# HEALTH STARTS HERE

## A BLUEPRINT FOR ACTION

*CONVERGENCE COLLABORATIVE ON SOCIAL FACTORS OF HEALTH*

JULY 2024

CONVERGENCE

# TABLE OF CONTENTS

# INTRODUCTION

It is now widely understood in the United States that more than good health care is needed to achieve good health in communities and households. A growing body of research indicates that many "upstream" factors, from housing conditions and the availability of good nutrition to the availability of social services and basic education, influence a person's or community's health status. Some experts estimate that as much as **80 percent of a person's health status** may be the result of such factors. And while addressing social factors helps improve the health of people in all communities, the health benefits of tackling them are especially pronounced in underserved communities.

Several terms are applied to these social factors. Currently the most common is social determinants of health (SDOH). Others prefer the less deterministic social "drivers" or "dynamics" of health, while still others put the emphasis on weaknesses in the social influencers of health by using the term "health-related social needs" (HRSN). Unless the context calls for another term, in this Blueprint for Action we generally use SDOH because it is the most widely understood term.

Recognizing this connection between upstream social factors and health, many health systems have begun to form cross-sector partnerships with a range of organizations focused on housing, nutrition, transportation, and other social services. These partnerships seek both to refer patients to social services that are likely to enhance the effectiveness of medical care and to help address deficiencies in upstream social supports that contribute to poor health.

The policy environment is unfortunately not always conducive to these cross-sector partnerships to address SDOH. In general, health policy at the federal and state levels concentrates on the financing and delivery of medical services rather than on encouraging partnerships to address social factors that can undermine health. To be sure, policymakers at all levels of government have been increasingly active in helping to foster more multi-sector partnerships. For example, the federal government has been providing more precise guidance on using social services **in lieu of medical interventions** (ILOS) under Medicaid. The White House and federal agencies also recently distributed a "**playbook**" with **guidance** on addressing SDOH and health-related social needs. Meanwhile, a wide range of states are making use of **Medicaid 1115 waiver requests** to experiment with combining medical and social services, including housing and nutrition, to improve health outcomes for certain populations.


Some researchers suggest that housing conditions, available social services, nutrition, and other social factors account for as much as 80 percent of a person's health status.

**National Academy of Medicine**

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# About the Collaborative

It was to find such agreement that Convergence brought together a group of representative stakeholder organizations and experts from health and social policy organizations. Initially, in a series of three brainstorming sessions, the group sought to identify key themes and questions that would have to be explored to reach agreement. Then the group met as a working Convergence Collaborative over several months to identify an agreed set of policy actions, primarily at the federal and state levels. At these meetings, we also invited several "observers"—organizations and experts, including government officials, who contributed greatly to the discussion but for institutional reasons could not add their names or organizations to a policy statement.

These convenings were supported with generous financial support by **CommonSpirit Health**, the **Episcopal Health Foundation**, and **Kaiser Permanente**. Their commitment to the Convergence process of building consensus among people and organizations with different views and priorities made the project possible.

# About Convergence

Convergence is the leading organization bridging divides to solve critical challenges through collaborative problem solving across ideological, political, and cultural lines. For more than a decade, Convergence has brought together leaders, doers, and experts to build trusting relationships, identify breakthrough solutions, and form unlikely alliances for constructive change on seemingly intractable issues. Our process is improving the lives of Americans and strengthening democracy for a more resilient and collaborative future.

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## MEMBERS OF CONVERGENCE COLLABORATIVE ON SOCIAL FACTORS OF HEALTH

The following individuals and organizations took part in the Convergence Collaborative that achieved this Blueprint for Action. **Involvement in the Collaborative and crafting of the consensus Solutions does not imply that every individual or organization endorses every recommendation.**

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*** Collaborative members have joined in their individual capacities, and institutional affiliations are provided for identification purposes only. The views expressed are those of Collaborative members alone and are written in their personal capacities. As such, those views do not necessarily reflect the views of their employers.**

# AREAS OF CONSENSUS

In the initial brainstorming meetings, the group identified four main themes and associated questions which would need to be resolved in order to reach agreement:

## 1 Improving system integration

The brainstorming group agreed that beyond fostering partnerships among organizations, there must be an updated vision of how the roles of different sectors in addressing SDOH can be better integrated.

