



Foley Hoag DE&I Thought Leadership Series: Summit for Health Equity

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How CMS is Advancing Health Equity and Social Determinants of Health



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Session Overview

- What does CMS mean when it uses the terms “health equity” and “social determinants of health”?
- How has CMS addressed these issues in prior Administrations?
- What CMS is doing now
 - Applying health equity in Medicare
 - CMMI initiatives
 - Applying health equity in Medicaid
 - Guidance to states and providers
 - Section 1115 waivers and other state initiatives
 - Telehealth

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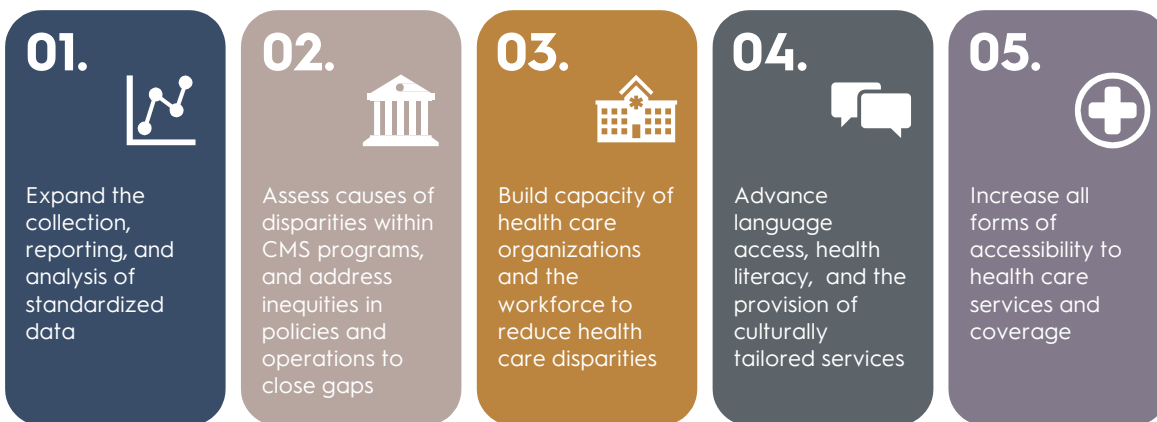
Definitional Terms

- In the Spring of 2022, CMS released its Framework for Health Equity and defined the term “**health equity**” as follows:
 - The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes
- Also important is CMS’s definition of “**social determinants of health**” (SDOH)
 - The conditions in the environments where people are born, live, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks

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CMS Priorities

CMS identified five priorities to support health equity goals:



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SDOH Domains

- CMS has also identified five domains into which SDOH can be grouped:



- Addressing social determinants of health is captured as part of CMS's second health equity priority: assessing causes of disparities and addressing inequities in policies and operations to close gaps
- CMS more recently began referring to SDOH as health-related social needs, or HRSN

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How Have HHS, CMS, and Congress Addressed Health Equity in the Past?



- **1985:** HHS Secretary's Task Force on Black & Minority Health issues the Heckler Report.
- **1986:** As a response to the Heckler Report, Congress creates the Office of Minority Health within HHS.
- **1988:** HHS establishes the CDC Office of Minority Health.
- **2001:** Medicaid managed care final rule is published by the Clinton Administration. Pursuant to the rule, CMS (then called HCFA) requires Medicaid managed care plans to ensure that services are provided in a culturally competent manner to all enrollees.
- **2002:** Bush Administration notes HHS's goal of "eradicating racial and ethnic disparities in health care by the year 2010" in its version of the Medicaid managed care rule.
- **2010:** During the Obama Administration, Congress enacts the Affordable Care Act (ACA), which reauthorizes the Office of Minority Health, establishes the Offices of Minority Health within six HHS agencies, and re-designates the NIH National Center on Minority Health and Health Disparities as the National Institute on Minority Health and Health Disparities.
- **2015:** CMS Office of Minority Health issues "The CMS Equity Plan for Improving Quality in Medicare."
- **2017:** Trump Administration releases an Accountable Care Communities model, which includes a community needs assessment for the social determinants of health.
- **2021:** President Biden issues Executive Order 13985 on "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government."
- **2022:** CMS issues "CMS Framework for Health Equity 2022-2032."

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Enhanced Focus on HRSN and Health Equity at CMS Today



- CMS is laser-focused on addressing health equity in the Medicare and Medicaid programs
 - We can see this in CMMI initiatives, Medicaid waivers, and Medicaid managed care requirements
 - Initiatives might apply to multiple programs (e.g., Medicare and Medicaid) to address enrollees' specific health needs
- Example: CMS Sickle Cell Disease (SCD) Action Plan
 - New codes in CY 2023 Medicare Physician Fee Schedule to improve access to chronic pain management and treatment
 - Cell & Gene Therapy (CGT) Access Model (Medicaid-focused CMMI model) would establish a partnership among CMS, manufacturers, and state Medicaid agencies, to test new outcomes-based agreements (OBAs) to help Medicaid beneficiaries access high-cost specialty drugs
 - Leveraging National Quality Strategy framework to assess quality-of-care issues for patients with SCD in Medicare and Medicaid
 - Roundtables with patients, caregivers, and providers throughout Fall 2023 to address barriers to care
 - Outreach from the Office of Minority Health to help providers furnish quality care for SCD patients

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Medicare Shared Savings Program ACOs

