



September 21, 2021

**Submitted via Google Survey**

Congressional Social Determinants of Health Caucus

Re: Social Determinants of Health Request for Information Response

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The Health Care Transformation Task Force appreciates the opportunity to respond to the Request for Information posted by the [Social Determinants of Health \(SDOH\) Caucus](#). The SDOH Caucus - led by Rep Cheri Bustos (IL-17), Rep. Tom Cole (OK-04), Rep GK Butterfield (NC-01), and Rep Markwayne Mullin (OK-02) - posted this RFI to learn about stakeholder's experience with SDOH challenges, strategies for improving alignment between health care organizations and other organizations, best practices and opportunities for addressing SDOH, and actions to transform health care payment.

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

**Experience with SDOH Challenges**

- 1) What types of gaps in care, programs, and services serve as a main barrier in addressing SDOH in the communities you serve? What approaches have your organization, community, Tribal organization, or state taken to address such challenges?**

A major barrier mentioned by our membership is a lack of data that allows policymakers and other stakeholders to accurately understand the health and other needs of the underserved and vulnerable. Gathering data from patients proves to be a very difficult task, and the data in EHRs is often not as accurate as organizations would like it to be to accurately identify patients' social needs. One challenge in collecting data is individuals' reluctance to respond to social needs

questionnaires without fully knowing how their information will be used. Specific fears include child protective services taking custody of children if the individual shares information on unstable housing, or deportation in relation to sharing immigration status. As part of training to collect SDOH data from patients, staff should be trained to incorporate an explanation of why the data is needed and how it will be used.

## **2) Are there other federal policies that present challenges to addressing SDOH?**

A few federal policies that create barriers and challenges to addressing SDOH have been brought to our attention. For example, the Federal Communications Commission (FCC) launched a telehealth program – the [Connected Care Pilot Program](#) – to support selected applicants with the provision of connected care services. The program included funding to cover 85 percent of eligible costs of broadband connectivity, network equipment, and information services necessary for the intended patient population. While the overall intent of this program was positive, the final rule restricted eligibility to non-profit organizations, which limited the impact for many underserved populations that could have benefitted from the program.

Another example is the [Coronavirus Response and Consolidated Appropriations Act of 2021](#), which contains a provision requiring Medicare beneficiaries using behavioral telehealth services to attend an in-person office visit within six months of a telehealth visit, thus imposing a burden on beneficiaries who may not have the means to access an in-person visit due to health status, transportation, or other factors. The same legislation also requires the elimination of audio-only telehealth services following the end of the public health emergency, which will disproportionately impact those in rural and other communities that are underserved by broadband and cannot access video telehealth visits.

### **Improving Alignment**

#### **1) Where do you see opportunities for better coordination and alignment between community organizations, public health entities, and health organizations? What role can Congress play in facilitating such coordination so that effective social determinant interventions can be developed?**

Congress can play a role in funding public and private entities to implement and train staff on use of infrastructure (including data systems) that support better coordination and alignment between community organizations, public health entities, and health organizations. Many states and non-profit organizations (particularly in the aftermath of the COVID-19 pandemic) do not have the resources to design or implement the technology or other systems needed to coordinate across organizations. We recommend Congress look to programs such as the former State Innovation Models (SIM) program, which provided states with resources to invest in innovation and infrastructure that support APM implementation. We focus on APMs because they give participating health system organizations greater flexibility to support coordination

efforts. These investments can also be applied at the local level to support training and implementation of community health workers, patient navigators or other care management models to reduce patient barriers to accessing care. For example, Colorado – under a three-and-a-half-year State Innovation Models (SIM) grant to support behavioral health integration – implemented a [regional health connector program](#). Although no longer running, the program saw great success in finding unique ways to address behavioral health among communities served. Similar mechanisms should be applied at a hospital or health care level to enter a community, learn about barriers for community members, and help patients navigate those barriers.

**2) What potential do you see in pooling funding from different sources to achieve aligned goals in addressing SDOH? How could Congress and federal agencies provide state and communities with more guidance regarding how they can blend or braid funds?**

Aligning federal agencies for the purpose of pooling funding is a key strategy to address the challenges imposed by SDOH. The Task Force encourages Congress and federal agencies to work together to develop opportunities for aligning “buckets” of spending across government agencies to create additional flexibilities in program financing. Furthermore, the Task Force recommends federal agencies work closely with their respective Office of the Actuary’s (OACT) to address cost-neutrality over a longer-term horizon instead of expecting cost savings in the short-term.

