NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

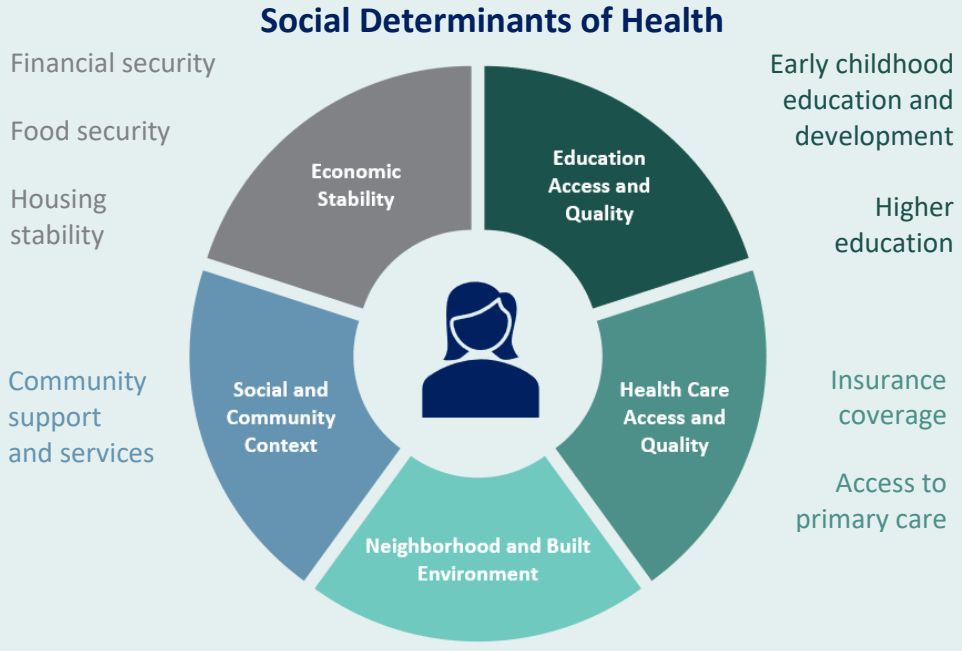
The Social Determinants of Health Federal Policy Landscape: A Look Back and Ahead

The National Alliance to Impact the Social Determinants of Health

Founded by Governor Mike Leavitt and Dr. Karen DeSalvo in 2018, the National Alliance to Impact the Social Determinants of Health (NASDOH) works to address the social determinants of health (SDOH) as a core component of value-based care transformation.

> *"The interest in addressing the social determinants as a core component of organizational strategy in value-based care transformation has dramatically increased in the past year. This is in part due to organizations taking a closer look at those populations that, despite excellent medical care, continue to experience poor health outcomes. The reason is often that these populations are medically and socially complex and need additional supports to address the non-medical drivers of outcomes."*
>
> *- Dr. Karen DeSalvo and Gov. Mike Leavitt, Health Affairs, 2019*

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 SDOH. These non-medical drivers include access to healthier foods, safer neighborhoods, reliable transportation, and educational attainment. They also include how we behave in our environment such as exercise, eating habits, and tobacco use. SDOH accounts for more health outcomes, including cost, than medical care alone."[i]



Source: adapted from Healthy People 2030

Since NASDOH's inception, the Alliance is proud to have played a role in the changes in healthcare, including a remarkable acceptance of the concepts underlying SDOH and significant practical steps toward addressing social needs as part of healthcare – supported by evolution of federal policy and private payment systems. Over the past five years, more healthcare stakeholders started screening for health-related social needs (HRSN), Medicare Advantage plans started covering HRSN supplemental benefits, and states have leveraged opportunities within the Medicaid program to address SDOH and improve the quality of care for vulnerable populations.[ii] NASDOH's goal is that over the next five years, there will be widespread adoption of effective policies and programs to address SDOH and social needs.

A Word on SDOH Terminology

Social needs, also known as health-related social needs, are the immediate non-medical needs of an individual. Efforts to address social needs provide invaluable assistance to individuals – for example, providing food, housing, and transportation to a person or their family – but not the underlying economic or social conditions that lead to social needs.

Social determinants of health, also known as non-medical determinants of health or the drivers of health, are conditions in the environments where people are born, grow, live, work, and age that affect health outcomes and risks; and the broader systems that shape those conditions, including social, political, and economic programs, and policies. Efforts to address SDOH prioritize the underlying social and economic conditions in which people live, rather than the immediate needs of any one individual.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Addressing adverse SDOH is an important component of achieving health equity.

