July 6, 2021

Submitted via https://Regulations.gov

The Honorable Shalanda Young
Acting Director, White House Office of Management and Budget
725 17th St. NW
Washington, D.C. 20503

RE: Request for Information: Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government

Dear Acting Director Young,

Thank you for the opportunity to provide input and recommendations on Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government.

We support the many steps that the Biden-Harris Administration has taken to advance equity for all, including people who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. In particular, we support the Biden-Harris Administration's steps to advance health equity including through initiatives to support and improve maternal health, and to address social determinants of health (SDOH).

Aligning for Health is an advocacy organization that brings together a broad coalition of members focused on improving health and wellbeing through interventions related to better aligning health and social needs. We are supported by an Advisory Board of individuals representing public health, mental health, housing, community development, human services, and many other sectors.[1]

There is a significant body of academic work showing that economic and social conditions have a powerful impact on individual and population health outcomes as well as health care costs. These non-clinical factors – such as housing, food assistance, income, employment status, education and transportation – have the potential to contribute to health outcomes more than clinical health care. In fact, one widely cited study found that while ten percent of premature deaths in the U.S. are due to clinical health care, social and environmental factors are estimated to account for sixty percent of health outcomes.[2]

As a coalition, we work to develop and promote actionable policies that create opportunities - and remove challenges - for states and local governments, health care organizations, and non-healthcare organizations to work together to develop cross-sector, coordinated solutions to address both health and social needs. For instance, we have worked to energize stakeholders and policymakers around the need for targeted technical assistance and funding to states and communities to help them design high-impact, cross-system strategies that achieve better health outcomes for Medicaid beneficiaries, improve program effectiveness, and lower health care costs.[3] We have also supported policies that would catalyze the

[1] https://aligningforhealth.org
[2] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine 50(2):129-135.
[3] https://aligningforhealth.org/social-determinants-accelerator-act/

development and expansion of integrated community referral and information exchange networks to better connect health and social services providers to improve outcomes for all.[4]

Below, we are pleased to provide comment in response to several of the questions posed.

1. **Equity Assessments and Strategies**

What are some promising methods and strategies for identifying systemic inequities to be addressed by agency policy? How might agencies collect data and build evidence in appropriate and protected ways to reflect underserved individuals and communities and support greater attention to equity in future policymaking?

As OMB notes in the Request for Information, advancing equity will require federal agencies to implement new approaches to assess whether policy and programs are effective in advancing equity. As part of this effort, we believe that it is important for agencies such as the Centers for Medicare and Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS), to improve the collection and reporting of standardized social needs data and encourage cross-sector coordination and data sharing across organizations in the health and social service sectors.

The conditions or environments that we inhabit, including our communities, our homes, and our access to healthy foods, education, employment and transportation, all impact our health outcomes. Social risk factors and social needs increase the risk of, and exacerbate existing, chronic conditions and lead to poorer health outcomes.[5] Additionally, surveys have found that respondents who self-report poor health and higher health care utilization, and who experience high inpatient or ER utilization, are more likely to report multiple unmet social needs.[6]

Comprehensively documenting social risk and social needs data and promoting greater exchange of such data will ensure payers and providers delivering health and non-health care to individuals have a more comprehensive view of the factors affecting an individuals' wellbeing as well as the disparities contributing to health inequities.

However, collecting social needs and risk factor data has proven to be a continuous challenge. Such data is not always routinely or systematically collected across the health care system and often is not collected in a standardized way, making it difficult to integrate into health records, to share across coordinated entities, or to use for purposes of risk adjustment. For instance, a 2020 report from the CMS found that social needs data had only been collected and reported for 1.4 percent of Medicare beneficiaries, a fraction of the likely population with social needs.[7] This information is the foundational first step toward cross-sector and more integrated care models that drive better alignment between health and social needs to improve patient outcomes.

[4] https://aligningforhealth.org/lincact/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/
[6] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/insights-from-the-mckinsey-2019-consumer-social-determinants-of-health-survey
[7] https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf

Therefore, we recommend OMB work with the HHS, and CMS, to encourage and incentivize greater identification, documentation, and exchange of social risk and social needs data across its programs by removing barriers and by providing education and incentives.

Moreover, the siloed way in which health care, public health, and social services are paid for and administered has limited cross-sector coordination and data sharing across organizations in the health and social service sectors. Breaking down the siloes and incentivizing connectivity and coordination between programs and systems will help to ensure that they are most effective in improving health and wellbeing.

Over the past few years, CMS and HHS have made strong investments and taken significant steps to promote and require interoperability and exchange of health data. However, social service and community-based organizations (CBOs) have not benefitted from the same level of infrastructure and systems funding, and often experience difficulty in connecting with and sharing information with health care organizations.

Statewide or regional efforts to connect health care organizations and CBOs for purposes of electronic referrals, outcomes tracking, electronic resource directories, and care coordination help to bridge some of these gaps. Integrated network models like North Carolina's NCCARE360 bring together CBOs, private foundations, health care organizations, and technology vendors to provide a common point of connection and resources, alleviating the burden of multiple one-off connections and exchanges. Coordinated networks also provide users with greater insight on resource availability and allocation across health and social services providers.