**3) How could federal programs such as Medicaid, CHIP, SNAP, WIC, etc. better align to effectively address SDOH in a holistic way? Are there particular programmatic changes you recommend?**

At a federal level, the Special Supplemental Nutrition Assistance Program (SNAP) for Women, Infants, and Children (WIC) offers a positive example of coordination across federal programs. Through adjunctive eligibility, individuals can establish their income eligibility by showing proof they participate in Temporary Assistance for Needy Families (TANF), SNAP, or Medicaid. This streamlines the burden for administration as well as for individuals participating in the programs. Lessons learned from the coordination between WIC, Medicaid, SNAP, and TANF should be applied a greater level to streamline application processes for government safety-net programs. For example, Medicaid and SNAP often have conflicting renewal processes for re-determining eligibility after the end of a predefined cycle. CMS and the USDA Food and Nutrition Service should work together to encourage states to coordinate Medicaid and SNAP enrollment and renewal (e.g. Georgia’s [HB 163 Bill](#)) by using SNAP income data for Medicaid renewals, aligning SNAP and Medicaid renewal due dates, and utilizing Express Lane Eligibility.

Further, there are several examples of state agencies that are working in concert to remove barriers and align efforts, which in turn, reduces barriers for individual's receiving support from various programs. The National Academy for State Health Policy's (NASHP) Health and Housing Institute supported five states - [Illinois, Louisiana, New York, Oregon, and Texas](#) – in their efforts to break down silos within government agencies to support low-income and vulnerable populations in finding and remaining in stable housing. Similar agency alignment efforts are present in Georgia. Georgia recently passed [HB 163](#) which directs the Department of Community Health to seek federal approval to establish express lane eligibility for Medicaid, and directs the Department of Human Services to automatically enroll and renew eligible children in Medicaid based on application data received for the Supplemental Nutrition Assistance Program (SNAP). Streamlining programs like this – where entrance into one program triggers enrollment into another – reduces the burden on a patient, and also allows them to access more services to address the social determinants of health.

**4) Are there any non-traditional partners that are critical to addressing SDOH that should be better aligned with the health sector to address SDOH across the continuum from birth through adulthood? What differences should be considered between non-health partners for adults' social needs vs children's social needs?**

Transportation and housing services are often overlooked in relation to health care, yet both are imperative to supporting meaningful access to health care for underserved and vulnerable populations. Without stable housing, a patient will likely struggle to comply with care protocols. Similarly, patients without reliable transportation (such as those without a car who must rely on public transportation) may arrive late to their appointment or forgo appointments altogether. Both situations may decrease the potential for individuals to address chronic health care needs and result in the need for acute and/or emergency care, which can lead to poor outcomes as well as to higher costs to the system. Working closely with organizations that have the ability to provide housing and transportation is critical to addressing SDOH.

Another area that greatly impacts a person's health is [environmental insecurity](#) (the lack of relative public safety from environmental dangers caused by natural or human processes). While relevant to all people, this has recently become a focus area for maternal health advocates. The National Partnership for Women & Families released the series [Saving the Lives of Moms & Babies](#), a 10-part series that connects the dots between how different socioeconomic factors affect maternal and infant health, and the outsized impact these factors have on Black Indigenous, and other People of Color communities. In speaking with our members, we heard that it is challenging for people to understand the link between environmental insecurity and poor health outcomes. It is imperative to both align non-traditional partners that focus on environmental health (such as organizations that provide air filters, clean drinking water, air

conditioning units, etc.) with health systems, as well as to educate general society on the link between the environmental problems and health.

**5) What opportunities exist to better collect, understand, leverage, and report SDOH data to link individuals to services to address their health and social needs and to empower communities to improve outcomes?**

To understand, leverage, and report SDOH data requires comprehensive collection of accurate demographic data beyond race and ethnicity. One model to look at is the [Epic Social Determinants of Health \(SDOH\) Wheel](#), a graphic that represents ten domains: financial resource strain, transportation needs, alcohol use, depression, intimate partner violence, social connections, physical activity, tobacco use, stress and food insecurity. Patients' responses to demographics and medical history questions turn the panels in the wheel graphic green (low risk), yellow (moderate risk), or red (high risk), allowing providers to better identify and address the social needs of patients. Currently, the SDOH Wheel is available to participating providers in ambulatory settings, as well as in inpatient and emergency departments, in organizations that use the Epic EHR model.

