March 30, 2022

The Honorable Richard Hudson
Security Subcommittee
Healthy Future Task Force
U.S. House of Representatives
Washington, DC 20515

The Honorable Tom Cole
Security Subcommittee
Healthy Future Task Force
U.S. House of Representatives
Washington, DC 20515

The Honorable Jim Banks
Security Subcommittee
Healthy Future Task Force
U.S. House of Representatives
Washington, DC 20515

RE: Healthy Future Task Force Security Subcommittee – Request for Information

Dear Representatives Hudson, Cole, and Banks:

Thank you for the opportunity to provide input into the request for information from the Security Subcommittee of the Healthy Future Task Force regarding pandemic preparedness, public health, and supply chains. Aligning for Health was pleased to see questions focused on addressing social determinants of health as part of a broader public health strategy, and writes to provide input regarding this topic.

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. 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-health care organizations to work together to develop cross-sector, coordinated solutions to efficiently and effectively address both health and social needs.

As such, we remain committed to addressing social determinants of health (SDOH) and engaging with Congress to advance bipartisan policies to improve SDOH. Below, we provide comments in response to specific questions posed around social determinants of health and maternal health within the RFI.

Generally, our comments fall into several themes –

- Reduce silos between existing efforts funded by governments and encourage more collaboration.
- Improve the screening and collection of social needs data to improve interventions and evaluate outcomes.
- Enhance coordination between government and non-government organizations working to address social needs through shared regional networks that support coordination, information sharing and referrals.

Social determinants of health are another key driver of healthcare spending. Individual behavior and social and environmental factors are estimated to account for 60% of health care costs.

- ***To what extent do federal health programs already account for and address social determinants of health?***

There is a significant body of academic work showing that economic and social conditions have a powerful impact on individual and population health outcomes. 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 clinical health care is estimated to account for approximately 10-20 percent of health outcomes for a population, health-related behaviors, social and environmental factors (otherwise referred to as social determinants of health) are estimated to account for 80-90 percent of health outcomes.[1] As such, addressing medical care alone is insufficient to ensure better overall health outcomes. Accordingly, we recognize the huge opportunity to impact the overall health and wellbeing of Americans by better addressing social and environmental factors – and potentially preventing or mitigating unnecessary medical care.

Federal health programs under both Republican and Democratic Administrations have increasingly begun to focus on addressing social determinants of health. Recent examples include: the release of long-anticipated guidance from CMS in early January 2021 under the Trump Administration outlining opportunities for state Medicaid and CHIP agencies to address social determinants; the CDC establishing a Social Determinants of Health program to provide funding to state and local governments to develop Social Determinant Accelerator Plans; and the current Administration's plans to incorporate health equity and address social needs throughout CMS Innovation Center models and Medicaid and CHIP.

Congress has also taken steps to address social determinants through the over 270 bills introduced related to social needs in 2021, through efforts such as the creation of the bipartisan Congressional Social Determinants of Health Caucus and through numerous hearings on legislation examining different aspects of health and social needs.

However, while there has been great momentum in addressing social determinants of health at the federal level, many barriers still exist. Several of these are ripe for Congressional leadership and we believe should be considered as part of the Healthy Future Task Force effort:

- Program administration often exists in siloes – funding, eligibility, outcome measures, reporting, and data systems all tend to be program specific. Therefore, efforts to better coordinate care and services provided across health and human service programs, or to reduce burden on individuals applying for or receiving services, are often difficult to accomplish. Demonstration projects that waive certain requirements, allow for braided or blended funding to more efficiently use federal dollars, or shared incentives and outcome metrics can help to break down some of these barriers.

- Improving screening and collection of information on individuals' social needs would be helpful to organizations working to address SDOH. Capturing and reporting such data through electronic health records and other systems of record will help health care providers to have a better

[1] 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.

understanding of a patient's whole health and life history, but allows for data exchange with other health and social service providers. Social needs data can potentially be leveraged alongside health care data to risk adjustment payments or quality in order to provide additional resources to providers working to provide care to more vulnerable and higher risk populations.

- Comprehensive, standardized, and timely data is a key component to successful care coordination and to connect individuals to needed services to address their health and social needs. But data sharing requires ensuring privacy and security protections are in place and that CBOs and other entities have the technical capability and capacity to seamlessly share data with the health care system or health care organizations. Addressing this issue could address siloed program administration.

- Organizations do not always have the ability to see if someone has been referred or successfully connected to social services or government benefit programs, which is a huge disconnect and gap for ensuring individuals have the resources they need.

Addressing some of these barriers would ensure efficiency in addressing social determinants through federal programs and ensure that efforts can better address the health and social needs of individuals.