Progress on Addressing Social Needs and SDOH over the Last 5 Years:

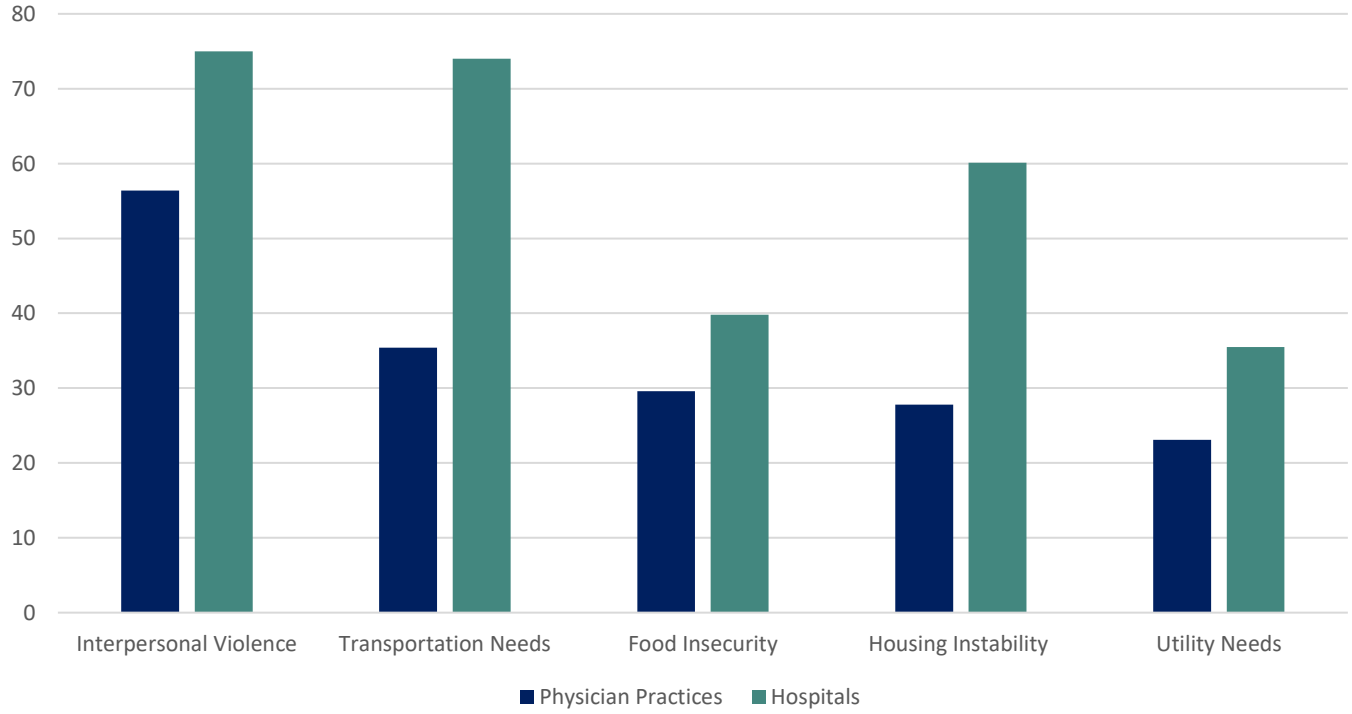
When NASDOH was established, many in the federal and state governments and the private sector were early in their efforts to identify and address SDOH and social needs in the healthcare setting. A significant portion of the early efforts were demonstration programs centered around screening for and addressing HRSNs, such as nutrition, housing, and transportation. These efforts varied widely and often targeted certain segments of the population, such as people with patterns of high healthcare utilization or individuals with a certain diagnosis. Over the last five years, as additional demonstrations have emerged and the learnings from these demonstrations have been reflected in policy, there has been a significant expansion of social need- and SDOH-related activities, reaching a larger population.

Screening for HRSNs:

While many hospitals reported a commitment to establishing and developing processes to systematically address social needs as part of clinical care in 2017, much of the hospital activity in this space, including screening for social needs, was ad hoc, such as occasional screening for one social need and which only targeted some of the population.[iii] In addition to hospitals, screening for HRSNs by physician practices was sporadic and varied by social need. For both hospitals and physician practices, screening rates for interpersonal violence were higher than screening for any other HRSNs, and ***only 15.6% of physician practices and 24.4% of hospitals reported screening for all five social needs.***[iv]

A survey of 300 hospitals conducted by Deloitte in 2017 found higher rates of screening for HRSNs among inpatient populations and people with patterns of high healthcare utilization, and that "the healthcare system's shift toward value-based care may spur more investment and activity around addressing social needs" as "hospitals that are further along in the journey to value-based care report the largest investments and most activity around addressing social needs." Source