- Medicare Shared Savings Program allows doctors, hospitals, and other providers to form accountable care organizations (ACOs) to collaborate in furnishing high-quality care to Medicare patients while reducing costs.
 - ACOs can participate in the Quality Payment Program (QPP), which includes MIPS and APMs
- **CMS in the CY 2023 Medicare Physician Fee Schedule Final Rule announced that ACOs can earn up to 10 health equity bonus points (added to the ACO's MIPS Quality performance category score)**
 - Applicable to ACOs reporting all-payer eCQMs/MIPS CQMs
 - Based on high quality measure performance and providing care for a higher proportion of underserved or dually eligible beneficiaries (enrolled in Medicare and Medicaid)
- **Policy adds bonus points to ACO's MIPS quality score based on (1) performance for each quality measure, and (2) proportion of the ACO's assigned beneficiary population that meets definition of "underserved"**
 - CMS determines "underserved populations" by assessing the area deprivation index (ADI) score, enrollment in Medicare Part D low-income subsidy (LIS), and Medicare and Medicaid dual eligibility status
- This is one of the first payment policies that **promotes equity in a value-based care program**
 - Adjustment does not "risk adjust away disparities" (thereby hiding them)

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CMMI Models

- CMMI is authorized to test innovative payment and service delivery models to reduce expenditures and maintain or improve care quality
- CMMI expressed its focus to embed health equity in every aspect of their models and increase focus on underserved populations
 - **ACO Realizing Equity, Access, and Community Health (REACH) Model**
 - Redesigned in 2023 to increase focus on health equity
 - Participants must submit a health equity plan based on CMS's disparities impact statement and report demographic and health-related social needs
 - Participants eligible for upward adjustment in the benchmark for ACOs serving higher proportion of underserved beneficiaries
 - **Enhancing Oncology Model (EOM)**
 - Consider a cancer patient's preferences, goals, health-related social needs, and psychosocial needs
 - Additional support for providers treating underserved patients (e.g., low-income, dual eligibles, etc.)
 - **NEW: States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD Model)**
 - Partnership with states to reduce costs, improve population health, and reduce disparities in health outcomes
 - Participating states will develop Statewide Health Equity Plans

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Medicaid

- In January of 2021, CMS issued a State Health Officials letter describing opportunities for state Medicaid plans to address social determinants of health
- The guidance makes clear that states can use existing flexibilities in Medicaid to design benefits addressing access to healthy food, safe housing, and others, in a way that addresses SDOH, and obtain FMAP for those expenditures
 - Done via SPA, waivers, managed care flexibility, integrated care models
- Examples might include use of Medicaid funds for:
 - Nutritional counseling
 - Non-emergency medical transportation
 - Home accessibility modifications (mold amelioration; air conditioning; adapting a home for individuals with disabilities)
 - Reimbursement to RHCs for screening individuals to identify social needs

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Medicaid 1115 Waivers

- Section 1115 allows states to carry out demonstration projects that further the goals of the Medicaid program
- CMS originally approved four 1115 waivers addressing HRSN - now there are nineteen approved waivers
- The 1115 waivers address health related needs, such as:
 - Access to healthy foods and nutrition counseling
 - Housing supports
 - Behavioral health supports
 - Employment counseling
 - Community supports

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Massachusetts 1115 Waivers

- In Massachusetts, CMS approved a waiver allowing Medicaid funding (and FMAP) for housing supports, case management, nutrition support, and transportation
- The waiver incentivizes hospitals in the state to develop and adopt community initiatives intended to reduce health disparities
- The waiver has a focus on the justice-involved population, individuals with disabilities, and pregnant and postpartum individuals
- The waiver authorizes funding for safety net providers and continues coverage expansion for individuals with incomes up to 300% of the FPL
 - Totally and permanently disabled children, in addition to non-disabled children from birth through age 18
 - Less than one year of age: 200.1% through 300% FPL
 - Ages 1-18: 150.1% through 300% FPL



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Oregon 1115 Waivers

- In Oregon, CMS approved a waiver allowing Medicaid funding (and FMAP) for health-related social needs
- Services to be included in the Oregon waiver are:
 - Housing supports: Rental assistance, medically necessary home modifications, pre-tenancy and tenancy sustaining services, among others
 - Food assistance: Medically tailored meal delivery, fruit and vegetable prescriptions, cooking and nutrition education, among others
- Oregon aims to support **individuals experiencing life transitions**, including, but not limited to, youth with special needs, youth involved in the child-welfare system (including those transitioning out), people experiencing homelessness or who are at-risk of homelessness, dual eligibles, and people being released from incarceration



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Arkansas 1115 Waivers

- In Arkansas, CMS approved a waiver (Arkansas Health and Opportunity for Me, or ARHOME) providing funding for housing and nutrition support
 - ARHOME uses Medicaid dollars to purchase private health insurance for enrollees
 - Focus is improving health overall (beyond health care coverage alone)
- ARHOME also includes Life360 HOMEs to provide supports to specific enrollees:
 - Maternal Life360: Support high-risk pregnant women and new moms and babies
 - Rural Life360: Supports enrollees with mental illness or substance-abuse disorders living in rural communities
 - Success Life360: Supports young adults at risk of long-term poverty and poor health outcomes
- Life360 programs seek to improve health coverage and provide housing, nutrition, and general case management support



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Legal Considerations and Pitfalls

- Does section 1115 provide CMS the authority to approve federal funding for various types of HRSN?
- Can CMS address HRSNs outside of the 1115 waiver process such as through a state plan amendment process?
 - Absent a waiver, Medicaid benefits must be uniform and available on a statewide basis
- HHS Office of Civil Rights insisted on including language in the Massachusetts waiver that seems to undercut HHS health equity goals
 - The language prohibits the state and hospitals from targeting Medicaid enrollees based on race, ethnicity, or national origin
 - Hospitals may only rely on health status, health needs, geography, gender/sex as necessary to design an intervention relevant to the specific measure

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Telehealth

- The COVID-19 pandemic brought to light many inequities in the health care system
- Social distancing and other mitigation measures made it difficult for individuals to access services in person
 - Barriers to in-person care have long existed for many
 - E.g., transportation, caregiver responsibilities, inability to take time off work
- Coverage and access to telehealth services expanded during the pandemic
- Expansion of telehealth services likely to remain in some form moving forward

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Telehealth

- CMS used waiver authority under the PHE to make major expansions of telehealth in the Medicare program
 - Removing geographic restrictions, type of service restrictions, requirements on site of service, availability of audio-only services
 - In the CAA of 2023, Congress extended through December 31, 2024 most of these Medicare-related telehealth flexibilities
- States have discretion for covering telehealth services in Medicaid and CHIP
 - All states expanded coverage and access to telehealth services during the pandemic
 - Many states have made COVID-era telehealth policies permanent

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Thank You!