Other examples of valuable demographic data include data on gender orientation ([Fenway Health's](#) efforts to capture these data is a useful example), data on written and spoken primary language, and veteran status, all of which can be used to even further develop interventions that address how inequities are affecting certain patient demographics.

Further, we urge Congress to work with CMS and the Office of the National Coordinator for Health Information Technology (ONC) to establish health information exchange that supports interoperable access to electronic health record (EHR) data. Private sector EHRs are successfully collecting demographic data – in many cases going beyond R/E to include data on other social determinants of health – with high volume and high levels of accuracy.

**6) What are the key challenges related to the exchange of SDOH data between health care and public health organizations and social service organizations? How do these challenges vary across social needs (i.e., housing, food, etc.)? What tools, resources, or policies might assist in addressing such challenges?**

There are several challenges related to the exchange of SDOH data between health care and public health and social service organizations. There are not specific methods or protocols for who should collect the data, and typically, not enough data is collected. To adequately track the social determinants of health and make progress toward achieving health equity, organizations need to collect race and ethnicity data, as well as other demographic data, and aggregate and stratify the data by various demographic categories. Once these data are collected, there must be a way to share the data across different health systems and community-based organizations. However, the combination of disparate data infrastructures across health systems, and lack of

data infrastructure connecting health systems and community-based organizations, creates significant challenges to the kind of data sharing that is needed in order to support underserved populations.

Alternative payment models (APMs) can be used as a lever to coordinate care across different health related organizations. Since APM payment is based on outcomes instead of volume of services, health care providers are incentivized to coordinate care to improve a patient's health. If a patient has any specific needs related to a social determinant of health, it is in the providers best interest to make sure this need is addressed for the patient. Furthermore, APMs provide waivers that allow for greater data sharing flexibilities.

However, there is still an issue of collecting adequate demographic data to determine a patient's social risk factors and social needs. The Task Force recommends that race, ethnicity and other demographics information be mandated to be collected to adequately address patient needs and improve health outcomes. Further, the Task Force recommends that Congress support health plan and provider efforts to standardize SDOH data collection and exchange protocols.

### **Best Practices and Opportunities**

- 1) Which innovative state, local, and/or private sector programs or practices addressing SDOH should Congress look into further that could potentially be leveraged more widely across other settings? Are there particular models or pilots that seek to address SDOH that could be successful in other areas, particularly rural, tribal or underserved communities?**

St Charles Madras, a Critical Access Hospital (CAH) in Oregon, has done work on developing [cultural competency training](#) for their Native American population (which makes up 30% of the population served). Implementing such a training allows care team staff to better connect to and understand their patients, which will in turn produce better health outcomes. A program like this warrants Congress' attention to see if it can be leveraged more widely across other settings.

### **Transformative Actions**

- 1) Alternative payment models help to measure health care based on its outcomes, rather than its services. What opportunities exist to expand SDOH interventions in outcome-based alternative payment models and bundled payment models?**

The Task Force is an organization dedicated to advancing the transformation to value-based payment as a driver toward improved care delivery. Thus, the Task Force understands the unique opportunity value-based payment offers to address disparities in health care delivery. Alternative payment models (APMs) that establish incentives to providers to move beyond fee-for-service delivery to deliver coordinated, high-value care for all patients that results in

improved outcomes at lower costs can also be a vehicle toward providing more equitable care, if so incentivized. To provide health care organizations with a framework to assess their current practices and strategically plan effective, person-centered care programs and policies that advance health equity in their journey to transform care from volume to value, the Task Force developed [Person-Centered Care as a Cornerstone of Value-Based Payment: Five Guiding Principles](#). Other organizations have created similar documents that provide guidance for implementing health care transformation in an equitable way. For example, Families USA created a [National Priority Agenda to Advance Health Equity Through System Transformation](#), which provides 19 recommendations that highlight a path towards an equitable, transformed care system.

