Updates from NASDOH on the National Landscape of NMDOH Policies

June 27, 2024

NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

Agenda

- Background on NASDOH
- Federal Policy Landscape
- Future of SDOH Policy
- Q & A

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NASDOH

ABOUT US

NASDOH is a multi-sector coalition of stakeholders working to advance widespread adoption of effective policies and programs to address health-related social needs as well as the underlying social and economic conditions in which people live—often called social determinants of health (SDOH). NASDOH was founded in 2018 by Governor Mike Leavitt and Dr. Karen DeSalvo to address these issues as a pivotal element in the transformation toward value-based care.

OUR MISSION

NASDOH's mission is to advance widespread adoption of effective policies and programs to address SDOH. NASDOH's work focuses on improving regulatory and reimbursement frameworks, supporting funding opportunities, and addressing practical challenges to implementing and sustaining public and private sector efforts to address SDOH as a core component of advancing health equity.

2024 Updated Goals

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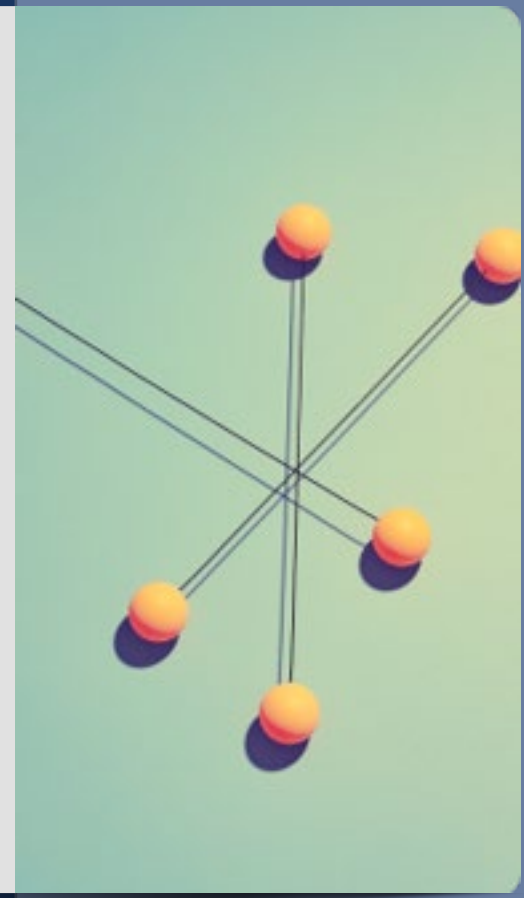
GOAL 1. Advocate for sustainable, scalable, and coordinated multi-sector efforts to address SDOH as a core component of advancing health equity.	Goal 2: Embed identifying and addressing social needs into the delivery and payment of care.	Goal 3. Advance efforts to address upstream drivers of health.
• NASDOH's goal is that there will be widespread adoption of effective policies and programs to address SDOH and social needs. This requires an ongoing commitment from health care, public health, and social care sectors to embed SDOH policies into programs beyond pilots and demonstrations, and ensure funding streams support coordinated, sustained, multi-sector efforts.	• Addressing social needs is a critical part of an overall approach to improving health and wellbeing and embedded efforts necessitate appropriate support and compensation for enhancing the social service structure.	• NASDOH's goal is to impact the underlying conditions which drive health outcomes. NASDOH will pursue opportunities to advance progress on SDOH and the upstream drivers of health.

NASDOH Members

NASDOH brings together stakeholders from different geographic regions with expertise in health care, public health, social services, patient and consumer perspectives, information technology, and business. NASDOH members include national, regional, and local organizations that share a commitment to addressing SDOH as a core component of advancing health equity. As a multi-sector alliance, NASDOH brings together and leverages the unique capabilities and perspectives of its members to have an outsized impact on SDOH policy.

