NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

Dear Trump Administration appointees and staff,

On behalf of the National Alliance to Impact the Social Determinants of Health (NASDOH) we write to provide six actionable recommendations on steps the Trump Administration can take to support the health and wellbeing of individuals across the country. NASDOH shares with your Administration the goal of reducing chronic diseases and improving the health of Americans by addressing the underlying causes of poor health. In fact, NASDOH started with the belief that the ability of individuals and families to lead healthy and productive lives is influenced by a multitude of factors. Beyond the more commonly recognized factors such as insurance coverage and access to medical care are the non-medical drivers, including access to healthier foods, reliable transportation, educational attainment, exercise, eating habits, and tobacco use.[1] We offer a set of policy recommendations below that build on the progress made during your first Administration.

About NASDOH

Founded in 2018 by Governor Mike Leavitt and Dr. Karen DeSalvo, NASDOH is a multi-sector coalition of stakeholders seeking to make a material improvement in the health of individuals and communities by advancing the adoption of effective policies and programs to address health-related social needs (HRSNs) – such as food insecurity, housing instability, and transportation insecurity -- as well as the underlying social and economic conditions in which people live (non-medical drivers). NASDOH brings together stakeholders from different geographic regions with expertise in health care, public health, social services, patient and consumer perspectives, information technology, and business to share learnings, develop policy recommendations, and build consensus on solutions to support health. Our website lists all of NASDOH members.

[1] DeSalvo, K. B., & Leavitt, M. O. (2019, July 8). For An Option To Address Social Determinants Of Health, Look To Medicaid. Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20190701.764626/full/.

Summary of Recommendations:

(1) Address food and nutrition security as a critical component of improving the health and wellbeing of all Americans by:
    a. Expanding access to Medicare coverage of nutrition and obesity counseling and medically tailored meals.
    b. Expanding the Centers for Disease Control and Prevention (CDC)'s State Physical Activity and Nutrition Program, which implements evidence-based nutrition and physical activity strategies to reduce chronic disease.
(2) Support expanding supplemental benefits by encouraging Medicare Advantage (MA) plans to propose innovations that improve the health and wellbeing of Medicare beneficiaries.
(3) Support flexibilities and waivers that allow states to provide non-medical services, building on existing medical services and supports, that improve health outcomes of Americans enrolled in Medicaid.
(4) Support research on improving health and health outcomes.
(5) Develop a new value-based care payment model that focuses on addressing the health and wellness of rural populations including through addressing non-medical drivers of health.
(6) Remove barriers to braiding, blending, and pooling funding to support the ability of states and communities to address whole person health more efficiently and effectively.