## 2 Developing financing approaches

The group wrestled with the challenge of who should finance collaborative structures to advance SDOH goals and how to integrate finances from different sectors and government departments.

## 3 Expanding data and evaluations

Issues associated with data collection, data sharing, and evaluation featured prominently in the preliminary discussions. In addition, the group discussed ways to foster greater experimentation to help build a better understanding of SDOH and ways to integrate programs.

## 4 Building the workforce

A frequent concern raised during the preliminary discussions was that "it is not really anyone's job" to encourage or oversee cross-sector and cross-departmental collaboration. The group discussed the importance of identifying who and what bodies should lead coordination and how to provide them with the necessary authority and support.

A summary of these discussions and the questions raised under each theme is available as a **Discovery Report** on Social Factors of Health.

Over several months following the brainstorming sessions, the stakeholders, experts, and observers met to seek agreement on a set of specific consensus solutions, both administrative and legislative at the federal and state level, that would create the best policy environment for local efforts and partnerships to address SDOH.

These consensus solutions build on work already undertaken and proposals already advanced. In general, the solutions did not involve new research, and many reflect other proposals already advanced by members of the Collaborative and others. For example, some consensus solutions reflect the working groups of the Partnership to Align Social Care, and the work of other organizations, such as the National Alliance to impact the Social Determinants of Health. Some are inspired by the actions of states and federal agencies, such as the Administration for Community Living. And many arise from policy positions which were first advanced by members of the Collaborative.

# AREAS OF CONSENSUS

As a set of policy solutions, they have three important characteristics:

**The Collaborative Members broadly agree on the solutions.**

**The Collaborative members agree these are priority actions, and that the administrative actions could be accomplished quickly.**

**The consensus solutions would help align the policy positions of the many organizations and individuals in the Collaborative.**

To reach agreement, members of the Collaborative had to resolve disagreements and bridge differences of preferred approach on several issues. For instance, there were sometimes challenging conversations on the choice and roles of community hubs in facilitating partnerships and the degree to which criteria should be established for hubs. There were also disagreements about the financing of SDOH initiatives. But thanks in part to the trust built up during the process, and in some instances a willingness to explore language that could accommodate contrasting views about the details of a recommendation, the group was able to find agreement on most issues they discussed.

The consensus solutions in this Blueprint for Action thus seek to create the best achievable policy environment for upstream local initiatives to improve household and community-level health by addressing SDOH. The focus is on administrative and statutory policies at the federal and state levels. The consensus solutions have the support of the listed organizations and individuals, who are drawn from health care, social services, housing, nutrition, and other sectors.

**The consensus solutions are grouped into four categories.**

- **Improving System Integration**
- **Building an SDOH Workforce**
- **Financing SDOH Approaches**
- **Addressing Data Sharing, Evaluation, and Experimentation**

# IMPROVING SYSTEM INTEGRATION

Collaborative members emphasized that inadequate collaboration and obstacles to local collaboration are major impediments to SDOH goals and that improved collaboration across social and health sectors, and between levels of private and public organizations, is essential for effective SDOH strategies. Achieving the necessary level of collaboration requires improving system integration.

## CONSENSUS SOLUTIONS

- Building on the release in 2023 of the federal SDOH "Playbook" and the clarification of Medicaid ILOS and settings rules, as well as similar playbooks from the private sector, states and the federal government should undertake a coordinated initiative to provide greater clarity and guidance. This should include more consistent compliance guidance on what cities and other local governments, and community-based organizations (CBOs), can do regarding SDOH-related coordination under existing laws and regulations. This should include more specific guidance on how CBOs can function as community care hubs. In this guidance, definitions and eligibility requirements should be harmonized across departments and programs.
- The federal government and states should revise regulations and undertake legislative actions to provide greater flexibility for braiding funds from different programs and better procedures for data sharing. In addition to the need for clarity and coordination, the federal government should issue clear and consistent guidance on what forms of braiding and blending of funds from which programs is permissible under existing program regulations and statutes.
- The federal government and states should consider creating and funding special high-level bodies with the charge of better coordinating programs across departments to advance SDOH initiatives, perhaps modeled on state Children's Cabinets and the Interagency Council on the Homeless, and State No Wrong Door Governance bodies. Ideally, this should be a funded task given to existing coordinating and policy bodies that already have the authority and can receive funding to revise regulations. These bodies should not impose a top-down vision of local coordination, but should instead foster local partnerships and initiatives.
- In order to expand housing-health partnerships and service coordination, the departments of Health and Human Services (HHS) and Housing and Urban Development (HUD) should expand grant information, data and other technical assistance which the agencies provide to states, cities and other local government, CBOs, and community care hubs.
- Congress should consider the Housing ACCESS Act, which would require joint guidance by Treasury, HUD, and HHS (especially the Centers for Medicare and Medicaid Services (CMS)) on how local organizations can combine housing tax credits, operating subsidies, and Medicaid to create supportive housing.
- CMS, with HUD and other agencies, should re-examine Medicaid ILOS rules to make it easier to use and pay for a wider range of services.