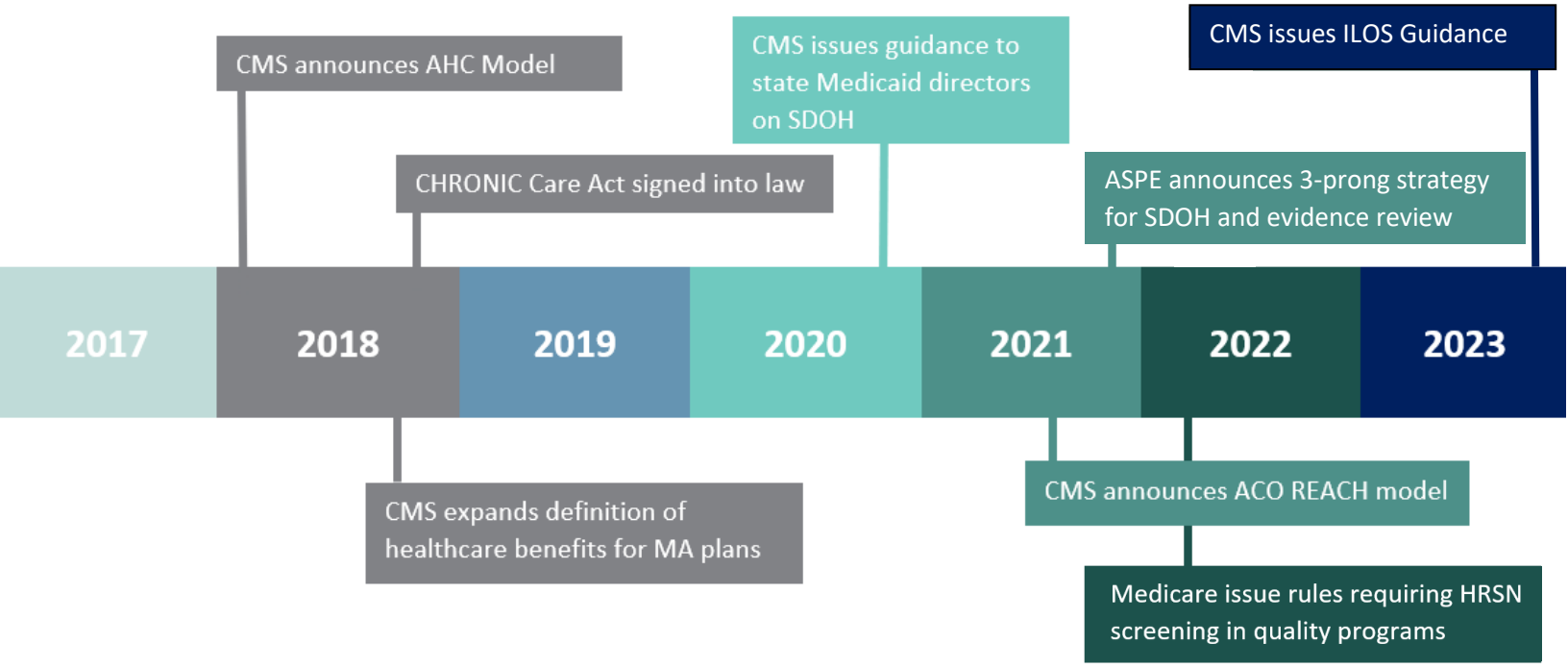
Percent of Physican Practices and Hospitals that Screen for Each Social Need, 2017



Over the past five years, screening for HRSNs within physician offices and hospitals has increased, in part due to federal policies promoting expanded screening. In 2017, the Center for Medicare and Medicaid Innovation (CMMI) announced the Accountable Health Communities (AHC) Model to test whether connecting beneficiaries to community resources can improve health outcomes and reduce costs by addressing HRSNs.[v] As part of the model, participants, including NASDOH member, Camden Coalition, used the AHC HRSN Screening Tool to universally screen Medicare and Medicaid beneficiaries for five HRSNs—food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal violence.[vi] The five-year CMS demonstration program has ended, and the demonstration has led to additional private-sector models. Additionally, the screening tool used by AHC participants was made available for public use, and NASDOH member, the Funders Forum on Accountable Health at George Washington University, has created a common table for public and philanthropic funders of AHCs to share learnings and explore best practices.[vii]

In a significant step forward in promoting increased HRSN screening, in the Calendar Year 2023 Medicare payment rules, the Center for Medicare and Medicaid Services (CMS) added screening-related measures to several quality programs, including the Merit-based Incentive Payment System (MIPS) measure set for hospitals. NASDOH supported the inclusion of the new Screening for Social Drivers of Health measure, which will assess screening across the five domains that were the focus of the AHC model. Including screening measures will encourage more providers to consistently screen for social needs across the five domains to gain a clearer picture of the individual's needs and highlight where additional screening may be needed, as well as the scope of services that are needed to improve care and health outcomes. Critically, CMS has also indicated it intends that future measures will eventually include follow-up to address identified social needs.[viii]

Major Federal Policy Developments



As CMS continues to push toward quality and value-based care, CMS is also proposing to include a measure for screening for social drivers of health as part of the Universal Foundation for use across CMS quality programs.[ix] As screening expands, collaborations between healthcare providers, community-based organizations, and the tools to support seamless coordination are critical to ensure services and supports to address HRSNs are offered to patients.