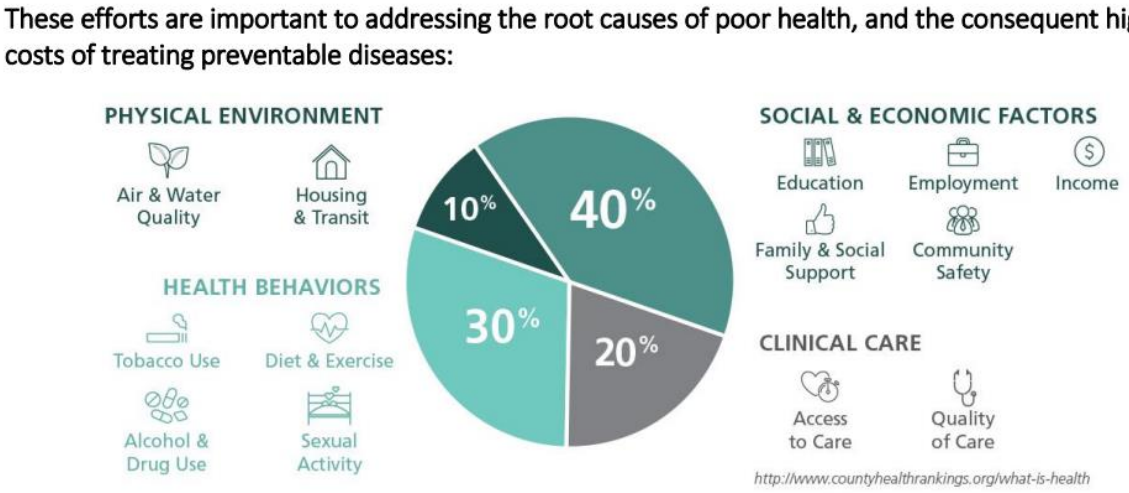
Background

Health begins long before illness or injury strikes—in our homes, schools, neighborhoods, and places of work. The ability of individuals and families to lead healthy and productive lives is influenced by personal choices, as well as our experiences and the choices available to individuals, such as the conditions in the communities where we live. Additionally, health and wellbeing are foundational to economic vitality and business competitiveness, personal achievement, and prosperity. An increased level of health for all Americans is key to the promotion of thriving lives, economies, and communities.

America is a world leader in health care and medical research. Yet, while spending approximately $3.0 trillion per year on health care—2.5 times the average of our industrialized peers—Americans have shorter lifespans and fare worse in many health indicators, including obesity and diabetes, infant mortality, and life expectancy.[2] Instead of a singular view of health as an output of health care and medicine, health is understood to be a combination of the impact of social and environmental

[2] Squires, D. "U.S. Health Care from a Global Perspective." The Commonwealth Fund, 8 October 2015. Available at https://www.commonwealthfund.org/ publications/issue-briefs/2015/oct/us-health-care-global-perspective.

conditions and personal choices, which can be influenced and improved through a combination of high-value medical care, illness prevention efforts, and social services.



Significant Policy Developments

NASDOH applauds the significant progress that was made during the first Trump Administration to address the underlying drivers of health, including the approval of North Carolina's Medicaid 1115 waiver, flexibilities provided to Medicare Advantage plans to cover HRSNs, and innovative models supported by the Centers for Medicare and Medicaid (CMS) Innovation Center. Specifically:

- Beginning in 2017, CMS allowed Medicare Advantage (MA) plans participating in the Innovation Center Value-Based Insurance Design (VBID) model to target benefits for enrollees, such as grocery assistance and transportation services, based on chronic conditions or socioeconomic characteristics.
- In 2017, the Innovation Center announced the Accountable Health Communities (AHC) Model to test whether connecting beneficiaries to community resources can reduce health care utilization and costs by addressing HRSNs. While the five-year CMS demonstration program has ended, program results on reduction of costs and utilization were recently released, and the demonstration has led to additional private-sector models.
- In October 2018, CMS approved North Carolina's Section 1115 waiver focused on addressing social needs for high-risk, high-cost beneficiaries through Health Opportunity Pilots. The pilots address housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress for a limited number of high-need enrollees.
- In 2019, CMS changed the definition of "primarily health-related" benefits for MA plans to include benefits such as adult day health services, home-based palliative care, therapeutic massage, support for caregivers of enrollees, and in-home support services to help enrollees with activities such as dressing, eating, and housework. A report by the Government Accountability Office (GAO) found that almost one-quarter of the plans that

were reviewed offered at least one these expanded primarily health-related supplemental benefits in 2022.[3]

- In 2019, the Office of the Inspector General (OIG) within the department of Health and Human Services (HHS) released a proposed rule designed to promote coordinated patient care and foster improved quality, better health outcomes, and improved efficiency. The proposed rule outlined several safe harbors from the federal anti-kickback statute. The proposed rule was finalized in November 2020.
- Beginning in 2020, the CHRONIC Act of 2018 allowed MA plans to offer non-primarily health-related Special Supplemental Benefits for the Chronically Ill (SSBCI). These supplemental benefits, for which NASDOH advocated, include services such as non-medical transportation, home modifications, general support for care at home, and pest control. The GAO report found that slightly over one-fifth of MA plans offered at least one SSCBI in 2022. The most commonly offered SSCBI benefit in 2022 was food and produce.
- In January 2021, CMS sent a letter to state health officials to describe opportunities under Medicaid and the Children's Health Insurance Program (CHIP) to better address SDOH and support states with designing programs, benefits, and services to more effectively improve population health, reduce disability, and lower overall health care costs in the programs by addressing SDOH.