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Encouraging Health Equity and Diversity in FDA-Regulated Clinical Trials



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- > **Literacy & Health Equity, Polling Questions**
- > Increasing Diversity in Clinical Trials
- > Clinical Trials: The Roots of Health Equity in Ad Promo
- > Diverse Representation in Pharma & Biotech

Poll Question 1



What percentage of the U.S. population has proficient literacy?

A. 22%

B. 12%

C. 33%

D. 5%

Answer

- Only **12%** of the United States population has proficiency in literacy, scoring in the level 4 and 5 range.
- Around one in six, or about 43 million, U.S adults scored below Level 2.

Poll Question 2

What is Health Literacy?

- A. Reading, writing, and numeracy skills necessary to make everyday health decisions**
- B. The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions**
- C. A constellation of skills, including the ability to perform basic reading and numerical tasks required to function in the health care environment**
- D. All of the above**

Answer

- **All of the above!**
- Healthy People 2030 describes health literacy in two ways, personal health literacy and organizational health literacy
 - **Personal health literacy** is the degree to which individuals have the ability to find, understand, and use information and services to inform health related decisions and actions for themselves
 - **Organizational health literacy** is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decision and actions for themselves and others

Poll Question 3

What percentage of the U.S. population has proficient health literacy?

A. 22%

B. 30%

C. 12%

D. 53%

Answer

- Only **12%** of the United States population has proficient health literacy skills
- 53% have intermediate health literacy, 22% have basic, and 14% have below basic
- Low health literacy is more prevalent among older adults, minority populations, low socioeconomic status, and medically underserved populations

Poll Question 4

What is Health Equity?

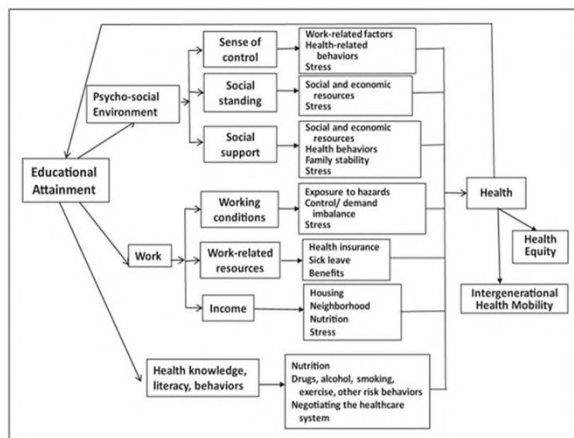
- A. Every person having the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances**
- B. Reducing and ultimately eliminating disparities in health and in the determinants of health that adversely affect excluded or marginalized groups**
- C. When everyone can attain their full potential for health and wellbeing. This is determined by the conditions in which people are born, grow, live, work, play, and age as well as biological and structural determinants**
- D. All of the above**

Answer

- **All of the above!**
- Healthy People 2030 defines **health equity** as the attainment of the highest level of health for all people. Requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities
- Health Equity focuses on targeting the **Social Determinants of Health** one of which is **Education and Literacy**

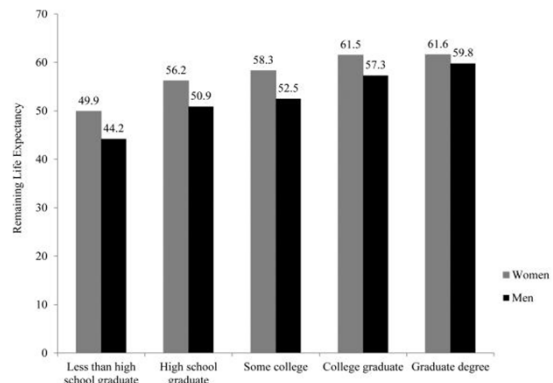
Literacy and Education's Intersection with Health Equity

- Poor education influences health outcomes in a variety of ways
- Poor health also influences education as it can lead to absenteeism or poor concentration
- Health literacy varies significantly by race as only **9% of White and Multiracial Americans and 13% of Asian/Pacific Islander Americans** had below basic health literacy rates but **24% of Black, 25% of American Indian/ Alaskan Native, and 41% of Hispanic Americans** had below basic health literacy rates



Education and Life Expectancy

- Education correlates to higher life expectancy
- Not all education is provided equally because funding is connected to property taxes
- Lower income communities as a result have fewer financial resources, which leads to less access to quality services and schooling



Source: Brian L. Rostron et al., "Education Reporting and Classification on Death Certificates in the United States," *Vital and Health Statistics, Series 2*, no. 151 (2010): 1-16.

HHS and Healthy People 2030

- Healthy People 2030 is working to address health equity and health literacy by improving access to culturally and linguistically appropriate health information and services, improving communication and informed decision making in the health care system, and promoting accurate, standards-based, and developmentally appropriate health and science information and curricula in childcare and education
- These objectives are being met by using evidence-based interventions and multisector collaborations
- **HHS Action Plan to Improve Health Literacy**
 - Promote changes in the health care system that improve health information, communication, informed decision-making, and access to health services
 - Support and expand local efforts to provide adult education, English language instruction, and culturally and linguistically appropriate health information services in the community
 - Increase basic research and the development, implementation, and evaluation of practices and interventions to improve health literacy

Agency Actions

■ **Centers for Medicare and Medicaid Services (CMS)**

- Focusing on making materials that are in multiple languages and at the appropriate literacy levels
- Providing navigators and certified application counselors to help consumers with health plan enrollment
- Ensuring members of underserved communities are able to understand their rights and access protections relate to surprise billing and unexpected health care cost