Coverage of HRSN Services and SDOH Supports:

Over the past five years, on a bipartisan basis across changes in Congress and two Administrations, Congress and CMS have taken a number of actions to expand coverage for HRSN services and allow states to use federal funding to support infrastructure for addressing SDOH.

Beginning in 2017, CMS allowed Medicare Advantage (MA) plans participating in CMMI's 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.[x] CMS recently announced it will extend the VBID model through 2030 and make updates to "more fully address the health-related social needs of patients, advance health equity, and improve care coordination for patients with serious illness."[xi]

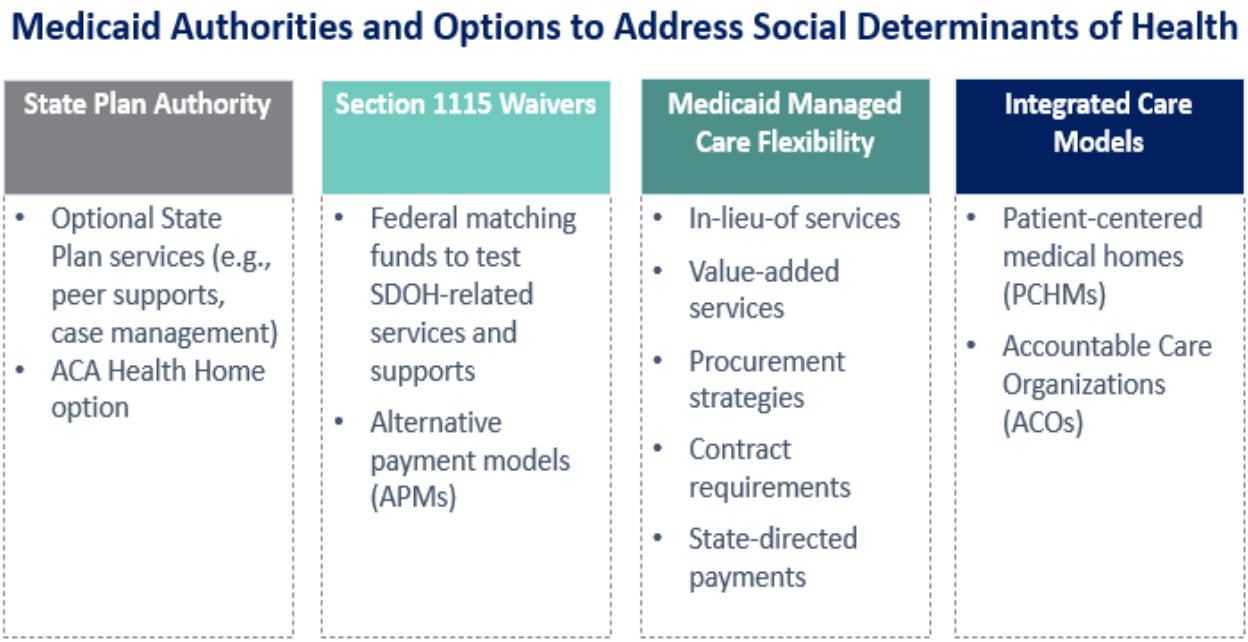
In 2019, CMS changed the definition of "primarily health-related" benefits for MA plans to include benefits such as adult day health services, home-based palliative care, therapeutic massage, support for caregivers of enrollees, and in-home support services to help enrollees with activities such as dressing, eating, and housework.[xii] A recent report by the Government Accountability Office (GAO) found that almost one-quarter of the plans that were reviewed for the report offered at least one these expanded primarily health-related supplemental benefits in 2022.[xiii]

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, which NASDOH advocated for, include services such as non-medical transportation, home modifications, general support for care at home, and pest control.[xiv] To deliver these services, health