NASDOH's policy recommendations build on these and other successes to improve the health and wellbeing of Americans. We are excited to share our recommendations with you and believe that by working together, we can achieve meaningful improvements in the health and well-being of all Americans.

Recommendations for the Trump Administration

(1) Address food and nutrition security as a critical component of improving the health and wellbeing of all Americans.

NASDOH appreciates the incoming Administration's prioritization of advancing health and healthy choices. NASDOH strongly encourages HHS to consider the importance of food and nutrition security in promoting health. "Food insecurity and the lack of access to affordable nutritious food are associated with increased risk for multiple chronic health conditions such as diabetes, obesity, heart disease, mental health disorders, and other chronic diseases. In 2020, almost 15% of U.S. households experienced food insecurity. This means that some household members did not have enough food to support active, healthy lifestyles. In nearly half of these households, children were also food insecure, which has implications for human development and school experience."[4]

The Administration has many programs and authorities—including Medicare and Medicaid—that can be leveraged to support food and nutrition security. Specifically, NASDOH recommends:

- Expanding access to Medicare coverage of nutrition and obesity counseling and medically tailored meals.

[3] https://www.gao.gov/assets/gao-23-105527.pdf
[4] https://www.nimhd.nih.gov/resources/understanding-health-disparities/food-accessibility-insecurity-and-health-outcomes.html

- Expanding the Centers for Disease Control and Prevention (CDC)'s State Physical Activity and Nutrition Program,[5] which implements evidence-based nutrition and physical activity strategies to reduce chronic disease.

(2) Support expanding supplemental benefits by encouraging Medicare Advantage (MA) Plans to propose innovations that improve the health and wellbeing of Medicare beneficiaries.

The MA program covers about half of all Medicare beneficiaries and offers benefits beyond medical care to help seniors improve their health. The rapid growth in MA enrollment has driven significant competition among plans, including by offering new or expanded supplemental benefit options for seniors. Initially limited to a core set of offerings including vision and hearing benefits, over the years, MA supplemental benefits have undergone significant changes that have led to a broader range of allowable benefits. By offering a wider variety of supplemental benefits, MA plans have provided seniors grocery assistance, non-medical transportation, home modifications, pest control, and in-home support services to help enrollees with activities such as dressing, eating, and housework. In 2023, the most common SSBCI offerings were groceries, meals delivered at home or in a congregate setting, general supports for living, and transportation for non-medical needs. MA supplemental benefits are critical to supporting the health outcomes of seniors and provide a model for how health care and social services can work together to support the health and wellbeing of all Americans.

Additional data is also needed in several areas to fully understand the impact of supplemental benefits and build the business case for continued provision of these benefits. This includes:

- granular information about which supplemental benefits are being used and by which beneficiaries, including out of pocket costs for beneficiaries.
- Data to assess the quality of each provider of supplemental benefits, level of variability in quality, and plans' success at overseeing these non-clinical service providers and the benefits offered.

Understanding utilization and quality of supplemental benefits would provide valuable information for stakeholders to design and implement meaningful benefits for seniors that address HRSNs and the underlying drivers that affect health and well-being outcomes for seniors. NASDOH encourages the Administration to support and build on the successes of supplemental benefits in improving health outcomes with requisite oversight and accountability for the plan offerings.

(3) Support flexibilities and waivers that allow states to provide non-medical services, building on existing medical services and supports, that improve health outcomes of Americans enrolled in Medicaid.