- ***How can Congress best address the factors that influence overall health outcomes in rural, Tribal, and other underserved areas to improve health outcomes in these communities? What flexibilities or authorities are needed to promote the adoption of policies and strategies in federal health programs to address these social determinants?***

Today's health and social services systems and services are largely siloed, despite clear evidence that social needs can have an impact on overall health and wellbeing. Investments to better align and coordinate between health care and social services providers will yield better, more efficient health interventions, reduce preventable health costs, and keep the most vulnerable populations from falling through the cracks. Reducing these siloes is the best way to make these programs more effective, particularly in rural, Tribal, and underserved areas.

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. Meanwhile, many states are more deeply integrating social determinants of health strategies within their Medicaid programs, with help from CMS.

However, one of the greatest challenges to 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.

There are several opportunities Congress can turn to when thinking about better coordination and alignment between health and social services organizations.

Bolstering CBO capacity is critical, including by providing CBOs with support and assistance in navigating health care partnerships, and in addressing data sharing exchange and privacy concerns. Partnerships between CBOs and trusted community partners such as community health workers or other health care supports close gaps in care and focus on more upstream challenges – improving outcomes.

An example is a "street team" community outreach initiative launched by the Alliance for Better Health during COVID-19 to share information on vaccine safety and increase vaccination appointments in New York's Capital Region. Trusted community messengers trained by the Alliance for Better Health distributed this information and engaged the community in a community-specific, culturally relevant way. This initiative was funded by the Collaborative Approach to Public Goods Investment (CAPGI) model, where a trusted partner like the Alliance convenes stakeholders to invest in a community-wide benefits initiative. Congress can take a more active role in providing supports to these types of collaborations.

Community information exchange (CIEs) or health information exchanges (HIEs) can be leveraged to connect different types of organizations for data sharing purposes. Congress should consider how to best leverage or develop connective infrastructure in states to capture different data sources across federal and other disparate programs. Additionally, data sets do not always include all patient information, which can be a challenge in getting the full picture and knowing which individual is receiving which services. Finding ways for SNAP, WIC, housing-related programs, and other federal programs to become part of the claims data system would be helpful in connecting these dots.

In addition to the above opportunities, Aligning for Health supports several pieces of legislation that seek to improve coordination and provide the tools needed for organizations to effectively address social determinants of health. The bipartisan *Social Determinants Accelerator Act* (H.R. 2503/S. 3039) is an example, which would combine targeted technical assistance with grant funding to empower communities to develop innovative, evidence-based strategies to address social needs. Additionally, the bill would create an inter-agency technical advisory council on social determinants 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.

Other examples of current bipartisan legislative approaches that seek to improve coordination, capacity, and evaluation of SDOH initiatives include:

- The **LINC to Address Social Needs Act (H.R. 6072/S. 509),** which was introduced by Reps. Hudson (R-NC), Walorski (R-IN), Blunt Rochester (D-DE), and Kildee (D-MI), would establish statewide or regional partnerships to better coordinate health care and social services.
- The **Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants of Health Act (H.R. 3894)**, which was introduced by Reps. Bilirakis (R-FL), Blunt Rochester (D-DE), and Ruiz (D-CA), would require the Secretary of HHS to provide guidance and technical assistance to states on how to address social determinants of health through Medicaid and CHIP.
- The **Care That's Fair Act (H.R. 4554),** which was introduced by Reps. Joyce (R-PA) and Butterfield (D-NC), would empower states to utilize medical claims, clinical, and social data to address racial disparities, SDOH, and maternal health.

- The **Addressing Social Determinants in Medicare Advantage Act of 2021 (H.R. 4074),** which was introduced by Reps. Bilirakis (R-FL) and Blumenauer (D-OR), would expand the availability of supplemental benefits to certain Medicare Advantage enrollees.

Improving coordination of federal programs and services is critical to removing certain barriers faced by individuals in accessing needed benefits and services. We encourage Congress 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, and 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.
- Streamline applications for federal programs and enable data sharing across programs that serve the same populations.

Finally, comprehensively screening for both health and social needs will allow providers and other clinicians to gain a better understanding of individuals' full story and the barriers that may impact their health and wellbeing. However, social needs screening and referrals have not traditionally been a part of health screenings and such data is often 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. We recommend that Congress take steps to ensure that individuals are comprehensively screened for both their health and social needs, that the data can be seamlessly collected and exchanged across programs, and to provide training, education, and resources for providers and others to make social needs referrals.

- ***What innovative programs or practices, whether operated by non-governmental entities or local, State, or Tribal governments, might Congress examine for implementation on a national scale?***

Aligning for Health is made up of a coalition of members focused on improving health and wellbeing through interventions related to better aligning health and social needs. Our members are leaders in developing innovative cross-sector partnerships and advancing whole health. Our members represent and serve diverse populations, who often face varying challenges when it comes to having their social needs met. Many organizations, both those within and outside of Aligning for Health's membership, have worked on innovative initiatives to address social determinants of health in the populations they serve.