SDOH and Technology

Technology infrastructure, including cross-sector closed-loop referral systems, are a critical component of the care transformation conversation and national efforts to shift to value based payment. Many federal actions have focused on adoption of HRSN technology. These include: The Office of the National Coordinator for Health IT (ONC) furthering data and interoperability standards to include SDOH data elements, CMS authorizing the direct funding of state-wide HRSN technology infrastructure via state 1115 waivers, and the Centers for Disease Control and Prevention (CDC) including closed-loop referrals as a requirement for key program implementations. NASDOH member Unite Us has partnered on a number of projects, including several of the examples mentioned in this report, to enable in-workflow HRSN screenings as well as closed-loop referrals and invoicing across payers, providers, and community-based organizations (CBOs).

plans are partnering with CBOs like NASDOH members US Aging and Volunteers of America affiliates across the country. The GAO report found that slightly over one-fifth of MA plans they reviewed offered at least one SSCBI in 2022. The most commonly offered SSCBI benefit in 2022 was food and produce, which was offered by almost 15 percent of plans. Under 6% of plans were offering each of the other supplemental benefits like transportation for non-medical needs, general supports for living (e.g., subsidies for rent or utilities) or pest control.[xv]



Source: adapted from Kaiser Family Foundation

In addition to innovations for the Medicare population, CMS has worked with states to adopt flexibilities in the Medicaid program to address HRSNs. Medicaid programs are the primary provider of healthcare benefits to tens of millions of Americans with limited incomes and resources, many of whom are vulnerable to adverse SDOH and as a result, 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. The evidence demonstrates that social risk factors combined with related non-medical health needs or social needs, negatively impacts healthcare utilization, costs, and outcomes.[xvi]

States have used several mechanisms to address HRSNs and SDOH, including 1115 waivers and in-lieu-of-services. State Medicaid programs have used these flexibilities for a range of new activities, such as expanding coverage for specific health-related social needs for targeted populations, such as individuals with chronic conditions, and supporting local organizations in building local infrastructure for addressing underlying SDOH, 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. NASDOH member Unite Us' technology platform is being used to make referrals to approved social care services, facilitate payment for those services, and collect data to inform the demo and future policymaking efforts.

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, and the proposals reflect a range of activities to address HRSNs and SDOH from targeted populations to the broader Medicaid population. The waivers for Arkansas, Arizona, and California highlight the range of options for which states are using 1115 waivers.

18 states have approved 1115 waivers to address social needs and SDOH.

11 states have pending 1115 waivers to address social needs and SDOH.

Additionally, in January 2023, CMS released a letter to state Medicaid directors to provide additional guidance about how in-lieu-of-services (ILOSs) can be used by states and managed care plans to address Medicaid enrollee's HRSNs.[xvii] Importantly, CMS indicated that these ILOS need to be medically appropriate and cost effective, but not necessarily cost neutral. The data that states will report to CMS under their new guidelines will eventually help the federal government and states understand the impact of these interventions.

1115 Waiver Demonstration Spotlights

Arizona's Healthcare Cost Containment System 1115 waiver established an H2O program to provide housing supports and case management to Medicaid enrollees who are experiencing homelessness or at risk of becoming homeless and who meet at least one of a list of specified clinical and social risk criteria (e.g., serious mental illness designation, high- cost high needs chronic health conditions or co-morbidities, or are enrolled in AZ's Long Term Care System).

The waiver also supports the **Targeted Investments 2.0 program** which provides funding for Medicaid Managed Care Organizations to use for activities aimed at meeting performance metrics, including conducting population health analyses related to HRSN and implementing national standards for culturally and linguistically appropriate services. The program also offers providers access to a closed-loop referral system.

Arizona can also claim federal FMAP funding for infrastructure investments to support the implementation and delivery of HRSN services, including technology; development of business or operational practices; workforce development; and outreach, education and stakeholder convening.

The Arkansas Health and Opportunity for Me (ARHOME) 1115 waiver established a Life360 HOMEs program which will provide intensive care coordination and connection to services to different focus populations, including individuals with behavioral health needs who live in rural areas, individuals with high-risk pregnancies, and young adults at high risk for long-term poverty.

Through the waiver, Arkansas' Medicaid program will cover housing supports, nutrition supports, and case management, outreach and education for Life360 HOME beneficiaries.

The California Advancing and Innovating Medi-Cal (CalAIM) 1115 demonstration is a multi-year plan to provide a broad set of medically appropriate HRSN services for eligible individuals. The waiver also provides for HRSN infrastructure investments, including technology; development of business or operational practices; workforce development; and outreach, education and stakeholder convening.