[5] https://www.cdc.gov/span/php/about/index.html

The evidence demonstrates that social risk factors combined with related non-medical health needs or social needs, negatively impacts healthcare utilization, costs, and outcomes.[6] Medicaid programs are the primary provider of healthcare benefits to tens of millions of Americans with limited incomes and resources, many of whom are more likely to experience housing instability, food and transportation insecurity, and other social risks. A 2019 survey of Medicaid beneficiaries indicated that around two-thirds of survey respondents reported one or more unmet social needs. States have used several mechanisms to address non-medical drivers of health and advance value-base care, including 1115 waivers and in-lieu-of services (ILOS) which can support new activities such as expanding coverage for specific HRSNs for targeted populations, including individuals with chronic conditions, and supporting local organizations in building local infrastructure for addressing underlying needs, including closed-loop referral tools and payments technology.

In October 2018, CMS approved North Carolina's Section 1115 waiver focused on addressing social needs for high-risk, high-cost beneficiaries through Health Opportunity Pilots. The pilots address housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress for a limited number of high-need enrollees. Since the approval of North Carolina's waiver, many other states have implemented an 1115 waiver to address social needs and SDOH and additional states have pending 1115 waivers. The waivers allow states to manage demonstration programs to address the needs of the state Medicaid population such as nutrition counseling and instruction, home delivered meals, nutrition prescriptions, and grocery provisions for certain individuals with certain health conditions or for high-risk individuals.[7] In order to address nutrition, "North Carolina's Healthy Opportunities program requires fruit and vegetable prescription services to be "WIC-eligible," meaning they meet certain nutritional requirements."[8] Additionally, "Michigan's ILOS policy guidance requires that:

- Medically Tailored Home Delivered Meals meet the Food Is Medicine medically tailored meal nutritional guidelines;
- Healthy Home-Delivered Meals meet one-third of the recommended Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences (except where inappropriate given an enrollee's nutrition-sensitive condition) and national nutrition-related guidelines such as the Dietary Guidelines for Americans;
- Healthy Food Packs do not contain ultra-processed foods or foods with excessive sugar or salt; and

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

[7] https://www.medicaid.gov/health-related-social-needs/downloads/hrsn-coverage-table.pdf

[8] https://www.chcs.org/media/Food-for-Thought-Medicaid-Nutrition-Benefit-Design-Approaches-for-Equitable-Implementation.pdf

- Produce Prescriptions are used for foods that align with "WIC-eligible fruits and vegetables, Gus Schumacher Nutrition Incentive Program-eligible fruits and vegetables and Double Up Food Bucks Michigan-eligible foods."[9]

NASDOH encourages HHS and CMS to further assist state Medicaid programs in addressing the non-medical drivers of health and improving health outcomes, including through clarifying that provision of evidence-driven non-medical health interventions can be counted as an incurred claim under the Medicaid Medical Loss Ratio.

(4) Support research on improving health and health outcomes.

While there is significant and growing research on the associations between the non-medical drivers of health and health outcomes, there is a need for more robust research, using consistent standards, definitions, and innovative methodologies to identify effective, scalable interventions that policymakers can implement to improve health outcomes.

Federal policy needs to be guided by a strong evidence base that is rigorously evaluated so that innovations can be scaled more widely, and the most effective can be prioritized. However, the lack of common definitions and standards for data or agreement on appropriate methodology inhibits a coherent body of research results that can be applied in policy and practice. Additionally, results of non-medical health research (and the underlying data that is used in research) are often closely held due to proprietary or privacy reasons, with little funding or incentive for making research widely available.