■ **FDA Office of Minority Health and Health Equity**

- Focusing on diversity in clinical trials
- Partnering with external stakeholders to strengthen community relationship
- Providing easy to read, culturally competent, and multilingual information

- > Literacy & Health Equity, Polling Questions
- > **Increasing Diversity in Clinical Trials**
- > Clinical Trials: The Roots of Health Equity in Ad Promo
- > Diverse Representation in Pharma & Biotech

Clinical Trial Diversity

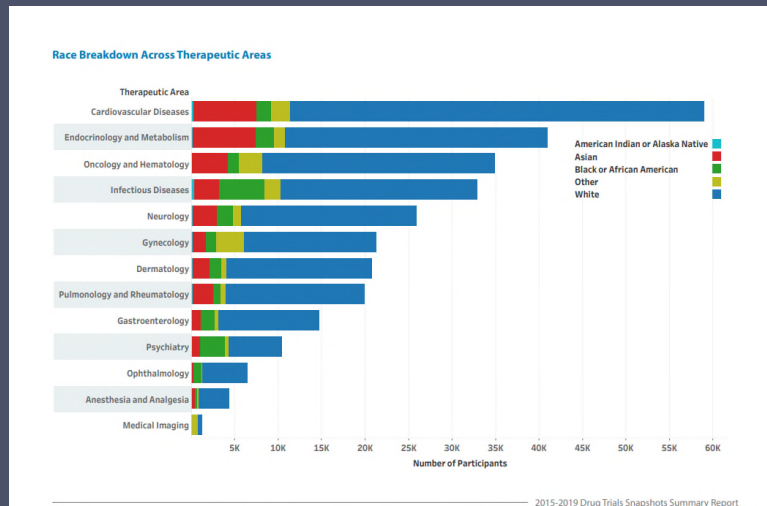
■ FDA Drug Trials Snapshots Summary 2022

- 37 Novel drugs approved
- Over 27,000 study subjects participated in pivotal trials
- Whites comprised the majority of patients enrolled in most of the pivotal trials, followed by Asians and Blacks
- Representation of Native American or Alaska Native and Native Hawaiian or Pacific Islander remains low

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FDA 2015-2019 Drug Trials Snapshot



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Clinical Trial Diversity



Why Should We Care?

- To reflect the racial and ethnic diversity of the intended use population of a medical product and identify safety or efficacy outcomes that may be associated with, or occurring more frequently, within these populations

Barriers to Achieving Diversity in Clinical Trials

- Mistrust in clinical trials and the medical system
- Lack of awareness and implicit bias
- Language, educational, cultural, and economic barriers
- Inadequate recruitment and retention efforts

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Clinical Trial Diversity

- Sex, pregnancy status, age, racial and ethnic characteristics can affect how an individual will respond to an investigational drug or therapy
- Approx. 1/5 of FDA drug approvals between 2008-2013 demonstrated some differences in exposure and/or response across racial/ethnic groups
- Lack of equal representation may contribute to persistent health disparities and compromises generalizability of clinical research findings to the U.S. population

Examples:

- Depression treatment: men appear to be more likely to respond to tricyclic antidepressants and women to selective serotonin reuptake inhibitors
- Blood clots: Populations with greater genetic African ancestry are more likely to require higher average daily doses of warfarin, whereas populations with greater genetic Asian ancestry require lower average warfarin doses

- Source: National Academies of Sciences, Improving Representation in Clinical Trials and Research (2022)

Mistrust of Clinical Trials

Historical mistreatment

- Tuskegee Study
- Mississippi appendectomy

COVID-19 studies highlighted lack of diversity

What other opportunities exist that may have direct benefits to disparate patient groups?

Clinical Trial Diversity

Efforts to Increase Diversity

- Enhanced data collection and reporting on population subgroups
- New requirement for sponsors to provide diversity plans
- Increased flexibility in clinical trial designs and use of technology
- Collaborations with community-based organizations
- Culturally and linguistically tailored educational materials and outreach
- Logistical and financial support for trial participation

Clinical Trial Diversity

Clinical Trial Diversity Plans

- Important part of development program and should be submitted as early as practicable during development
- Enrollment goals for underrepresented racial and ethnic participants
- Description of planned assessment and efforts to explore the potential for differences in safety and/or effectiveness associated with subgroup's throughout the product's lifecycle
- Metrics to ensure enrollment goals are achieved and corrective actions
- Operational measures to ensure diverse participation

Decentralized Clinical Trials

- Some or all activities occur outside of traditional clinical trial site
- Often incorporate digital health technologies (DHTs)
- Services such as home nursing or mobile blood draw can be used to collect some data
- Remote visits may be possible for some checkpoints
- May reduce economic, time, and physical burdens associated with traveling to clinical trial site

Clinical Trial Diversity



Partnering For Success

- What level of collaboration is ongoing/necessary between industry and FDA to enable the greatest impact for patients?

Impact on Access to Approved Medical Products

- How are the developments in Clinical Trial Diversity and industry/government partnerships having a positive impact on equitable access to approved medical products?
- What other opportunities exist that may have direct benefits to disparate patient groups?

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- > Literacy & Health Equity, Polling Questions
- > Increasing Diversity in Clinical Trials
- > **Clinical Trials: The Roots of Health Equity in Ad Promo**
- > Diverse Representation in Pharma & Biotech

Clinical Trials: The Roots of Health Equity in Ad Promo

- FDA requires that an Institutional Review Board (IRB) review and have authority to approve, require modifications in, or disapprove all research activities covered by the IRB regulations
- Part of the IRB's responsibilities is to review the methods and material that investigators propose to use to recruit subjects
- FDA considers direct advertising for study subjects to be the start of the informed consent and subject selection process
- IRBs to review the advertising to assure that it is not unduly coercive and does not promise a certainty of cure beyond what is outlined in the consent and the protocol
- Recruitment advertisements should be limited to the information the prospective subjects need to determine their eligibility and interest



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Diversity and Inclusion Makes a Difference

Cross-Functional Team Structure

Is there internal industry diversity in marketing teams to create awareness of diverse representation in advertisements?