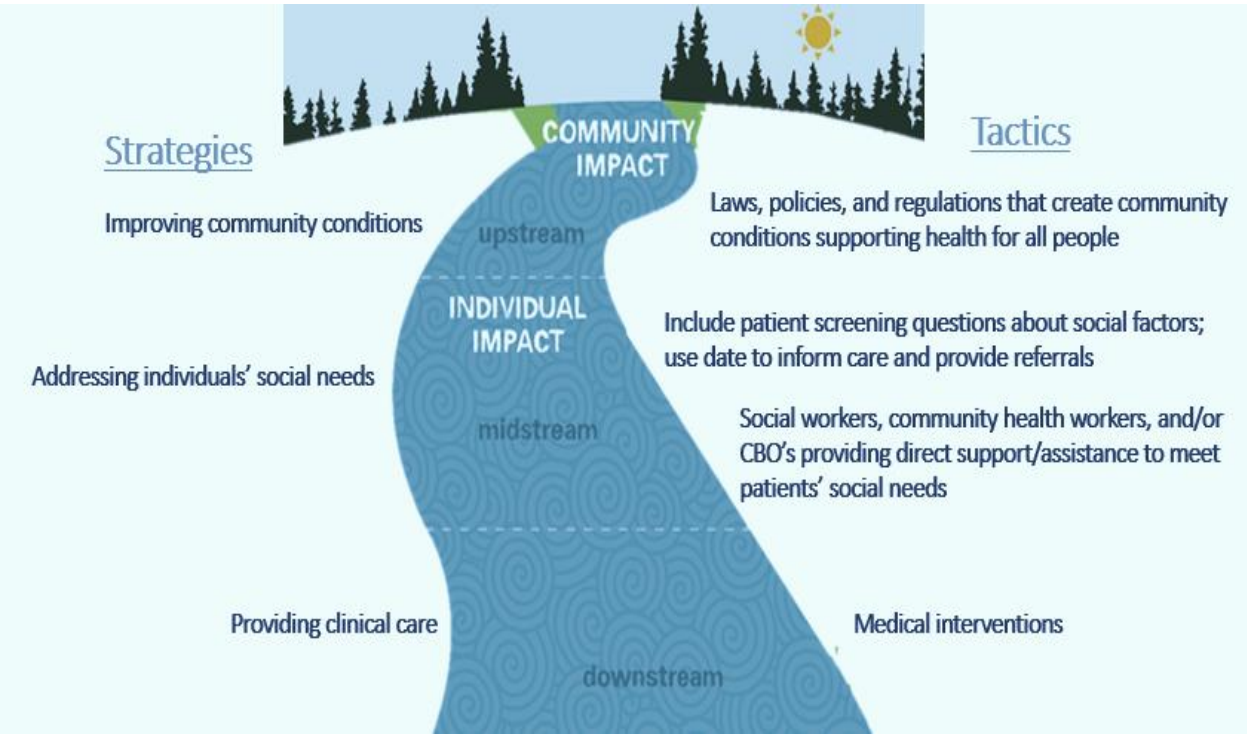
Additionally, the Hospital Quality and Equity Initiative includes up to $490 million in federal resources annually to fund financial incentives for participating hospitals that demonstrate improvement in healthcare quality and equity. To receive financial incentives, hospitals most achieve performance improvements in 3 domains: demographic and HRSN data, equitable access and quality, and capacity and collaboration.

Integrating Equity and SDOH Frameworks into Healthcare:

In recent years, several cross-cutting initiatives have been established to encourage healthcare organizations to advance equity and address the SDOH as part of their strategic priorities and organizational commitments. NASDOH co-led an effort supported by the Robert Wood Johnson Foundation to develop principles and actions for healthcare organizations to advance equity and improve quality across their roles as providers, employers, community members, and advocates. In the Summer of 2022, NASDOH released Raising the Bar – an actionable framework for the entire healthcare sector, from providers, to payers, to the public health community, to embed equity throughout its work and help achieve optimal health for all. Raising the Bar worked with a wide range of healthcare leaders and those who experience inequities to craft foundational, central principles that can serve as healthcare's gravitational force to continuously center equity work. Several organizations such as the American Hospital Association (AHA), the Joint Commission, and the National Committee for Quality Assurance (NCQA) and others have developed toolkits, measures, and standards that highlight the extent to which these are becoming a more mainstream part of healthcare.

Addressing Upstream Drivers at the Community Level:

IN addition to the efforts at the federal and state levels, there are other efforts to address the upstream drivers of health at the community level. In recognition that the healthcare sector cannot address these issues alone, several efforts have been launched to bring together stakeholders from multiple sectors into partnerships to address SDOH. In 2021, the U.S. Surgeon General created an initiative called "Community Health and Economic Prosperity" which included a focus on “engaging businesses to be community change-makers and forces for health in their communities.”[xviii] NASDOH member Doug Jutte from Build Healthy Places Network was a senior scientific editor of this report and Gov. Leavitt was a featured author.