Last year, NASDOH released a set of proposed principles for non-medical health research meant to serve as a guide to create a strong evidence base that is rigorously evaluated so that such innovations can be scaled more widely, and the most effective can be prioritized. NASDOH encourages the federal government to support studies on non-medical drivers that are:

- **Actionable:** Research needs to move beyond demonstrating or refining associations between adverse SDOH and poor outcomes and should focus on identifying effective policies, practices, and programs that can be implemented to address social needs of patients as well as broader community-level interventions that address non-medical drivers. Research should focus on practical questions decision-makers face (e.g., the comparative value of alternative infrastructure or programmatic investments, or how to braid and blend funding sources). To the extent possible, research should also provide the basis for action by specific stakeholders (e.g., the impact of policy interventions, and the costs and benefits by type of stakeholder).
- **Measurable:** Research portfolios should carefully balance the need for long-term studies with time to capture critical outcomes of interventions, but also recognize the importance of translating research into action (e.g., through interim measures). Similarly, research on SDOH should use outcomes measures that are as broad as practicable, expanding beyond process and short-term cost savings metrics to include longer-term health and well-being outcomes.

[9] https://www.chcs.org/media/Food-for-Thought-Medicaid-Nutrition-Benefit-Design-Approaches-for-Equitable-Implementation.pdf

- **Community-oriented:** SDOH research should be led by, or closely involve, community-based partners who are often the ones planning and implementing SDOH-focused solutions. The data and findings should also be accessible to communities that were studied or that can benefit from findings.
- **Focused on populations facing the greatest challenges:** Research should be designed to address the unique needs and priorities of populations that face the greatest challenges. Priority should be given to studies that can address the needs of such populations, and, at a minimum, provide for the collection and release of detailed race and ethnicity data. Research involving all populations should be conducted in accordance with the highest ethical standards and with respect for populations that historically have not benefited from research in which they participate or have experienced historical injustice in medical research.
- **Sustainable:** SDOH research should focus on how to achieve sustainable programs and interventions through policy change, sustainable funding streams, dedicated revenue sources, or other interventions that aren't dependent on discretionary grant funding.
- **Integrated:** Studies should recognize that adverse SDOH are often the result of highly related social and economic factors, rather than narrower problems or programs. Within the limits of effective research design, research should seek to address the cross-sectoral nature of both adverse SDOH and their solutions.

(5) Develop a new value-based care payment model that focuses on addressing the health and wellness of rural populations including through addressing non-medical drivers of health.

Rural communities face unique challenges when it comes to health. Residents are more likely to have chronic diseases such as heart disease, obesity, and diabetes, in comparison to non-rural residents,[10] and face additional challenges in accessing health care and improving health outcomes. Hospital closures, transportation barriers, limited access to healthy food, and lack of broadband contribute to health disparities in these communities.[11] For example, people living in rural areas often have to drive further to receive care. A study from the University of Washington found that median travel to access care for rural Medicare beneficiaries in small rural communities was 22.5 miles (31 minutes), whereas urban Medicare beneficiaries traveled 9.2 miles (18 minutes).[12] This is a substantial barrier for beneficiaries who do not have access to reliable transportation as missed appointments can result in adverse health conditions and transportation can also impact decision-making about whether to make an appointment out of town or to see a specialist.[13]

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[10] Need for Addressing Social Determinants of Health in Rural Communities: https://www.ruralhealthinfo.org/toolkits/sdoh/1/need-in-rural.
[11] Need for Addressing Social Determinants of Health in Rural Communities: https://www.ruralhealthinfo.org/toolkits/sdoh/1/need-in-rural.
[12] Ensuring Age-Friendly Public Health in Rural Communities: Challenges, Opportunities, and Model Programs: https://www.tfah.org/wp-content/uploads/2023/08/Rural_Healthy_Aging_Brief_FINAL.pdf.
[13] Ensuring Age-Friendly Public Health in Rural Communities: Challenges, Opportunities, and Model Programs: https://www.tfah.org/wp-content/uploads/2023/08/Rural_Healthy_Aging_Brief_FINAL.pdf.