Outreach into the community, often led by health systems, hospitals, and Federally Qualified Health Centers (FQHCs) is being undertaken in many areas and is encouraged by such things as mission, community benefit requirements on non-profit hospitals, and Medicare readmission penalties. Direct partnerships between health organizations and CBOs should be encouraged. But greater incentives and funding are needed to expand outreach and impact by empowering and supporting "community hubs" or "backbone organizations" and to ensure that they have the capacity to become more sophisticated and powerful local fulcrums of SDOH-related cross-sector collaboration at the community level. Collaborative members raised concerns, however. One was that although hubs need certain strengths and characteristics, and a staff team skilled in coordination to help develop and support partnerships and coordination, the best type of hub may differ in each community. Moreover, while certain functions and capacities appear important, it seemed too early to many Collaborative members to specify necessary features for all hubs. So, it was generally agreed that design flexibility is critical, and that it is premature to consider accreditation or standardization. Instead, it is essential to encourage innovation, with different models being tried, and to ensure that hubs are evaluated, and their lessons and key features identified. Another, related, concern was that, if states or the federal government specify hub requirements too precisely, hubs will likely become rigid and bureaucratized and more remote from their communities.

## CONSENSUS SOLUTIONS

- In general, hubs in different communities should not compete with each other but should form a network across counties and states. They should be trusted, community-focused, and neutral in fostering collaboration. In many cases, if supported by local CBOs and by the state or county, they should be permitted to help coordinate funds and be themselves funded to help carry out "back office" functions for smaller CBOs (e.g., reporting on grants and analyzing data).

- The federal government and states should identify the potential for some CBOs, such as housing associations, church-based organizations, community schools and charter schools, Community Development Corporations, FQHCs, etc., to act as specialized community hubs within a network or as partners with a larger hub. To assist this process, the federal government and states should undertake surveys and launch pilots to identify what changes in regulations, direct funding for overhead and the provision of multiple services, and workforce payment systems would help CBOs to launch these specialty CBOs.

- Congress should authorize funds for a capacity building program to help community hubs and CBOs develop the capacity to address SDOH. To benefit from their lived experience and local knowledge, members of the community should comprise the majority of the governing board of a hub, similar to the community member requirements for FQHCs.

- In order to indicate to CBOs and other service providers in a community that a hub has the capacity to handle support from federal funders, a hub must be able to demonstrate to potential partners and funders that it has the ability to braid funds and coordinate multi-sector services. If the partners and funders are satisfied, a hub should be given greater flexibility and technical support and allowed higher federal payment rates when handling federal funds.

- In order to indicate to CBOs and other service providers in a community that a hub has the capacity to handle support from federal funders, a hub must be able to demonstrate to potential partners and funders that it has the ability to braid funds and coordinate multi-sector services. If the partners and funders are satisfied, a hub should be given greater flexibility and technical support and allowed higher federal payment rates when handling federal funds.