Aligning for Health member organizations such as the American Hospital Association, Blue Cross Blue Shield Association, Signify Health, Vizient, 3M, and others have shared numerous resources describing their or their members' work to address social determinants.

CareSource's Healthy Beginnings at Home is one example of an innovative initiative to address housing as a social determinant of health for pregnant women and infants. The research project tests the impact of providing rental assistance with housing stabilization services to individuals who are pregnant, living in highly unstable housing, and are at greater risk of infant mortality. The project seeks to ensure needed housing during pregnancy in order to improve maternal and infant health outcomes. Initial results from the initiative found that birth outcomes improved for individuals who received housing intervention services.

UPMC Health Plan's Pathways to Work program recruits individuals to work for the health plan that have the skills that can translate to higher-paid work. The program blends and braids public workforce funding from the Workforce Innovation and Opportunity Act (WIOA), the American Rescue Plan Act (ARPA) and discretionary funding from the Department of Commerce with its own funds to support training and hiring of individuals who are unemployed or underemployed. The Freedom House EMT training provides 10-week EMT training for Medicaid and unemployed individuals in Pittsburgh. Pathways to Work and other programs like it can serve as a ladder for upward mobility for low-wage workers, a notion that was backed by research from the Federal Reserve that explored a skills-based approach to occupational mobility.

Atrium Health is an innovative nonprofit health system serving patients at 40 hospitals and across 1,400 care locations in North Carolina, South Carolina, and Georgia. Across their system, Atrium uses the Community Resource Hub, powered by findhelp, to stratify patient risk and connect patients directly to resources or Community Health Workers who can provide additional support. Community Health Workers and Care Managers use the platform to confirm patients received the help they needed from community organizations and close the loop on referrals to social care. Atrium has dedicated significant resources to this one care model approach, including a Community Impact team in every region and dedicated project managers who focus on building relationships between the health system and community partners. Atrium's bold goal with this one care model approach is to reduce the life expectancy gap in their most underserved communities by 2030.

Signify Health recently partnered with Humana and the Alamo Area Community Network (AACN) to support Medicare Advantage members in San Antonio by connecting individuals in need with health-related social services and community resources. AACN uses Signify Health's technology platform to ensure the entities that are part of AACN can connect individuals to social services and close the loop on referrals between AACN participants, helping to ensure the needs of individuals in the area are being met and better track and understand clinical outcomes over time. The partnership also leverages Social Care Coordinators that help conduct outreach to address unmet needs and improve health and wellbeing. Signify Health has also partnered with Independence Blue Cross in Philadelphia on a similar program.

Among the various examples across the country, Congress may also look to North Carolina's work in advancing innovative reforms aimed at addressing residents' social determinants of health as a best practice that can be replicated in other states and local jurisdictions. As one component of North Carolina's work, the state's Department of Health and Human Services (NCDHHS) worked with Unite Us to establish NCCARE360, a statewide network that unites health, human, and social services organizations in a common system and enables providers to better address community members' social drivers of health through linkages to services that meet basic needs such as housing and transportation. Launched amidst the first wave of the COVID-19 pandemic in May 2020 as part of the State's pandemic response strategy, NCCARE360 has additionally laid the groundwork for longer-term systemic changes focused on

improving health outcomes, access to services, and efficiency across government agencies. For instance, NCDHHS is leveraging NCCARE360 to reimburse community providers for services delivered under the flagship Medicaid Healthy Opportunities Pilots initiative and to support successful reentry for justice-involved individuals returning to their communities from jails and prisons - demonstrating how technology can streamline the delivery of services and reduce silos across government agencies.

How can Congress better utilize existing programs to address the maternal health crisis?

Addressing the maternal mortality crisis in the United States is of utmost concern to our members. A new report from the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics found that the number of maternal deaths rose 14 percent in 2020. There also continues to be stark disparities observed in these trends, as one-third of pregnant women and new mothers who died in 2020 were Black. The maternal mortality rate for non-Hispanic Black women was 2.9 times the rate for non-Hispanic White women in 2020.

Aligning for Health is committed to supporting legislation and policy aimed at addressing maternal health disparities and has been pleased to see further action on maternal health in Congress. We are supportive of legislation such as the bipartisan Maternal Health Quality Improvement Act (H.R. 4387/S. 1675) and the Helping MOMs Act of 2021 (H.R. 3345), as well as components of the Black Maternal Health Momnibus Act of 2021 (H.R. 959/S. 346).