Source: adapted from Castrucci and Auerbach

Additionally, in early 2022, the National Institutes of Health (NIH) Common Fund launched the Community Partnerships to Advance Science for Society (ComPASS) Program, which is funding community-led health equity structural interventions that leverage partnerships across multiple sectors to reduce health disparities.[xix] These efforts recognize the importance of community-led identification of issues and necessary local interventions.

The CDC also funds programs specifically related to addressing SDOH at the local level. CDC’s Closing the Gap with Social Determinants of Health Accelerator Plans grants fund recipients to develop plans to help accelerate future actions in state, local, and tribal jurisdictions that prevent and reduce chronic diseases among people experiencing health disparities and inequities,[xx] and the Racial and Ethnic Approaches to Community Health (REACH) program funds recipients to reduce health disparities among racial and ethnic

populations with the highest burden of chronic disease.[xxi] NASDOH advocated for more robust funding for these CDC programs and also advocated for several legislative proposals that were incorporated into the bipartisan Consolidated Appropriations Act, 2023 (P.L. 117-328), which authorizes CDC to provide grants to State, local, and tribal organizations to improve the capacity of these entities to address factors that contribute to negative health outcomes in communities.

The CDC and NIH programs represent important investments in community-led, multi-sector stakeholder efforts to address upstream drivers of health, including the built environment, housing, and access to healthy foods. These programs also advance the evidence base for SDOH interventions to inform further multi-sector policies and programs.

1115 Waiver Demonstration Spotlights

NASDOH member, Kaiser Permanente, has partnered with multiple local entities to support services related to holistic housing, home-delivered meals and nutrition services, preventing homelessness and creating job opportunities for individuals at-risk for incarceration. For example, a grant from Kaiser Permanente will help make home-delivered meals and nutrition services available at no cost to Coloradans with severe illnesses who live along the I-25 corridor. The project will also help to expand services to include more comprehensive client care, including nutritional counseling and wellness visits to address health challenges and review nutrition planning for clients' diagnoses. Peer support groups will also bring severely ill Coloradans with similar health conditions together in a virtual format to help them feel more empowered and less isolated in their health journey.

NASDOH member, Intermountain Healthcare, partnered with two communities in Utah to create the Utah Alliance for the Determinants of Health in 2019, seeking to improve health by focusing on non-medical factors that affect health, such as housing instability, utility needs, food insecurity, interpersonal violence, and transportation. Through this demonstration, the Alliance completed more than 20,000 social need screenings and community health workers assisted more than 1,800 individuals. The project saw a 34% decrease in nonemergent use of the Emergency Department among members in the two measured counties and many important lessons were learned. Though the formal Alliance demonstration has ended, the work continues to thrive.

Incorporating Addressing SDOH and Health Equity into Existing Programs:

Building on the evidence base by incorporating SDOH interventions into existing programs is critical for advancing value-based care and improving health outcomes. To guide the work of the Department of Health and Human Services (HHS), the Assistant Secretary for Planning and Evaluation (ASPE) released a report on strategies to address SDOH and HRSNs that have demonstrated success in improving health outcomes and lowering health costs."[xxii] ASPE also outlined a strategic approach for the department's efforts to address SDOH by: "(1) enhancing data infrastructure; (2) improving connections between health and social service providers; and (3) engaging in whole-of-government collaborations to implement comprehensive solutions."[xxiii]

CMS is implementing evidence-based efforts through its Framework for Health Equity which outlines a comprehensive 10-year approach to further embed health equity across all CMS programs,[xxiv] as well as a Strategy Refresh for CMMI that outlines a similar objective. The Strategy Refresh also indicated a focused effort to "Develop new models and modify existing models to address health equity and social determinants of health,[xxv] including through a requirement for all new models that participants will "collect and report the demographic data of their beneficiaries and, as appropriate, data on social needs and social determinants of health."[xxvi]

Cross-agency and cross-department collaboration are critical to bringing together the resources to address the upstream drivers of health. Importantly, in recent years there has been an increased focus on collaborative efforts to address SDOH. In September 2022, the White House released a National Strategy on Hunger Nutrition and Health to "end hunger and increase healthy eating and physical activity by 2030 so that fewer Americans experience diet-related diseases like diabetes, obesity, and hypertension."[xxvii] The national strategy sets goals and plans for departments and agencies across the Federal government to collaboratively provide the tools and resources needed to impact the SDOH and support health equity.