Federal Policy Landscape



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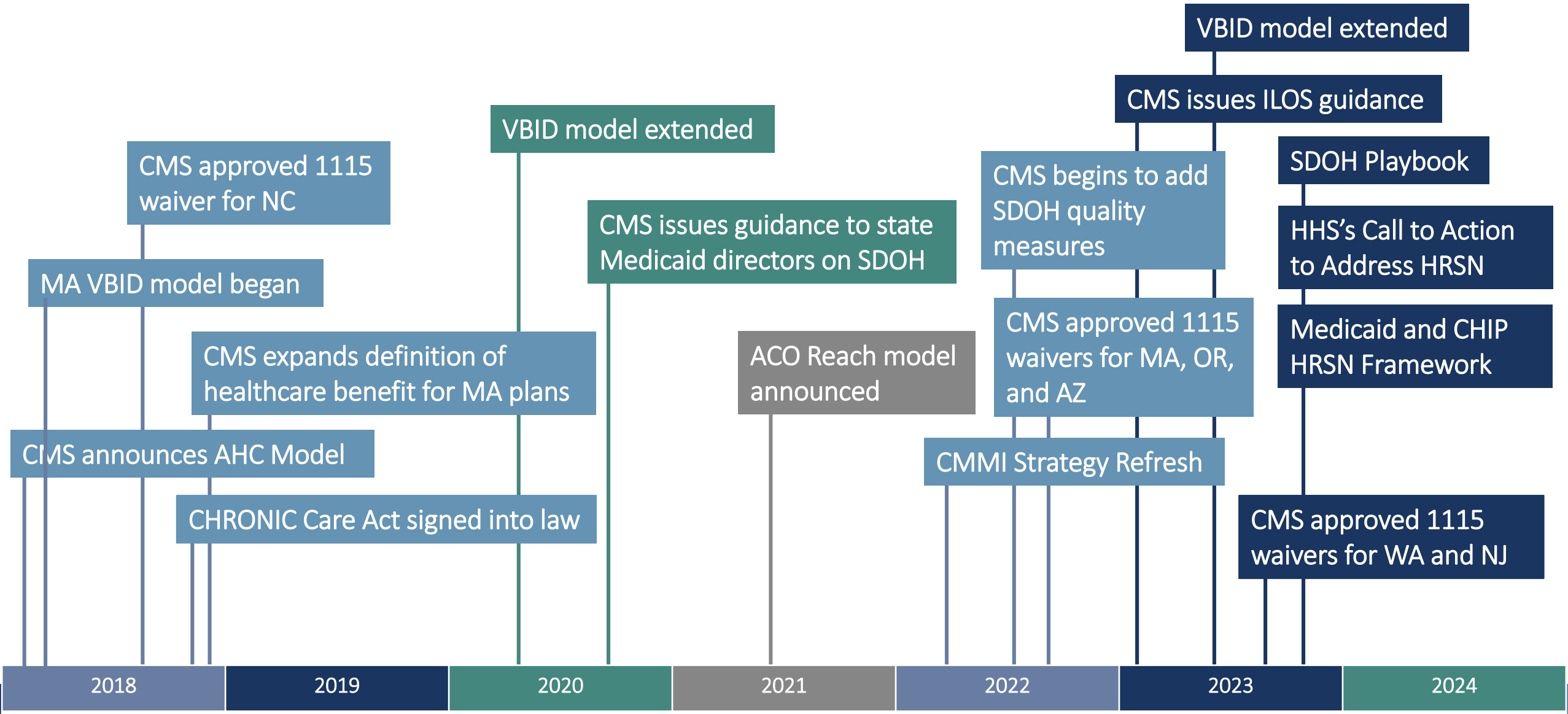
Major Federal Policy Developments



Highlighting Significant SDOH Developments

Medicare

- **Before 2021**
  - CHRONIC Act allowed MA plans to offer non-primarily health-related Special Supplemental Benefits for the Chronically Ill (SSBCI).
- **After 2021**
  - Quality Measures

Medicaid

- **Before 2021**
  - NC 1115 waiver
  - SHO letter on SDOH
- **After 2021**
  - ILOS Guidance
  - 1115 waiver approvals
  - HRSN Framework

CMMI

- **Before 2021**
  - AHC Model
  - Value-Based Insurance Design (VBID) model
- **After 2021**
  - Strategy Refresh

Other

- **Before 2021**
- **After 2021**
  - ASPE 3-prong strategy for SDOH and evidence review
  - SDOH Playbook
  - Hunger and Nutrition Conference
  - CDC and ACL grants

Highlights: Medicare Advantage

- In 2019, CMS **changed the definition of "primarily health-related" benefits for MA** plans to include benefits such as adult day health services, home-based palliative care, therapeutic massage, support for caregivers of enrollees, and in-home support services to help enrollees with activities such as dressing, eating, and housework. xii A recent report by the Government Accountability Office (GAO) found that almost one-quarter of the plans that were reviewed for the report offered at least one these expanded primarily health-related supplemental benefits in 2022.
- Beginning in 2020, the CHRONIC Act allowed MA plans to offer **non-primarily health-related Special Supplemental Benefits for the Chronically Ill (SSBCI).** These supplemental benefits include services such as non-medical transportation, home modifications, general support for care at home, and pest control.
- In 2024, CMS finalized **new guardrails for SSBCI** to ensure that these supplemental benefits offered by an MA plan meet the health needs of people with Medicare by being supported by evidence. The rule also requires MA plans to send a mid-year, personalized communication to their enrollees about accessing unused supplemental benefits.