- States should also foster the creation and strengthening of hubs that demonstrate the ability to carry out the necessary functions and CBO partnerships. Several states have already enacted legislation or are using Medicaid 1115 waivers to do so, including California, New Jersey, New York, Ohio, and Washington. State legislation can direct funding and support to a set of regional hubs for core infrastructure and provide access to relevant departmental data to facilitate cross-sector referrals, etc. Under Medicaid 1115 waivers, states could require Medicaid Managed Care Organizations (MCOs) to contract with CBOs from different sectors as full partners. Other states should examine such statutes and waivers and develop their own versions of these measures, making full use of the SDOH "playbooks" developed by the federal government and expert organizations. In all these efforts, it is critically important for states to ensure that reimbursements to CBOs reflect the services they provide, adequate overhead, and that the CBOs are fully involved in case management. Client information also needs to be shared appropriately between hubs and their partners and between state agencies.

- Public health agencies, especially at the county level, should increase their role in identifying SDOH concerns and understanding the lived experience of community residents. The agencies should work effectively with hubs and other departments to identify needs and help coordinate and deliver services.

# BUILDING AN SDOH WORKFORCE

Many in the health and social service workforce do not have the training, resources, flexibility, or authority needed to coordinate services across sectors to tackle social needs that affect a person's health. Collaborative members emphasized that it is often nobody's explicit job to coordinate multisector services. They also noted that training and licensing requirements and job descriptions often do not reflect the skills and responsibilities needed to achieve multisector coordination and that payment structures rarely provide adequate incentives and rewards for success. Success in addressing SDOH in a community, identifying a person's HRSNs, and coordinating services requires trusted community-based workers with strong local knowledge. Community Health Workers (CHWs), social workers, and similar professionals typically have these attributes. For any community, however, a team with workers at different decision levels is needed, and the best team depends on community characteristics. These considerations led the Collaborative to support several steps.

## CONSENSUS SOLUTIONS

- Effective coordination requires people with skills who have the necessary authority to coordinate services at different levels (i.e. from the "street" level to the federal level). CHWs can be very effective coordinators of services, and social workers are also trained for this work. Other professionals often are also effective coordinators. It should be up to communities and hubs to decide what team of workers functions best as coordinators.
- Workers in local communities should be recognized by public and private payers as primary professional service coordinators for SDOH strategies in communities, and provided with appropriate training, licensing, and authority.
- CMS should build care coordination costs into payments for Medicaid and Medicare services, just as Medicare reimbursements to hospitals include a portion for capital costs. Social workers and other non-medical workers should be eligible to receive payment under service agreements.
- CMS should provide specific guidance to states, hubs, and health plans on how they may categorize services and identify outcomes as a quality improvement cost for billing purposes when they are delivered by a hub or other coordinator.
- HHS, HUD, and other agencies should build on the November 2023 Playbook and Call to Action by providing greater opportunities for communities to use public funds to finance coordinators involved in the delivery to households of services from different programs.

# FINANCING SDOH APPROACHES

Upfront investments in non-clinical social services, and in the "infrastructure" of collaboration, are needed to achieve downstream gains. This raises questions about appropriate sources of SDOH funding and the possible implications for SDOH initiatives of different funding strategies. In addition, both public and private finance approaches are often subject to "wrong pockets" disincentives that need to be addressed (wrong pockets disincentives arise when one organization or department funds an investment, but another organization or department accrues most of the benefit). Investing in upstream SDOH strategies typically also benefits both the public and private sectors downstream and is an example of where it would usually make sense for both sectors to invest as partners in the local community, including in local businesses and institutions to strengthen the community while addressing SDOH. There was some disagreement among Collaborative members regarding the financial obligations and benefits for public and private sector partners, and the concern that health sector financing can lead to the "overmedicalization" of social services. But it was agreed that typically both government and private investment is needed and appropriate. It was also agreed that policy changes should ensure that budget rules, payment systems, etc., should make such community investment a logical business or public investment decision; that is often not the case today.

## CONSENSUS SOLUTIONS

The federal government should undertake a review of federal housing, social service, and other programs that impact health to explore the extent to which there could be significant improvements in individual and community health through a different allocation of existing funds, and how health investments impact the broader community. This review should also explore the impact of providing more flexibility in categorical grants to allow hubs to "braid and blend" funds from different sources. The review might be conducted by a special commission, a congressionally-mandated commission, or by an existing review institution such as the newly established Council on Federal Financial Assistance. Federal agencies also should raise awareness across federal and state partners of existing policy toolkits for braiding and blending funds, such as Blending and Braiding Funds: Opportunities to Strengthen State and Local Data and Evaluation Capacity in Human Services (2023) by The Policy Lab at Brown University, and the 2023 federal Playbook and Call to Action.