Additionally, the prevalence of food insecurity, which is associated with obesity in adults and children,[14] in rural areas was 10.8 percent in 2021.[15] Although this is similar to the prevalence of food insecurity in urban areas, healthy food is less accessible in rural communities.[16] Older adults, who make up a significant portion of rural populations, often lack access to innovative payment models or Medicare Advantage plans that can provide services to address HRSNs that are not covered by traditional Medicare.[17]

CMS' Innovation Center has a unique opportunity to transform rural health through innovative payment and service delivery models. A new model that focuses on rural areas should:

- Require model participants to address the identification, coordination, and provision of social care, as well as the underlying drivers of social needs in their communities.
- Allow or require participating organizations to pay social care providers for services offered following a referral.
- Test approaches to supporting social care infrastructure in rural areas through the payment model.
- Include outcome measures on the impact of the model on social needs and overall wellbeing of rural communities.

In developing and carrying out such a model, NASDOH strongly encourages the Innovation Center to publish learnings early and often and establish or expand existing learning collaboratives so that successful initiatives in any model can be rapidly disseminated and adopted by others.

(6) Remove barriers to braiding, blending, and pooling funding to support the ability of states and communities to address whole person health more efficiently and effectively.

Investments in non-medical drivers of health have the potential to help all people and communities become and stay healthy, achieve wellbeing, and thrive economically, thus alleviating pressure on the health system to treat preventable illness. Despite the potential benefits, the segmentation of funding streams in health and social services make it difficult for communities to be efficient and more effective in addressing health and social factors. Some organizations "braid" and "blend" or pool funding streams to support activities that address the whole person.[18] However, there are

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[14] Healthy People 2030: Food Insecurity: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity#cit21.
[15] USDA Household Food Security in the United States in 2021: https://www.ers.usda.gov/webdocs/publications/104656/err-309.pdf.
[16] Food Insecurity in the Rural United States: An Examination of Struggles and Coping Mechanisms to Feed a Family among Households with a Low-Income: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9785039/.
[17] Medicare Advantage Enrollment, Plan Availability and Premiums in Rural Areas: https://www.kff.org/medicare/issue-brief/medicare-advantage-enrollment-plan-availability-and-premiums-in-rural-areas/#:~:text=In%202023%2C%20a%20smaller%20share,and%2053%25%2C%20respectively
[18] POOLED FUNDING refers to the collection and combination of funding from multiple sources, which are "pooled" together in one organization for use in a common effort.

many barriers to pooled funding that the Administration could address in order to allow funding recipients to more effectively and efficiently use federal funding to address the needs of individuals and communities. NASDOH encourages the Administration to conduct a review of programs that support health and social care and address barriers to pooled funding, such as misaligned application timelines, disjointed funding periods, burdensome or duplicative reporting requirements, and other program administrative requirements that impede pooled funding absent clear guidance about when these requirements can be waived or flexibly applied. Following a review of relevant programs, the Administration could:

- Support better coordination between agencies and departments.
- Direct agencies to jointly award grant funding, utilize peer reviewers across agencies, and allow applicants to partner in order to meet eligibility for multiple awards.
- Develop and utilize a common application process for federal grants.
- Align application processes, funding cycles, eligibility restrictions reporting requirements, and evaluation metrics to support pooled funding.

We appreciate your focus on reducing chronic diseases and improving the health of Americans by addressing the underlying causes of poor health. Please consider NASDOH a resource in this effort. We would also welcome the opportunity to discuss these recommendations with you in more detail. Should you have any questions or wish to discuss our comments further, please contact Laura Pence at Laura.Pence@LeavittPartners.com.

Sincerely,

Laura Pence

Laura Pence
Advisor to NASDOH

BRAIDING: A type of fund pooling where resources are coordinated, but are allocated and monitored exclusively by each funding source. Blending is, operationally, difficult to monitor and report on because it can be challenging to discretely identify the benefit of a single dollar in a larger project.
BLENDING: A type of fund pooling where resources are combined, allocated, and monitored together rather than by the funding source.