SDOH-Related Policies in Recent Medicare Rules

CY2024 Physician Fee Schedule Rule (finalized)

- CMS added a new **SDOH Risk Assessment** as an optional, additional element with an additional payment to Medicare coverage for the Annual Wellness Visit (AWV) and added a new HCPCS code, GXXX5, to allow practitioners to bill Medicare for administering a standardized SDOH screening tool during certain evaluation and management visits.
  - NASDOH supported
- CMS finalized a policy to **pay separately for Community Health Integration (CHI), Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation (PIN)** services. CHI and PIN services involve a person-centered assessment to better understand the patient's life story, care coordination, contextualizing health education, building patient self-advocacy skills, health system navigation, facilitating behavioral change, providing social and emotional support, and facilitating access to community-based social services to address unmet social needs.
  - NASDOH supported

Highlights: Quality Measures

Program	Measure				
	Screening for Social Drivers of Health	Screen Positive Rate for Social Drivers of Health	Social Needs Screening and Intervention (SNS-E) Measure	Connection to Community Service Provider	Hospital/Facility Commitment to Health Equity
Hospital Inpatient Quality Reporting Program	Required	Required			Required
Merit Based Incentive Payment System (MIPS)	Included			Included	
Healthcare Effectiveness and Intervention Data Set (HEDIS)			Required		
Medicare Shared Savings Program/Alternative Payment Model Performance Pathway	Possible adoption in 2025 within Universal Foundation measure set	Possible adoption in 2025 within Universal Foundation measure set			
Inpatient Psychiatric Facility Quality Reporting Program	CMS is adopting the Screening for Social Drivers of Health (SDOH) measure beginning with voluntary reporting of CY 2024 data and required reporting beginning with the FY 2027 payment determination.	CMS is adopting the Screen Positive Rate for SDOH measure beginning with voluntary reporting of CY 2024 data and required reporting beginning with the FY 2027 payment determination.			CMS is adopting the Facility Commitment to Health Equity measure beginning with the FY 2026 payment determination.
PPS-Exempt Cancer Hospital Quality Reporting Program	Required starting in FY2026	Required starting in FY2026			Required starting in FY2026

Highlights: Medicaid 1115 Waivers

- In October 2018, CMS approved North Carolina's Section 1115 waiver focused on addressing social needs for high-risk, high-cost beneficiaries through Health Opportunity Pilots. The pilot address housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress for a limited number of high-need enrollees.
- Since the approval of North Carolina's waiver, many other states have implemented an 1115 waiver to address social needs and SDOH and additional states have pending 1115 waivers. As of April 23, 2024, there are:
  - **20 approved** 1115 waivers to address social needs and SDOH.
  - **17 pending** 1115 waivers to address social needs and SDOH.

	Infrastructure Funding or Delivery System Changes	Housing Supports	Nutrition Supports	Employment Supports	Medical Respite
Approved	10	18	8	5	5

Source: KFF

Medicaid Authorities and Options to Address Social Determinants of Health

State Plan Authority	Section 1115 Waivers	Medicaid Managed Care Flexibility	Integrated Care Models
• Optional State Plan services (e.g., peer supports, case management) • ACA Health Home option	• Federal matching funds to test SDOH-related services and supports • Alternative payment models (APMs)	• In-lieu-of services • Value-added services • Procurement strategies • Contract requirements • State-directed payments	• Patient-centered medical homes (PCHMs) • Accountable Care Organizations (ACOs)

Source: adapted from Kaiser Family Foundation

CMS Innovation Center Strategy Refresh (2022)