SDOH activities that improve health and reduce health care costs should be part of the basic operations of the public and private sectors. But currently, SDOH spending is often seen as corporate philanthropy, because payments do not align with the better outcomes achieved by addressing SDOH. Government investment in SDOH is often blunted by budget rules resulting in wrong pockets obstacles. Thus, a task force of foundations, representative CBOs, universities, major institutions in health care, housing, social services, nutrition, banking, and government-related bodies should explore budgeting tools to identify the multisector benefits and cost savings associated with SDOH investments. The task force should also explore how the value improvements or cost reductions resulting from SDOH investments might be shared among the sector partners involved, including the public sector.

- Medicaid 1115 waivers in recent years, in states such as Arkansas, Oregon, North Carolina, New York, and Massachusetts, have allowed states to use some federal Medicaid funds to pay for some housing, nutrition, and other non-medical services in experimental programs seeking to improve outcomes for some high-cost populations. These state-led actions are testing SDOH strategies. Thus, with the encouragement of the federal government through the waiver process, states should expand efforts to encourage health plans to launch and evaluate SDOH strategies that prominently include community providers, representatives, and institutions. CMS should also expand its convenings and other work with states to ensure that the lessons from these waivers are fully understood.

- Some states, such as California, have used Medicaid contracts to require health plans and Medicaid agencies to work more closely with local organizations, such as by requiring plans to contract with CBOs providing services and incorporate community organizations in an advisory capacity. Other states should consider such requirements to foster collaboration on SDOH strategies, with a focus on community hubs to streamline and coordinate activities and strengthen initiatives.

- Recent changes in IRS rules for nonprofit hospitals' community benefit requirements have made it clear that investments in screening, referral systems, and other SDOH-related activities may be reported as a community benefit. The approach of IRS requirements and guidance in this area should be to foster innovation through meaningful financial commitments. Building on this, the Treasury, in partnership with CMS, should review how guidance on community benefit requirements, and the obligations of financial institutions under the Community Reinvestment Act obligations, can be coordinated to permit more joint finance-health SDOH ventures in underserved communities.

Collaborative members seek to create a policy environment that encourages stakeholders in a community to invest in strengthening individual and population health by improving the community's priority social factors of health. The Affordable Care Act's Medical Loss Ratio (MLR) formula sets a minimum percentage of health plan spending that must be devoted to medical services and wellness and health activities to improve health care quality, rather than overhead and other administrative costs. How investments in health-improving SDOH are defined for the purposes of the MLR formula influences health plans' investments in SDOH. Collaborative members generally wish to encourage health plan investments in SDOH initiatives, and many members support allowing such investments to be considered as part of the MLR's required percentage of health care services and activities, instead of as administrative expenses. But members also raised two issues: the scope of expenditures that should be considered "medical services and health care quality improvement activities," and concern that including SDOH-related investments would strain the pool of available funding and misalign distribution of funds.

Although a May 2024 CMS final rule, **Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality**, attempted to clear up confusion around which SDOH-related activities may be included in the MLR numerator and to align public health plan rules with those for private health plans, vagueness and uncertainty remain. Collaborative members agree that several steps related to MLR are needed to provide better incentives for health insurance systems to scale, sustain, and expand their SDOH efforts, and foster partnerships between health systems and housing organizations, schools, food services, and other services. These steps would also encourage plans to provide more funding for HRSN screening, community health workers, data systems, hub services, and other elements of SDOH infrastructure. Collaborative members seek clarifications and changes to broaden the social factor interventions considered within the numerator of the MLR formula and seek to protect available federal funding for social factor interventions.