What can be the impact of non-diverse marketing teams on health equity?

Need to Have vs. Nice to Have?

Facilitate education through disease awareness campaigns/state, product advertising



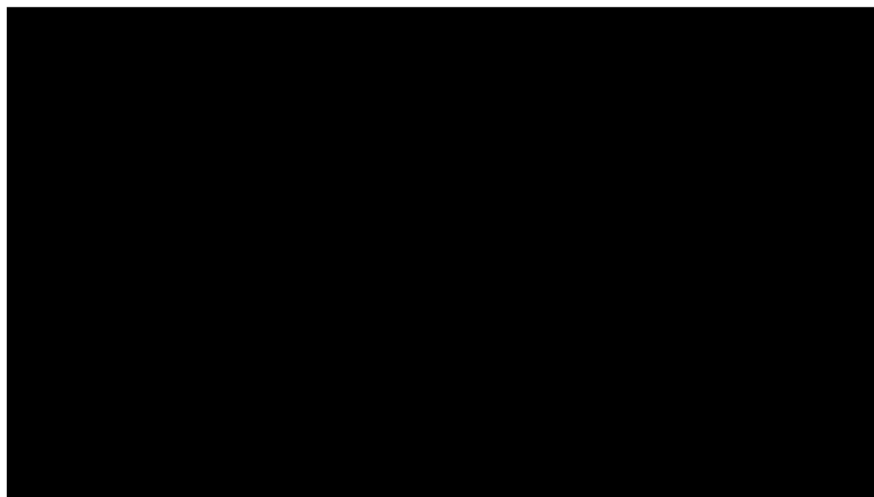
Product labeling and access to information in additional languages (that correlates with the promotional material for the product)

Could it be considered by the FDA as false/misleading for an industry to produce a product targeted for a specific population, but then fail to include that population in product advertising?

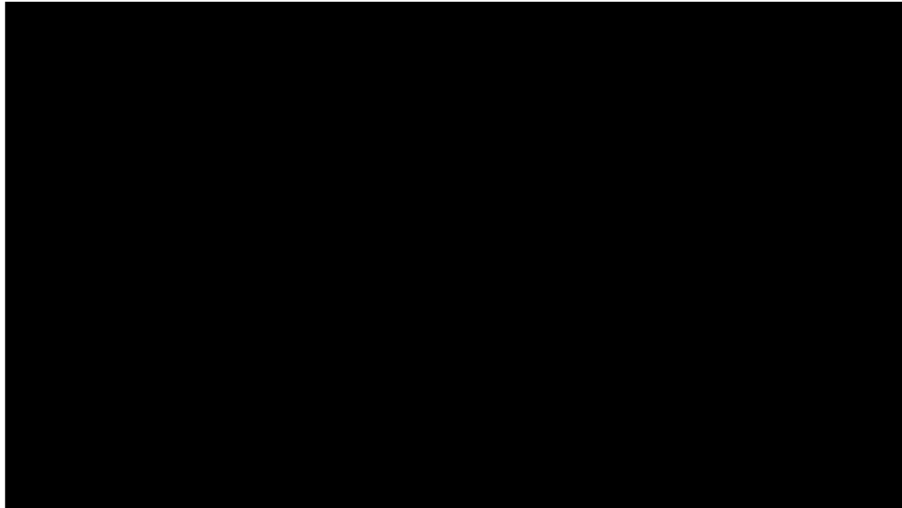
Bridging the Gap

- Disease Awareness and Help Seeking Materials
- Collaboration with key organizations within disadvantaged and/or underrepresented communities
- Diverse representation within promotional materials
- The role of market research

Example 1



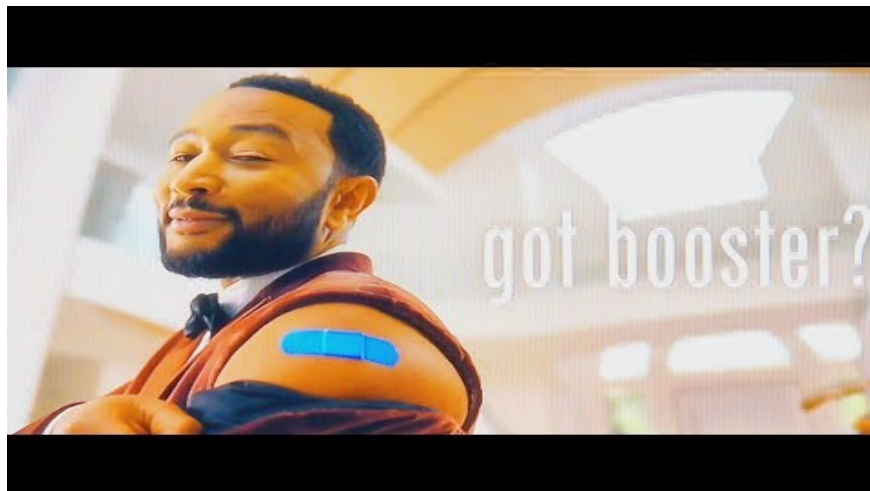
Example 2



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Example 3



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The Experience of Disability Discrimination in Accessing Healthcare



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Caring Across Generations



How Far We've Come

- A safe place for people to go during the day
- A place for people to go to learn daily living skills
- A place for people to go to prepare for work
- A place for people to go to work with others who have disabilities
- Support for people to work in the community
- Support for people with disabilities to choose and prosper in community jobs

Historical Perspective

- People with Disabilities forced into dependency
- Others speak for them, label them, and while often with the best intentions – generally don't view individuals with disabilities as deserving direct participation

A New Vision

- Self Advocacy and Individual Empowerment through inclusion in the political process
- Independent Living, Equal Rights and Access to ensure full citizenship and progressive participation in every facet of society

Disability Rights Movement

- Struggle to gain full citizenship
- Demand for equality, independence, autonomy, access to public life
- Integration vs. "separate but equal"
- Olmstead Supreme Court Decision

Vocational Policy

- **1954—The Vocational Rehabilitation Act** is revised, establishing a system of state vocational rehabilitation agencies
- **1956—The Social Security Amendments of 1956** creates the Social Security Disability Insurance (SSDI) program for disabled workers aged 50 to 64

Healthcare Policy

1965—The Social Security Act of 1965 establishes the Medicare and Medicaid programs under Titles XVIII and Title XIX. The initial purpose of Title XIX was to improve access to and the quality of medical care for all low-income people and did not provide services solely based on disability. States were required to provide certain services to individuals who were categorically needy; states could offer optional services and choose to cover individuals who were medically needy.