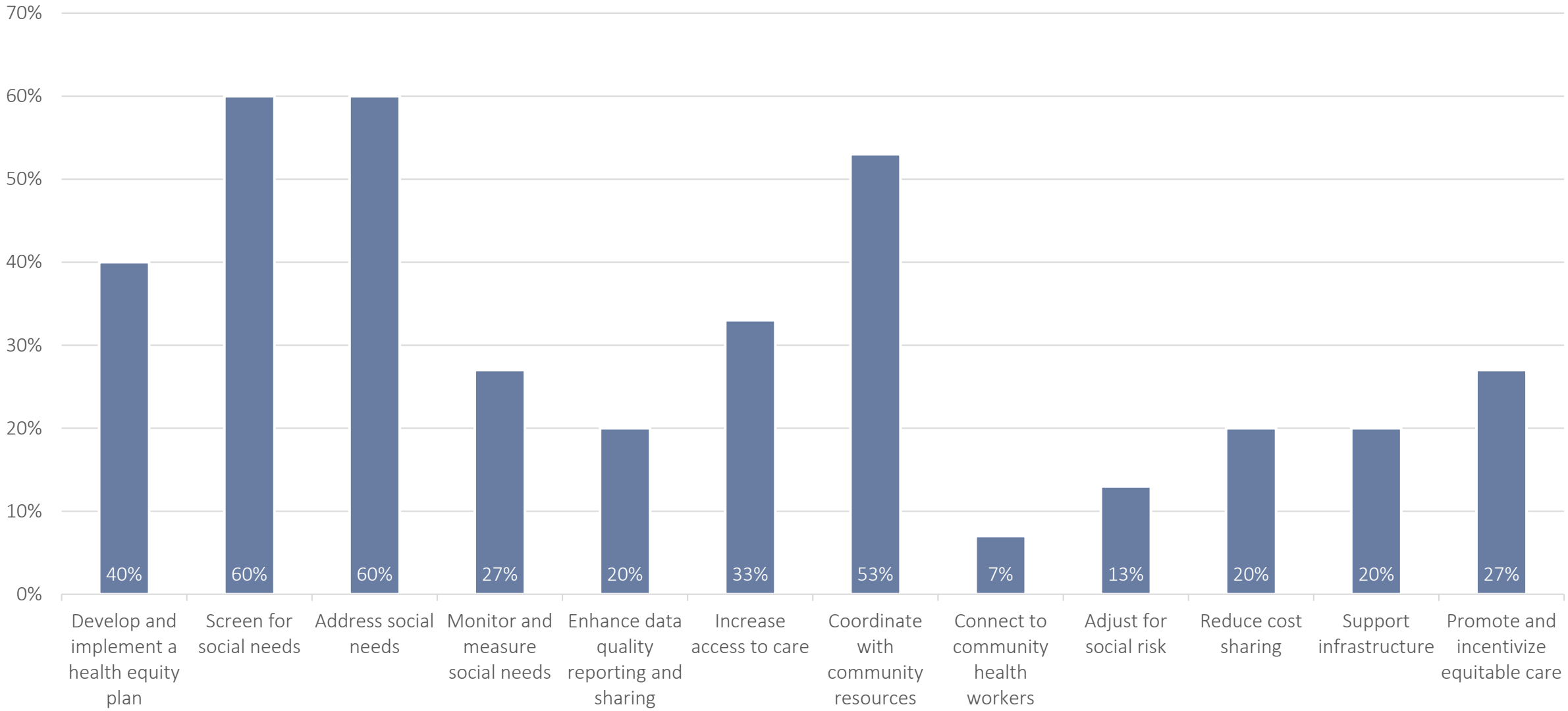
Source: INNOVATION CENTER STRATEGY REFRESH (cms.gov)

Highlights: CMMI Models

- In 2018, CMMI announced the AHC model to address SDOH.
- In 2022, CMMI released a Strategy Refresh that noted all new models will require participants to collect and report the demographic data of their beneficiaries and, as appropriate, data on social needs and SDOH.