## CONSENSUS SOLUTIONS

**Clarify CMS Guidance**. CMS should publish clear and consistent guidance for public and private health plans that explicitly specifies permissible non-clinical SDOH and HRSN services and supports, which may be included in MLR numerator calculations as wellness and health activities to improve health care quality. Appropriate spending on these services should be regarded as a quality improvement activity rather than an administrative cost, as it leads to measurable improvements in health outcomes and reduced health disparities. The guidance should:

- Distinguish and provide context regarding impermissible "general utility" services and supports, which CMS excludes for purposes of the MLR numerator.
- Include as permissible activities to improve health care quality: community health workers; HRSN screenings; and navigation, referral, and coordination of services, non-claims enrollee outreach activity expenses, and food as medicine/ nutrition security initiatives such as produce prescriptions and other initiatives designed to address SDOH and HRSN to promote holistic, beneficiary-centered care.
- Include as permissible activities: costs of evidence-based interventions that offset social service barriers to care, such as investments in CBOs that support value-based payments. For example, recent legislation in Texas permits Medicaid MCOs in the state's STAR program to include such services as quality improvement costs.

**Protect and broaden funding for Quality Improvement Activities (QIA)**. Congress should not cap or otherwise limit allowable "activities that improve health care quality" in 45 CFR § 158.150(b) and are not excluded under 45 CFR § 158.150(c) in calculating the MLR.

**Convene stakeholders regularly to update QIA.** CMS should convene "state of the evidence" conferences with the intent of reaching three outcomes:

- A robust set of social service billing codes which are applicable to all public and private payors for wellness and health activities to improve health care quality;
- A strategy-to-action framework to align across public and private payors the criteria for permissible payments of public funds for innovative, not-specifically-billable SDOH/HRSN approaches, and;
- Further development of the Accountable Care Organization Investment Model and the AHEAD Model and drive innovation with expansion to community care hubs. Payment for identified wellness and health activities to improve health care quality should be permissible costs included in the MLR numerator.

Collaborative members note that agreement on how, and by whom, investment for SDOH strategies should be paid for still leaves questions on how the optimal level of finance can be raised and what public policies would create the best environment to encourage SDOH-related investment.

## CONSENSUS SOLUTIONS

- States should explore a variety of ways to generate long term funding for SDOH initiatives. For example, and in addition to public funding, states and local governments should examine the potential of revolving loan funds, pay for success and tax credit models, and other collaborative approaches using long-term private-sector financing, including social impact bonds.
- Health plans should explore "co-opetition" and other joint private funding approaches to help provide a more adequate level of private financing for the infrastructure to support local cross-sector collaboration. In these approaches, competing firms jointly fund infrastructure that they expect will improve the outcomes for each firm. The federal government should provide guidance on how joint funding can avoid anti-trust concerns, and states should provide additional guidance and flexibility.
- Federal, state, and local governments should explore budget process reforms, such as portfolio budgeting and earmarking multi-department funds, and other ways to pool funds from different departments to help ameliorate wrong pocket disincentives for collaborative financing by different departments.

# ADDRESSING DATA SHARING, EVALUATION, AND EXPERIMENTATION

Collaborative members felt that improving the collection and use of data is a critical element in fostering collaboration to advance SDOH approaches. For example, they see data sharing as essential for effective screening and then for successful referrals. Accurate and timely data is also needed to measure the effectiveness of SDOH strategies and to build a more complete understanding of the connection between nutrition, housing, education, transportation, other factors, and community health. Improved data and cost-benefit tools are also seen as important for measuring the broader multi-sector impacts of an SDOH investment. The federal government and states need to consider several steps to help build a cross-sector information infrastructure.

## CONSENSUS SOLUTIONS

- The federal government should share consistent guidance and best-practice examples with CBOs, hubs, housing providers, cities, and local governments on how to avoid breaching existing privacy rules in SDOH data-sharing partnerships. As necessary, the federal government should also review and amend HIPAA, FERPA, and other privacy rules that discourage data sharing.

- Health systems, communities, states, and other institutions and levels of government should share lessons from experiments with different data sharing and referral models. Philanthropic organizations could support convenings where lessons are shared.

- Congress should consider the Social Determinants Accelerator Act and the Leveraging Integrated Networks in Communities (LINC) Act. If enacted and funded, the provisions of these measures would be modest but important steps to help states and local government to increase collaboration to address SDOH.

- Congress should provide financial assistance to hubs and CBOs to develop data systems, as it did for hospitals under the HITECH program. This action would build on the new Uniform Guidance released in April 2024, issued by the Office of Management and Budget, which clarifies that federal grants may be used to build information technology capacity and evaluation.