Federal Coordination Spotlight

The Community Care Hub National Learning Community program is supported by the Administration for Community Living and the CDC. Community Care Hubs serve as the bridge between CBOs, healthcare payers and providers, and public health systems to provide services to address health-related social needs. They centralize administrative functions and operational infrastructure including contracting with healthcare organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting. The Community Care Hub National Learning Community program allows selected organizations to "participate in shared learning, information and resource sharing, and technical assistance coordination with the goal of building the strength and preparedness of each Community Care Hub to address health-related social needs and public health needs through contracts with healthcare entities."

Moving Forward:

As we celebrate the progress made during the past five years, we also underscore the need for continued work to address SDOH. Notable steps forward have been made in screening for HRSNs, expanding coverage for addressing HRSNs, and funding efforts to address the upstream drivers of health, but these activities vary significantly in their status of implementation as efforts are beginning to move from small-scale pilot programs to broader implementation. NASDOH's goal is that over the next five years, there will be widespread adoption of effective policies and programs to address social determinants. Specifically, NASDOH envisions that by 2028:

To advance health equity, clinical care providers and systems will routinely seek to understand and respond to the health-related social needs of individual patients while appropriately protecting privacy and confidentiality.

NASDOH's goal is that the healthcare sector will expand screening for individual needs, and addressing social factors through partnerships with social service providers will be the standard of care for comprehensive prevention and treatment plans.

Robust networks and partnerships will seamlessly connect healthcare providers, social service organizations, and public agencies to enable effective and sustained support for individuals.

Artificial barriers will have been eliminated through effective information sharing, use of community health workers and other intermediaries, and financing mechanisms will be established that follow individuals across healthcare and non-healthcare sites and pay for the infrastructure to support closed-loop referrals and payments to CBOs.

Communities will have effective mechanisms for cross-sector collaboration to address underlying social and economic factors that drive health and health equity.

The Federal government can advance this goal by establishing pathways for cross-sector partnerships using categorical program funding; facilitating cross-enrollment in federally funded health and social programs; and supporting state innovation in program administration through waivers, demonstrations, and funding flexibility with appropriate guardrails.

Patients and community members will be empowered through mechanisms to provide community input to healthcare providers, and civic engagement to influence policies.

SDOH policies will be developed with community-based partners who are often the ones planning and implementing SDOH-focused solutions as well as individuals with lived experience.

Healthcare, governments, employers, payers, and community organizations will align around shared goals and strategies for addressing underlying social determinants through effective policy, investment in social services, and access to preventive healthcare.

To accomplish this, each sector must embrace its roles in the community as a partner in addressing social needs and broader social determinants and supporting community development.

Public and private payment systems will include benefits for HRSNs, finance interventions to address HRSNs, and support efforts by providers to generate value through participation in multi-sector efforts to address underlying SDOH.

Over the next five years, the Federal government must continue to interpret payment systems rules to maximize support for social needs and explore legislative changes where existing authority is too narrow.

A robust, accessible evidence base will be available to support public and private decision-making for effective policies and programs to address social determinants, allowing healthcare institutions and payers to integrate SDOH into their business plans.

The Federal government must accelerate the evolution of the SDOH evidence base by investments in research and systematically compiling and sharing evidence as it emerges from research, pilot projects, and waivers.

NASDOH's ambitious yet attainable goal for the next five years requires participation by all stakeholders – government, philanthropy, business, technology sector, healthcare, CBOs, patients, consumer advocates, community members, public health, and academia – to improve health outcomes in communities across the nation. NASDOH will continue to be a forum to bring together these multi-sector stakeholders to address SDOH and advance health equity by broadening understanding and awareness of the value of addressing SDOH; advocating for public policies, particularly at the Federal level; and tackling barriers to progress on SDOH in both the public and private sectors.

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ABOUT NASDOH

The National Alliance to impact the Social Determinants of Health (NASDOH) is a group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement and economic vitality of families and communities. The Alliance brings together health care, public health and social services expertise, local community experience, community-convening competence, business and financial insight, technology innovation, data and analytics competencies, and policy and advocacy acumen to assess and address current regulatory frameworks, funding environments and opportunities, and practical challenges to implementing and sustaining social determinants of health efforts.

We seek to make a material improvement in the health of individuals and communities and, through multi-sector partnerships within the national system of health, to advance holistic, value-based, person-centered health care that can successfully impact the social determinants of health. To learn more, visit us at NASDOH.org.

NASDOH CO-FOUNDERS

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Former Secretary, US Department of Health and Human Services
Former Administrator, US Environmental Protection Agency
Founder of Leavitt Partners

Dr. Karen DeSalvo

Former Health Commissioner, City of New Orleans
Former Acting Assistant Secretary, US Department of Health and Human Services
Former National Coordinator for Health IT, Office of the National Coordinator for Health Information Technology

MEMBERS

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