Model	Description	SDOH-Related Activities and Impact
Accountable Health Communities Model **Stage:** Not Active (Completed) **Participants**: Community Bridge organizations	Over a five-year period, the model provided support to community bridge organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their HRSNs:	• **Screen** beneficiaries to determine unmet HRSNs and **refer** beneficiaries to community services. • Provide **navigation services** for high-risk beneficiaries to help access community services. • **Align clinical and community services** to assure availability and responsiveness to needs.
Medicare Advantage Value-Based Insurance Design Model (MA VBP) **Stage:** Announced – Applications Under Review **Participants:** Medicare Advantage plans	The VBID Model allows MAOs to further target benefit design to enrollees based on chronic condition, socioeconomic characteristics and/or place of residence and/or incentivize the use of Part D prescription drug benefits through rewards and incentives. MAOs may also offer the Medicare hospice benefit to its enrollees as part of the VBID Model.	• Allows Medicare Advantage Organizations to further **target benefit design to enrollees based on chronic condition, socioeconomic characteristics** (i.e., Low Income Subsidy eligibility, dual eligibility, underserved area deprivation index). • Participating MA plans may provide patients with **tailored supplemental benefits** (e.g., lower costs for prescription drugs, grocery assistance, transportation services, support managing chronic health conditions), reduced copayments).
Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model **Stage:** Active (Performance Year 2023 Applications Closed) **Participants:** Providers (i.e., primary care physicians, specialty care physicians)	The model requires all participating ACOs to have a robust plan describing how they will meet the needs of people with Traditional Medicare in underserved communities and make measurable changes to address health disparities. Additionally, the model uses an innovative payment approach to better support care delivery and coordination for people in underserved communities.	• Trial an innovative payment method to **enhance care delivery and coordination** for underserved patients. • Create and execute a **health equity plan** targeting underserved communities, • Implement initiatives to **measurably decrease health disparities** within their beneficiaries.

Percentage of Evaluated CMMI Models Utilizing Specific SDOH Components



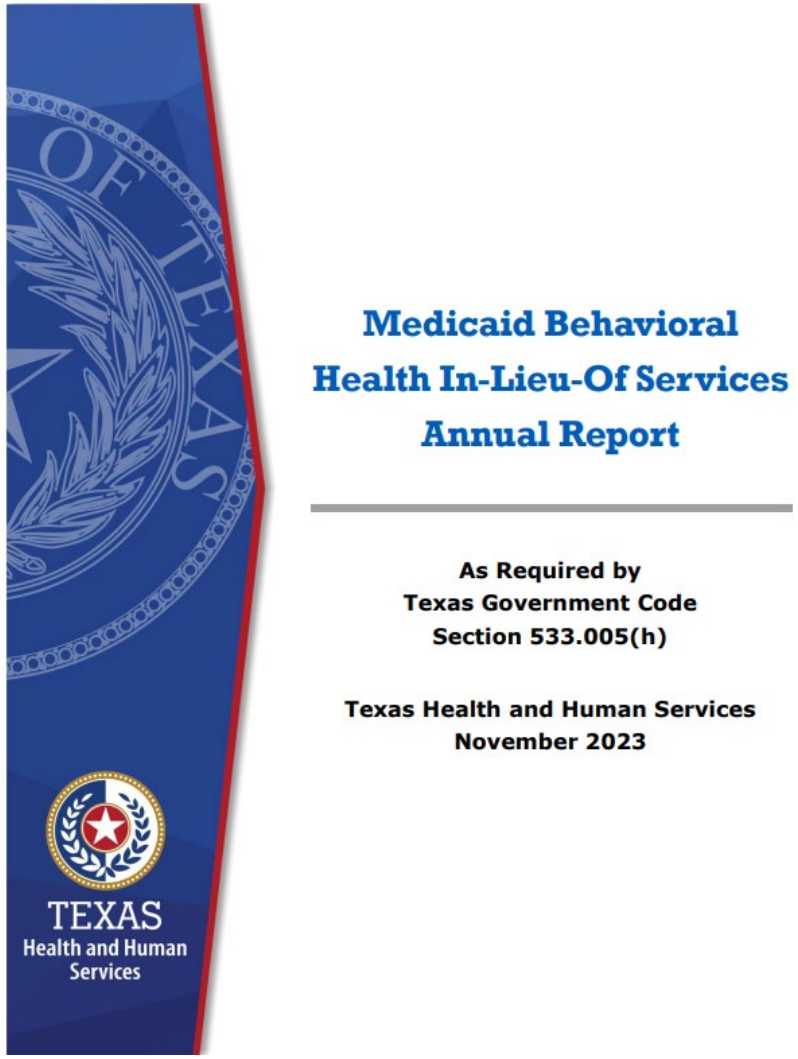
CMMI Models – TX Participants

Model Name	Organization Name	State
ACO REACH	UT Southwestern Accountable Care Network	TX
ACO REACH	CareAllies Accountable Care Solutions, LLC	TX
ACO REACH	RGV ACO Health Providers, LLC	TX
ACO REACH	Accountable Care Coalition of Direct Contracting, LLC	TX
ACO REACH	Accountable Care Coalition of Southeast Texas, Inc.	TX

In Lieu of Services (ILOS)

"New Centers for Medicare & Medicaid Services (CMS) guidance on *in lieu of* services (ILOS) is changing this dynamic. ILOS are defined as medically appropriate and cost-effective substitutes for state Medicaid benefits, with special treatment in managed care rates (discussed below). ILOS authority is particularly valuable for states aiming to avoid a Section 1115 demonstration, which involves lengthier planning and negotiation, and may face delays in federal review and approval. States with 1115 demonstrations that address HRSN may also use ILOS as part of their overall HRSN strategy."