- The federal government should improve coordination within agencies including HUD, and between agencies, to address barriers in creating seamless data sharing and referral systems for social services. Social service organizations have grown frustrated at the slow progress in helping them to create seamless data systems that can connect with health data systems. Similarly, the federal government should improve the integration of SNAP, WIC, and Medicaid data so that nutrition benefits can be better coordinated with health services. The role of HHS Office of the National Coordinator for Health Information Technology (ONC) **leading the development and harmonization of interoperability and standards between health and human services** can help to advance seamless data sharing, including in referrals, claims, and navigation tracking systems for social services. ONC also **works to incorporate relevant health IT standards as appropriate and feasible into programs across HHS**.

- The federal government should actively engage state and local government data leaders to identify collaborative opportunities to strengthen federal, state, and local data to address SDOH. This should build on recent revisions to OMB's Uniform Guidance that allow federal grants to be used for data and evaluation. The federal government should also stress the degree to which grants can also be used for data systems to enhance community engagement. This action should acknowledge and build on ongoing implementation efforts for Community Health Integration (CHI) and Principal Illness Navigation (PIN) services codes included in the 2024 Physician Fee Schedule Final Rule.

- The White House Deputy Chief Technology Officer and OMB's Office of Federal Financial Management should launch a campaign to expand state and local adoption of innovative financing mechanisms that leverage federal funds from multiple sources to sustain and enhance integrated data and social service systems that can address SDOH. Onerous regulatory and reporting requirements discovered during the campaign should be referred back for modification or greater flexibility.

- The Federal Chief Data Officers (CDOs) Council should convene federal and state CDOs that steward data sets that, if merged, can produce actionable insights for decision-makers at every level. The convening should establish shared objectives for focused collaborations that would address social determinants, including: identifying key questions that require merging individual and community-level data across programs and levels of government; identifying best practices and barriers (perceived and real); developing common terms and uniform standards; and setting up working groups to overcome barriers and facilitating matchmaking of solutions-oriented federal and state officials to move forward improvements.

The Collaborative members pointed to continuous experimentation and evaluation as critical for discovering better techniques to achieve policy objectives. Different SDOH approaches have been introduced in a variety of ways. Nutrition, transportation, and various social services, for instance, can now be included as additional benefits available under Medicare Advantage plans. Under the Accountable Health Communities model, which was launched in 2017, over 30 organizations received funds from the CMS Innovation Center to screen Medicare and Medicaid beneficiaries for HRSNs such as food or housing insecurity and address those needs. Also, a growing feature of Medicaid 1115 state waivers is exploring and evaluating a variety of approaches to SDOH. The Collaborative agreed that making wider use of government-sponsored experimentation, with careful evaluation, would accelerate our understanding of SDOH techniques and encourage innovation.

## CONSENSUS SOLUTIONS

- CMS should expand the number and range of pilots related to SDOH while simplifying the application process, pushing the envelope on its authority to launch pilots, and seeking more congressional authority as necessary.

- To improve the broader usefulness of pilots and waivers, and partnerships with CBOs launched by health systems, states should provide data and financial resources to explore the wider impacts of an initiative. For example, with the support of the federal government, state Medicaid agencies could explore the statewide implications; various state agencies could help investigate the cross-sector impacts of, say, a health system investment in housing or nutrition.

- The Administration should encourage more states to request Medicaid 1115 waivers to test the potential of new SDOH approaches. Recent waivers, in Arkansas, Oregon, New York, California, North Carolina, and other states are testing the effect on health outcomes of a variety of SDOH-related services, such as improved nutrition assistance. Drawing from this experimentation, the federal government should use 1115 waivers to explore such opportunities as more flexible ILOS and payment rules, and other approaches to addressing SDOH. To ensure that current and a greater volume of future waiver applications are handled more swiftly, CMS should be provided with sufficient funding and staff. States should also ensure that waiver applications are adequately staffed.

- Building on recent Medicaid 1115 waivers that permit housing supports and nutrition, Congress should consider statutory changes to broaden Medicaid 1115 waiver authority for SDOH strategies by allowing limited funds from a wider range of other programs to be included in the determination of federal budget neutrality.

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