Policy That Followed the Disability Rights Movement

- **1970:** Urban Mass Transit Act: requires that all new mass transit vehicles be equipped with wheelchair lifts
- **1975:** Developmental Disabilities Bill of Rights Act: among other things, establishes Protection and Advocacy (P & A)
- **1975:** Education of All Handicapped Children Act (PL 94-142): requires free, appropriate public education in the least restrictive environment possible for children with disabilities - this law is now called the Individuals with Disabilities Education Act (IDEA)
- **1978:** Amendments to the Rehabilitation Act: provides for consumer-controlled centers for independent living

Americans with Disabilities Act

- The Americans with Disabilities Act of 1990 (ADA) is the most significant civil rights legislation to be enacted by Congress since the Civil Rights Act of 1964
- The ADA makes it illegal to discriminate against anyone who has a mental or physical disability in the area of employment, public services, transportation, public accommodations and telecommunications

Growth of Home and Community Based Services

- 1980s - Medicaid program amended to allow waivers to states to provide Home and Community based services as an alternative to facility-based services (nursing homes and ICFs/IDD)
- Recent expansions of Medicaid HCBS

Employment Services for Disabled Employees

- Job search skills training
- Job training
- Job placement
- Job coaching and employment supports
- Alternatives to employment
 - Day Habilitation Services
 - Volunteerism and internships as work preparation

Advances in Employment

- **45+ states have some type of “Employment First” movement**
- About **2/3** of efforts are directed by state policy units or are legislatively based
- About **1/3** of efforts are grassroots based –i.e., outsiders working to influence state policy and practice
- At least **30** states have official Employment First legislation and/or policies

Employment First

- Employment in the community is the first/primary service option for individuals with disabilities
 - Where the assigned work tasks offer at least minimum or prevailing wages and benefits,
 - Where typical opportunities exist for integration and interactions with co-workers without disabilities, with customers, and/or the general public,
 - And being the first and preferred outcome for working-age youth and adults with disabilities, including those with complex and significant disabilities, for who working in the past has been limited, or has not traditionally occurred.

The Workforce Innovation and Opportunity Act (WIOA)

WIOA

The Workforce Innovation and Opportunity Act (WIOA) of 2014 (P.L. 113-128) reauthorizes and updates existing federal workforce development programs including the Rehabilitation Act, which provides for vocational rehabilitation (VR) services for people with disabilities. WIOA focuses VR outcomes on competitive, integrated employment as well as promotes greater emphasis on transition services for youth with disabilities through: emphasis on coordination between VR and other agencies; extending the initial time period for VR supported employment services (from 18 to 24 months); and modification of eligibility determination to promote access to VR by people with the most significant disabilities.

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State Plans

- Interagency coordination
- The department of education, the DD agency and VR must work together.
- **July 22, 2016:** deadline for provisions related to subminimum wage for people with I/DD.

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The Workforce Innovation and Opportunity Act (WIOA)

- Goal is to increase employment of people with disabilities in integrated employment settings; attempts to significantly limit the use of 14(c), particularly for transition-age youth:
 - Defines and prioritizes integrated employment as work at or above minimum wage, with wages and benefits comparable to people without disabilities and fully integrated with co-workers without disabilities
 - Limits entry into sheltered workshops: Anyone under 24 must try integrated employment before being placed in a sub-minimum wage setting; schools cannot contract with sub-minimum wage providers

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NIMHD Decision

- Major reversal
- The designation of people with disabilities as a health disparity population, is a landmark event –following years of advocacy
- A population can receive this designation “if there are significant disparity in the overall rate of disease, prevalence, morbidity, mortality or survival rates in the population, compared to the health status of the general population”; the Director of NIMHD makes the designation
- In 2021, NCD outlined overwhelming evidence that people with disabilities face “significant disparities”—which reflects the views of the disability community, across the lifespan continuum
- Although recommendations were given to the NIMH to include people with disabilities as a disparity populations, those recommendations were not accepted until October of 2023 – 33 years after the signing the ADA in 1990

Importance of the “A” in DEIA

- Accessible and inclusive workplaces are better for all
- Consider in recruitment, interviewing and onboarding.
- The value of disabled employees to a workforce is for more than a bottom line
- Look at policy and procedures
- Consider natural supports

Thank you!



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Health Access Options for Non-Citizens



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- > Eligibility for non-citizens (the PRWORA framework)
- > Lawfully residing option for Medicaid/CHIP
- > Eligibility for Medicaid/CHIP/Marketplace and QHPs
 - > The special case of DACA recipients
- > The public charge rule
- > Application process
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- > Access to coverage for PRUCOL
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Eligibility for non-citizens in Medicaid and CHIP under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)



- Since the enactment of PRWORA in 1996, the following individuals may be eligible for Medicaid and CHIP
 - Qualified non-citizens who entered the United States before August, 1996
 - Qualified immigrants (i.e., lawful permanent residents/green card holders) who have satisfied the “5-year bar”
 - Some states impose coverage restrictions beyond five years
 - Qualified immigrants who are exempt from the 5-year bar
- No federal funding is available for individuals without documentation other than for emergency services, but individual states do provide broader coverage options
 - “Emergency” is defined as a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in placing the patient’s health in serious jeopardy or impairment or dysfunction of bodily organs or parts

Who is a “qualified non-citizen”?