Furthermore, a resource from the Center for Health Care Strategies, [Leveraging Medicaid Accountable Care Organizations to Address Health Equity: Examples from States](#), highlights how accountable care organizations (ACOs) can be a powerful tool to address health equity and the social determinants of health. States with successful ACO programs describe formulating payment around data collection, paying for equity using value-based payment, adjusting for social risk factors, increasing member engagement, supporting non-traditional providers, increasing ACO internal capacity to advance a culture of equity, partnering with community-based organizations, and integrating the social determinants of health into care.

As the Centers for Medicare and Medicaid Services (CMS) Innovation Center (CMMI) moves into its second decade, CMMI should evaluate episode payment models to identify potential unintended consequences (on both patients and providers) resulting from bundled payment rates not accounting for the needs of underserved patients who may be receiving care at a later stage of their condition/disease. CMMI should also address the lack of a requirement that participants in the Bundled Payments for Care Improvement Advanced (BPCI-A) model to collect race and ethnicity data. Without accurate demographic data, payers and providers are unable to stratify data in a way that allows for targeted interventions. To this end, CMMI should evaluate the effects of APMs on patients, stratifying outcomes by race, ethnicity, and other demographics. The Task Force encourages the mandated collection of race, ethnicity, and other demographics data in all future alternative payment models, as well as the use of a standardized set of evaluation metrics (based on outcome measures that are applicable to both primary care providers and specialists participating in a model) that can be stratified by these factors to compare different population segments and identify any existing health disparities.

Finally, the Task Force recommends making the Value-Based Insurance Design (VBID) model expansion permanent to allow more providers to invest in SDOH long term.

**2) A critical element of transformation, particularly for new models of care, is measurement and evaluation. With SDOH in mind, which are the most critical**

## **elements to measure in a model, and what differences should be considered when measuring SDOH outcomes for adults vs children?**

The Task Force agrees that measurement and evaluation are critical elements to understanding new models of care. We emphasize the need for clinical outcomes measures (as opposed to clinical process measures), which can be stratified by race, ethnicity, and other demographic variables to truly understand how policies and models are affecting different populations. We also support measures of patient and family/caregiver engagement, as well as patient-reported outcome measures (PROMs). Finally, for clinical providers who primarily serve vulnerable populations, we support broadening of risk adjustment criteria, to accurately encompass all factors that impact equity in health care.

### **3) What are the main barriers to programs addressing SDOH and promoting in the communities you serve? What should Congress consider when developing legislative solutions to address these challenges?**

The main challenge cited by many Task Force members is the lack of adequate and sustainable funding for historically underserved communities, including the community-based organizations that address the social determinants of health within said communities. It is imperative that the federal government develop a comprehensive strategy that allocates federal resources to address structural racism and the infrastructure developed around it in many communities across the United States. The Task Force recommends that Congress consider the following points when developing legislative solutions:

- **Build capacity among community-based organizations.** Improving federal program supports ability to reach the intended recipients requires community-based organizations to serve as partners. For too long, the expectation of community-based organizations to serve as points of contact for various federal programs has been built on an expectation not grounded in the reality of underfunded organizations. Establishing funding streams that go directly to community partners for capacity building to help individuals connect with agencies and community-based organizations is a key component to addressing underserved individuals' unmet needs.
- **Allow flexibilities in how federal health care dollars can be spent.** Providers – particularly those in health systems – are eager to offer patients with ways to address social risk factors that can be detrimental to the clinical care being delivered. For example, patients with cardiac or respiratory conditions may receive the finest clinical care within the walls of the health system, but if they go home to an environment that lacks food, clean air, or climate control, the clinical treatment will not have its intended effect.



- **Fund Community health workers (CHWs).** CHWs have proven to improve the health outcomes of vulnerable populations; however, there is not a sustainable financing mechanism to pay CHWs for their work, with some state and local agencies relying solely on grant funds. Several states are exploring opportunities to use Medicaid to fund CHWs and we urge CMS reduce barriers so Medicaid can more easily pay CHWs to address inequities. The Association of State and Territorial Health Officials (ASTHO) has [outlined](#) bills introduced by states that would reimburse CHWs through Medicaid.
- **Refer to lessons learned and best practices** from Community Health Centers and Federally Qualified Health Centers regarding successful financial assistance provisions.