and limited resources to adapt and duplicate existing systems - often done at the expense of serving fewer people.

Protecting Individual Privacy

Incorporating referrals to social care into our healthcare infrastructure relies on the collection, storing, and sharing of some of the most private and personal information. As states across the country expand upon the current infrastructure for facilitating referrals from healthcare providers to HSOs, it will be imperative that privacy is at the center of this conversation, with individuals maintaining control over their personal information.

In some cases, states are defaulting to the same all-in consent model used within the healthcare system, where sharing health information is needed to ensure continuity of care. In the healthcare context, participating entities are governed by HIPAA standards. But within these growing social care referral networks, many participating entities are not governed by HIPAA. Using a one-time all-in consent in this context, to allow a broad network of service providers to access information in a centralized database, compromises the privacy of an individual's most personal information.

We believe that best practices build upon a consumer-directed privacy model, where individuals opt-in to share their information for each referral and network members' access to referral history is permission based. While HIPAA dictates how health information is shared between HIPAA-covered entities, in the social care context, data sharing must be driven by the individual.

States are beginning to develop best practices that should be implemented to ensure that individual data and privacy is protected in scenarios like the one described above. For example, New Hampshire adopted legislation in 2022 requiring a per-referral consent and opt-in on each referral, and any access to an individual's referral history by any individual or entity would have to be permission-based. Similar legislation is being considered by many state legislatures across the country in 2023. We encourage CMS to require NC DHHS to examine this model legislation to inform the privacy approach for the social needs referral and data platform. Best practices include:

- Require a consumer directed consent model, in which individuals are asked to opt-in to share their information for each referral. Ensure social care network members' access to referral history is permission-based.
- Maintain the individual's right to obtain help without conditioning referrals on consent to share personal information.
- Require that individuals seeking help maintain the right to opt-out of sharing their information at any time, and ensure that revoking network access to personal information is simple for the individual.
- Allow HIPAA-covered entities to continue following existing pathways for sharing staff-generated referrals with Health Information Exchanges (HIEs) or other covered entities, pursuant to data sharing or network agreements.
- Establish provisions governing the length of time non-health identifiable information will be maintained in a database.
- Prohibit the sale of personal information without explicit individual consent.

Privacy and confidentiality should be a focus area for CMS in reviewing this waiver renewal request because of the numerous concerns and stakeholder quotes in both the waiver renewal request and the state's Rapid Cycle Assessment Report (dated March 24, 2023) relaying privacy and confidentiality concerns with NCCARE360 (see also *Public Comments submitted to NC DHHS*; page 295 (4th paragraph); accessed December 20, 2023).

Again, we appreciate CMS leadership in this important area as we are at a pivotal moment that will set the course for how states construct coordinated systems of care. We welcome the opportunity for further discussion of the critical policy issues outlined in our comment. We are happy to connect with CMS to discuss any of the above topics. Please feel free to contact Justin Hage at jhage@findhelp.com.

Submitted on behalf of findhelp, a Public Benefit Corporation.