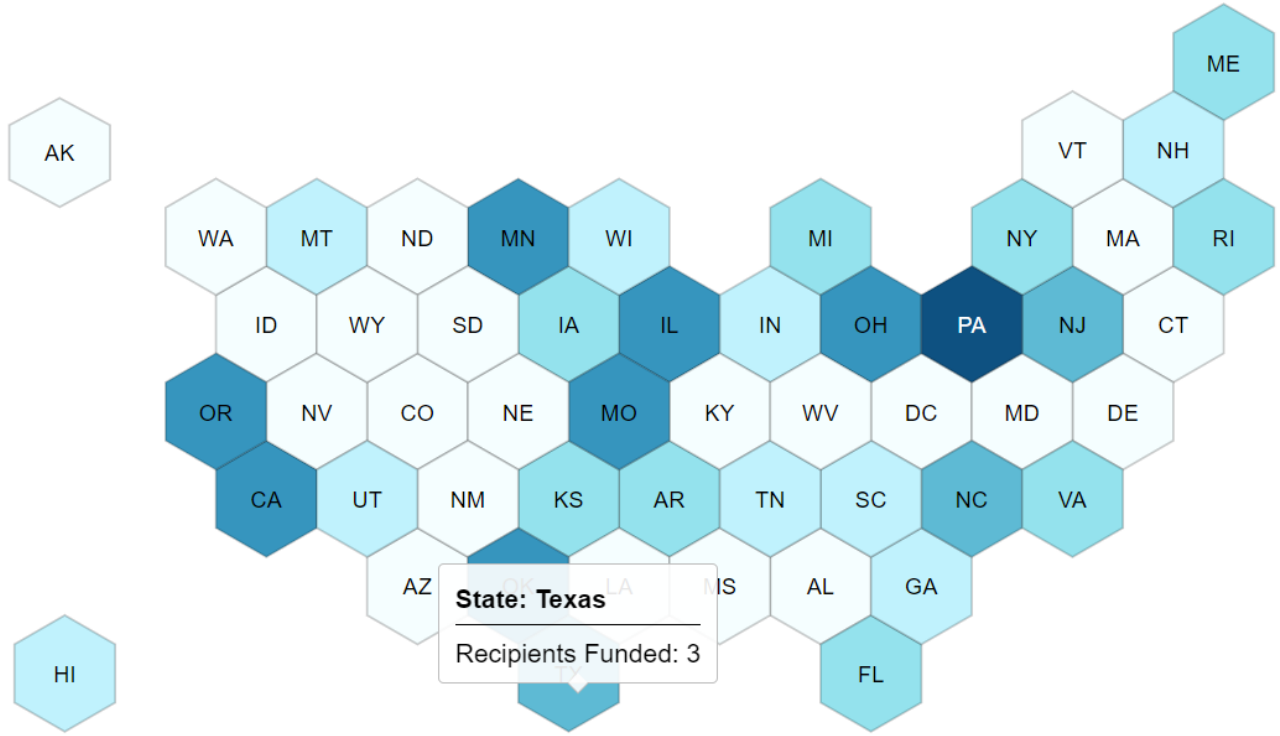
-Center for Health Care Strategies



CDC Funding for SDOH Accelerator Plans

- The purpose of the SDOH Accelerator Plans is to accelerate action in state, local, territorial, and tribal jurisdictions that lead to improved chronic disease outcomes among persons experiencing health disparities and inequities.
- Since 2021, the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has funded 71 recipients to develop multisector, implementation-ready Accelerator Plans to address SDOH.
  - **2023-2024:** 15 recipients
  - **2022-2023:** 36 recipients
  - **2021-2022:** 20 recipients

Map shows the number of Closing the Gap with Social Determinants of Health Accelerator Plans recipients, by state or territory, funded between 2021-2023. Each recipient was funded once for a year.