We recommend OMB work with HHS to continue to promote, and with Congress to catalyze, further development of such statewide or regional, integrated networks.[8,9]

2. Barrier and Burden Reduction

How can agencies address known burdens or barriers to accessing benefits programs in their assessment of benefits delivery? Are there specific requirements or processes (e.g. in-person visits, frequency of recertification of eligibility) that have been shown in rigorous research to cause program drop-off or churn by underserved individuals and communities?

OMB notes that members of underserved communities may experience a variety of external factors that may disproportionately affect their access to information about programs or program eligibility, or that may serve as a barrier to receiving support for which they are eligible. Barriers such as childcare needs, housing insecurity, limited transportation access, and other factors serve not only as a barrier to accessing benefits and services due to operational complexities, but also affect individuals' health and wellbeing.

Improving coordination of federal programs and services is critical to removing certain barriers faced by individuals in accessing needed benefits and services. States, local governments, health care providers, payers, social services providers, community-based organizations (CBOs), and others are increasingly seeking to partner to better coordinate care and services. However, one of the greatest challenges to

[8] https://acl.gov/framework

[9] https://www.congress.gov/bill/117th-congress/senate-bill/509?s=1&r=17

high-impact interventions is the difficulty in navigating and coordinating fragmented and complex programs aimed at addressing health care needs, food insecurity, housing instability, workforce supports, and transportation reliability, among others. In particular, the siloed funding, data systems, and administration of many of these programs at the state and local, and nongovernmental levels create barriers to effective coordination and partnership.

Aligning for Health supports the bipartisan *Social Determinants Accelerator Act (H.R. 2503),* which would combine targeted technical assistance with grant funding to empower communities to develop Social Determinants Accelerator Plans. These Accelerator Plans would drive innovative, evidence-based interventions, coordinate resources, and identify barriers to integrated systems-level approaches to addressing both the health and social needs of families and individuals on Medicaid. Additionally, the *Social Determinants Accelerator Act* would create an inter-agency technical advisory council on social determinants of health tasked with identifying and coordinating cross-agency opportunities to improve the health and wellbeing of low-income and at-risk populations and to address SDOH.

A related program is currently being implemented by the CDC's newly established Social Determinants of Health Program. The Closing the Gap with Social Determinants Accelerator Plan grant opportunity will provide funding for states and local governments to develop Social Determinants Accelerator Plans to address social determinant needs that lead to improved chronic disease outcomes.[10]

We recommend OMB work with agencies to create, to the extent possible under current law, opportunities for states and local governments to develop strategies to improve cross-sector coordination of programs and services. Additionally, we support the President's fiscal year 2022 funding request to increase funding for the CDC's Social Determinants of Health program from $3 million to $153 million.[11]

Additionally, we encourage OMB to consider advancing policies and strategies that would help to coordinate eligibility and enrollment processes for cross-sector programs. Examples could include:

- Provide flexibility and/or additional funding to states to cross-train and leverage community health workers, eligibility support workers, Navigators, social workers and others to assist with eligibility and enrollment processes, referrals, and other supports and services. Doing so will help individuals to be able to support applicants in understanding, applying for, and enrolling in multiple benefit programs, or to help provide referrals to other non-governmental support.
- Encourage states to integrate and align eligibility and enrollment processes for benefit programs. This could include use of an integrated application and eligibility system, or expansion of express lane eligibility initiatives to include additional populations, allowing individuals to jointly apply for and enroll in programs such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Medicaid, among others.

[10] https://www.cdc.gov/nccdphp/dnpao/state-local-programs/sdoh-2111/SDOH-accelerator-planning.html
[11] https://www.whitehouse.gov/wp-content/uploads/2021/04/FY2022-Discretionary-Request.pdf

3. **Procurement and Contracting**

OMB's Request for Information notes that federal agencies should assess opportunities to invest in underserved individuals and communities, including by promoting business diversity and resiliency and by providing opportunities for underserved individuals and communities.

As federal, state and local government agencies continue to invest in cross-sector strategies to address both health and social needs of individuals and to advance equity, many have sought to leverage blending and braiding of program and operational funding. Blending and braiding provides much needed flexibility to support integrated programmatic needs, and may incorporate federal, state, and local government, as well as nongovernmental sources of funding, to maximize available funding streams. We support additional flexibility for braiding and blending of programmatic funding, where appropriate, to support innovative, integrated program designs. Moreover, it is important for federal agencies to consider ways to ensure that downstream uses of federal funding maximize competitive contracting or participation opportunities for underserved communities, or business and entities representing underserved populations.

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Thank you for the opportunity to share our comments and perspective. Please do not hesitate to reach out if Aligning for Health can be a resource to you. You can contact me at mquick@aligningforhealth.org with any questions.

Sincerely,

Melissa Quick

Melissa Quick, Co-Chair, Aligning for Health