- The following individuals are “qualified non-citizens”:
 - Lawful permanent residents (green card holders)
 - Asylees and refugees
 - But not asylum applicants; although some states provide Medicaid or other limited coverage for asylum applicants
 - Cuban/Haitian entrants
 - Individuals who have been paroled into the United States for more than one year
 - Battered non-citizen spouses and children
 - Victims of trafficking
 - Veterans and active military, their spouses, and children
- LPRs who entered the US before August of 1996 and all others on the list above are exempt from the 5-year bar.

The “CHIPRA Option”

- Under the Childrens Health Insurance Plan Reauthorization Act (signed into law in January 2009), states may (at their option) provide Medicaid coverage (with federal matching) for children and/or pregnant women who are:
 - Lawfully present
 - Otherwise eligible for Medicaid (e.g., meet income and resource limits)
- No five-year bar for these individuals in states that have adopted the CHIPRA option, regardless of date of entry to the US
- As of November 2022, 35 states have adopted the CHIPRA option (at least for children)

“Lawful Presence” in the United States

- Access to QHP on an Exchange depends on lawful presence
- The following individuals are considered “lawfully present”:
 - Qualified non-citizens (regardless of five-year waiting period)
 - Humanitarian status (TPS, SIJS, asylum applicants with employment authorization, Convention Against Torture)
 - Valid non-immigrant visa holder
 - Lawfully present in American Samoa and Northern Mariana Islands
- Generally, access to a QHP is available only for individuals with income between 133-400% FPL, but immigrants with income below that threshold who are ineligible for Medicaid because of immigration status can also qualify for a QHP on an Exchange.

“Lawful Presence” (cont.)

- Notably, DACA recipients are not currently considered “lawfully present” and therefore do not qualify for Medicaid, CHIP or Exchange coverage
- On April 26, 2023, CMS proposed a rule re-defining “lawful presence”, the effect of which would be to treat DACA recipients as “lawfully present” and therefore eligible for coverage for a QHP on an Exchange
 - This rule has not yet been finalized; goal had been to finalize before open enrollment begins

Public Charge

- Access to Medicaid, CHIP, Medicare Part D low-income subsidy, and QHP/Exchange coverage does not make a green card or visa applicant a public charge and therefore ineligible to adjust status
 - Exception: receipt of long-term care paid for by Medicaid
- The public charge rule finalized in 2019 was formally repealed on December 23, 2022. Adjustment of status applications postmarked on or after that date will be adjudicated under the new rules

Application Process

- States may only require information of an applicant that is necessary to make an eligibility determination
 - States may ask non-applicants only for enough information to determine eligibility for an applicant (e.g., income, relationship)
- States should not ask citizenship/immigration status of non-applicants for any reason
- States may ask non-applicants for Social Security number only to determine eligibility of an applicant

Access to Medicaid for PRUCOL

- PRUCOL = Permanently Residing Under Color Of Law
- In a limited number of states, undocumented individuals who are PRUCOL can nevertheless qualify for full Medicaid benefits

Eligibility Options for Non-Citizens

Program	Summary of Eligibility Rules
Medicaid/CHIP	▪ Qualified non-citizens ▪ Five-year waiting period applies for some subcategories of non-citizens who entered the United States after August 1996 (some states may impose more restrictive requirements) ▪ States have option to cover lawfully residing pregnant women and children without the five-year bar (35 states have adopted) ▪ PRUCOL qualify in some states
Exchange/QHP	▪ Must be lawfully present to purchase QHP on an Exchange (DACA recipients considered not lawfully present, but regulation in process may alter this policy) ▪ Under 133% FPL may be eligible for subsidies to purchase QHP on an exchange if lawfully present and if immigration status precludes Medicaid coverage ▪ Asylum applicants can qualify if granted employment authorization

Massachusetts Case Study



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About Health Law Advocates (HLA)

- Non-profit, public interest law firm
- Pro bono legal services for Mass. residents (< 300% FPL)
- Legal issues we address:
 - Overcoming barriers to care and coverage
 - Appeals of insurance denials (public and private coverage)
 - Eligibility for public health care benefits
 - Medical debt, including bills in collections
 - Access to services through schools and state agencies for young people facing mental health challenges

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Access to Care and Coverage Practice at HLA

- Public Health Care Programs Advocacy
 - MassHealth, the Health Safety Net, eligibility for Connector Care
- Private Health Insurance Advocacy
- Immigrant Health Initiative
 - Includes our Medical-Legal Partnership for Immigrants (MLPI)
- Mental Health Parity
- Medical Debt Initiative
- Access to health care for people with disabilities
- Gender-Diverse Health Access Project

Mental Health Advocacy Program for Kids

- Legal representation regarding:
 - Special education eligibility, services and placements, Individual Education Plans (IEPs)
 - School discipline hearings
 - Manifestation determination reviews
 - Eligibility for Department of Mental Health (DMH) and Department of Developmental Services (DDS), and appealing denials
 - Discharge planning from inpatient stays and Community Based Acute Treatment (CBAT)
 - Step-down programs
 - School planning
 - Community- and home-based services

MHAP for Kids improves the health and increases the educational success of children with unmet mental health needs.