This legislation and others like it would make critical investments in social determinants that influence maternal health outcomes for pregnant and postpartum women; provide funding to community-based organizations that are working to improve maternal health outcomes and promote equity; make investments in community-based programs to support moms with maternal mental health conditions and substance use disorders; and promote innovative payment models to incentivize high-quality maternity care, among other provisions. These are critical actions that require comprehensive, coordinated solutions and we encourage Congress to take action on this legislation.

Addressing the maternal health crisis is a top priority for many of our members, as evidenced by the many initiatives underway to address this issue. For example, the Blue Cross Blue Shield Association (BCBSA) has partnered with the March of Dimes to expand access to its "Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare" training program, which aims to help improve maternal health equity outcomes for moms and babies. This partnership has been implemented in 20 states thus far and will enable companies to offer March of Dimes' implicit bias training to providers, nursing and medical students, perinatal quality collaboratives, community organizations, and their employees. BCBSA and Blues Plans have also made it a goal to reduce racial disparities in maternal health outcomes by 50 percent over the next five years as part of its National Health Equity Strategy.

Signify Health has developed a maternal episodes-of-care program with the Eastern Connecticut Health Network (ECHN). This program looks at the total care an expectant mother receives during all phases of pregnancy, delivery and postpartum, and leads to better outcomes for mothers and babies. Even though this program launched during the pandemic, ECHN elevated their personal care with each expecting mother and, as a result, they have seen good prenatal care return rates.

In 2021, findhelp joined the Indiana Pregnancy Promise Program, a statewide program sponsored by Indiana Family and Social Security Administration (FSSA) and CMS, which is available to pregnant Medicaid beneficiaries who struggle with opioid addiction. Once enrolled, participants receive assessments and

screenings, care coordination, and resources that provide a path to recovery. Statewide partners use findhelp to offer a No Wrong Door approach for participants and care navigators. In support of this program, findhelp has added approximately 300 programs that expand access for this beneficiary population and has enabled connections and referrals to the programs that are aligned with the populations' needs. In addition, findhelp convenes health care collaboratives in Indiana that provide cross-sector collaboration and information sharing leadership, serving as a forum for best practice sharing as it relates to information exchange and interoperability.

What other policy considerations should Congress examine concerning improving public health and public health infrastructure?

The need for coordination across sectors has been emphasized by our experience during COVID-19. Both health care and social service organizations have been forced to rapidly adjust to changing demands on their services – often exposing structural weaknesses in care delivery. Bright spots exist however, where better coordination between health and social service sectors led to stronger, more resilient communities where health and social service organizations were able to respond to the challenge of COVID-19 together.

As you know, the COVID-19 pandemic has laid bare the inequities that exist in our health care system. It has also disproportionately harmed minority and underserved communities, and those with underlying health conditions or other risk factors, which are often exacerbated by existing social determinants of health. More broadly, the pandemic has emphasized the need for improved coordination across sectors to better identify and meet the needs of patients and improve their overall health outcomes, helping to build stronger, more resilient communities.

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 services organizations and 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. Many CBOs do not have the capacity to invest in the tools and functionality required to connect with individual providers or other entities that would allow for seamless closed loop referrals and data exchange.

Technological infrastructure is needed to connect these sectors together and ensure that funding can flow where the referrals are going. These investments to connect health care and social services organizations can help to reimburse CBOs, track capacity, and understand the true cost of and where such organizations are successful in addressing basic needs.

We recommend that Congress work with CMS and HHS to promote and catalyze additional efforts to develop statewide or regional, integrated networks that have the infrastructure necessary to exchange data.

As one such solution, Aligning for Health supports the bipartisan *LINC to Address Social Needs Act (H.R. 6072/S. 509)* as an example of a bill that can address this issue. The bill will assist states in building statewide or regional collaborations to better coordinate health care and social services by leveraging local expertise and technology to help connect people to social services and supports.

The *LINC to Address Social Needs Act* would provide one-time seed funding for states, through representative public-private partnerships, to build or enhance sustainable networks that facilitate cross-

sector communication, service coordination and consumer assistance, referral and capacity management, and outcome tracking between social service providers and health care organizations. The funding may be used to establish or expand existing secure, interoperable technology networks and provide technical assistance and support to entities in connecting to the networks. States will have flexibility to design networks that are responsive to the unique cultures and needs of their state.

This bill will create a new and unprecedented ability to coordinate care and measure the impact of social care interventions on health, health care spending, and community wellbeing. It will also allow health and social services organizations to better coordinate care and ensure maximum impact for available resources.

******

Thank you again for the opportunity to provide comments on this important issue. Please do not hesitate to let us know if you have any questions. I can be reached at mquick@aligningforhealth.org.

Sincerely,

Melissa Quick
Co-Chair, Aligning for Health