**Mental Health
Advocacy Program
for Kids**

MHAP for Kids

HLA's Immigrant Health Initiative

- **Free legal services** for immigrant clients with low incomes, regardless of status
- **Trainings** about immigrants' access to coverage under Massachusetts public programs
- **Policy advocacy** to address systemic barriers
- **Medical-Legal Partnership for Immigrants** in collaboration with hospital and health center partners to help immigrant patients access care and coverage

**Many immigrants are in the wrong
health coverage in Massachusetts!**

Immigration Status + Immigration Law

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Immigration Category + Public Benefits Law

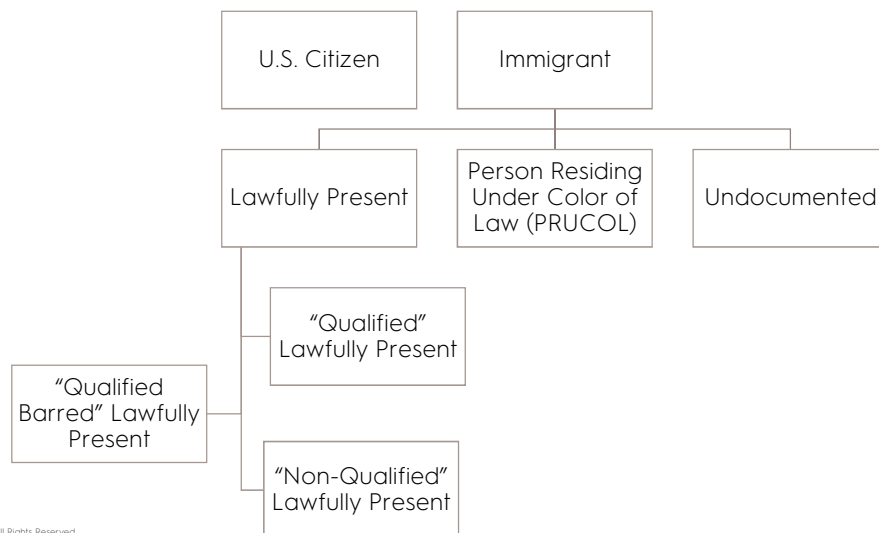
Health Coverage for Immigrants in Mass. Overview

- Type/quality of coverage depends on immigration status
- However, Mass. residents with low incomes *almost always* are eligible for some coverage, even without documents

Immigration Categories for Public Health Insurance Benefits

- Citizen (naturalized)
- Lawfully Present
 - "Qualified" Lawfully Present
 - "Qualified **Barred**" Lawfully Present
 - "Non-Qualified" Lawfully Present
- **PRUCOL** ("Person Residing Under Color of Law")
- Undocumented

MassHealth Immigration Eligibility Categories



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Lawfully Present: Examples

"Qualified Noncitizen"

Lawful permanent residents (LPRs) with a green card for *5 or more years*; Refugees/Asylees, Cuban-Haitian Entrants, certain trafficking victims, etc.

"Qualified Noncitizens Barred"

LPRs with green cards, parolees, and certain survivors of domestic violence who have had the status for *fewer than 5 years*

"Nonqualified Individuals Lawfully Present"

Non-immigrant visa holders, employment authorization but no "qualified" status, Temporary protected status (TPS), medical deferred action, etc.

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In Massachusetts, PRUCOL Includes:

- **Pending application** for immigration status
- Granted Deferred Action for Childhood Arrivals (“**DACA**”) or have a pending application
- Indefinite stay of deportation or indefinite voluntary departure
- Entered and continuously lived in U.S. since before January 1, 1972;
- *Living in U.S. with “knowledge and consent” of DHS + DHS “does not contemplate enforcing” departure*
- And more!

PRUCOL: A Philosophical Question

- Are individuals PRUCOL if:
 - They’re in *deportation* proceedings
 - Don’t have a “status,” and
 - Don’t have a pending application for status?
- MAYBE!
 - HLA memo to MassHealth re: I-220As “release on recognizance”

Immigrant Health Coverage Overview in Mass.

■ Lawfully Present (Qualified) – same elig. as citizens!

- Infants to elderly, <133%FPL: *MassHealth Standard* (up to 150% FPL for ages 0-20)

■ Lawfully Present (Nonqualified and barred)

- Adults, 134-300%FPL: *Connector Care* (Qualified, too)
- Adults, <133%FPL: *Connector Care + MH Limited*
- Youth ages 1-20, 0-150%FPL: *MassHealth Standard*
- Youth ages 0-18, 150-300%FPL: *MassHealth Family Assistance*
- Infants to elderly, 301-400%+FPL: *federal APTCs*

■ PRUCOL

- Infants to elderly, 0-300%FPL: *MassHealth Family Assistance*

■ Undocumented

- Adults, <133%FPL: *MassHealth Limited + Health Safety Net*
- Youth ages 0-18, <133%FPL: *MH Limited, HSN, CMSP*

Immigration Category + MassHealth Coverage

“Qualified Noncitizen”

- Same eligibility rules as U.S. citizens

“Qualified Noncitizens Barred”

- Adult under 65, ≤ 300% FPL: **ConnectorCare**
- Adult over 65, ≤ 100% FPL: **MH Family Assistance**
- Disabled adult under 65, ≤ 100% FPL: **MH Family Assistance**
- Kid/YA, ≤ 150% FPL: **MH Standard**

“Nonqualified Individuals Lawfully Present”

- Kids/Adults, ≤ 300% FPL: **MH Family Assistance**
- Disabled kids 18 or younger, any income: **CommonHealth**
- Disabled 19 to 20 yrs old, ≤ 150% FPL: **CommonHealth**

New Arrivals in Massachusetts

- Many new arrivals can get comprehensive health benefits
 - Afghans
 - Haitian Entrants
 - Ukrainians
- More difficult for people from Central or South America
 - Still possible depending on paperwork

Afghan and Haitian Arrivals: A Tale of Two Policy Approaches

- Many Afghans and Haitians have been entering Mass. (and the US) since late 2021.
- Government response to *Afghan* arrivals has more welcoming and accommodating than for *Haitian* arrivals.
 - Afghan Supp. Appropriations Act (9/2021) entitled Afghan parolees same benefits as refugees
 - MassHealth updated application systems for Afghan arrivals
 - **Haitian arrivals:** No federal legislation, No MassHealth changes, millions less in state \$\$ for Haitians than for Afghans

Thank You!



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