Community Care Hub National Learning Community

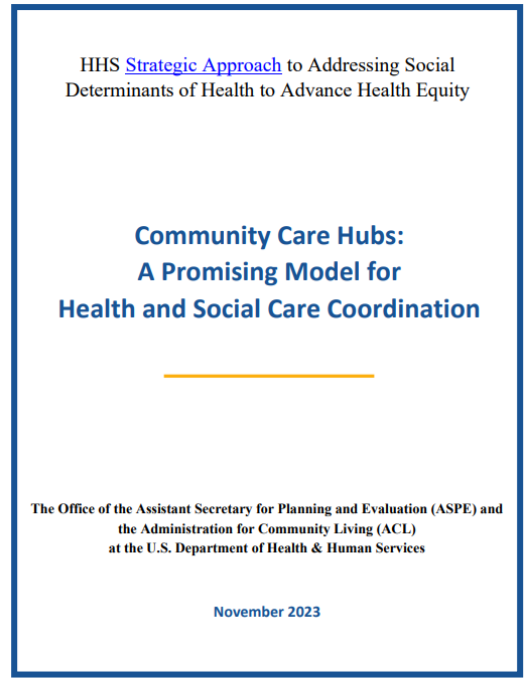
- ACL and CDC selected 58 organizations across 32 states, for participation in the Community Care Hub National Learning Community (NLC).
- The organizations will engage in one of two learning tracks to bring together organizations serving as Community Care Hubs that are either in development or interested in expansion.
- The selected organizations will participate in shared learning, information and resource sharing, and technical assistance coordination with the goal of building the strength and preparedness of each Community Care Hub to address health-related social needs and public health needs through contracts with health care entities.

Texas Participants

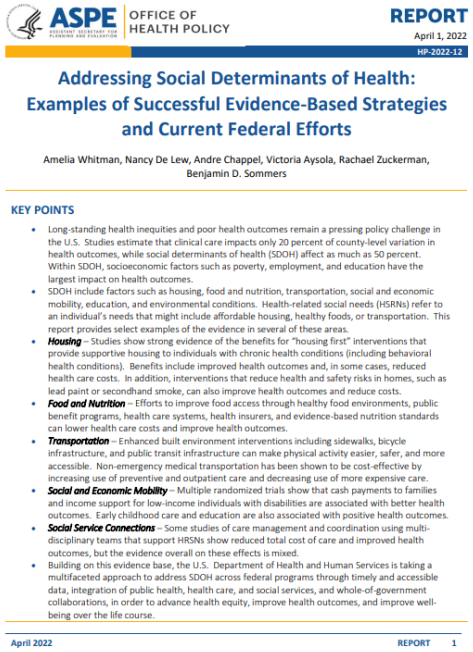
- Community Council of Greater Dallas/Dallas Area Agency on Aging
- Coalition for Barrier Free Living
- Houston Health Department
- Texas Healthy at Home

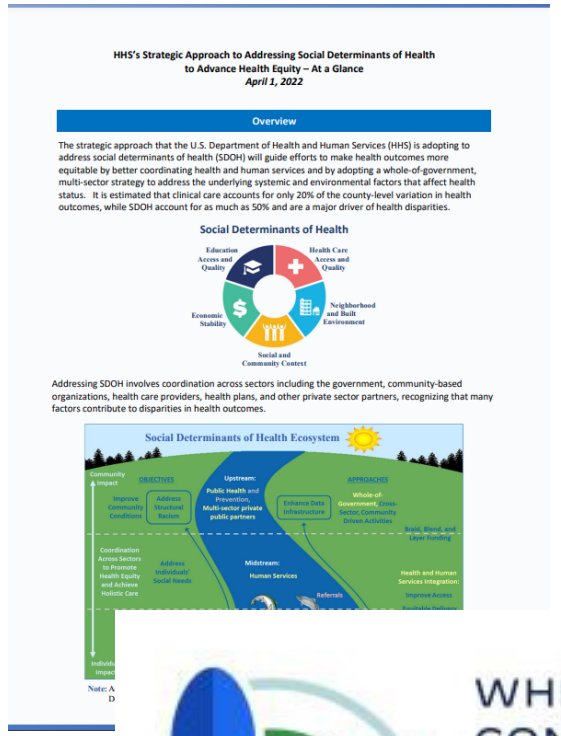
ACL
Administration for Community Living

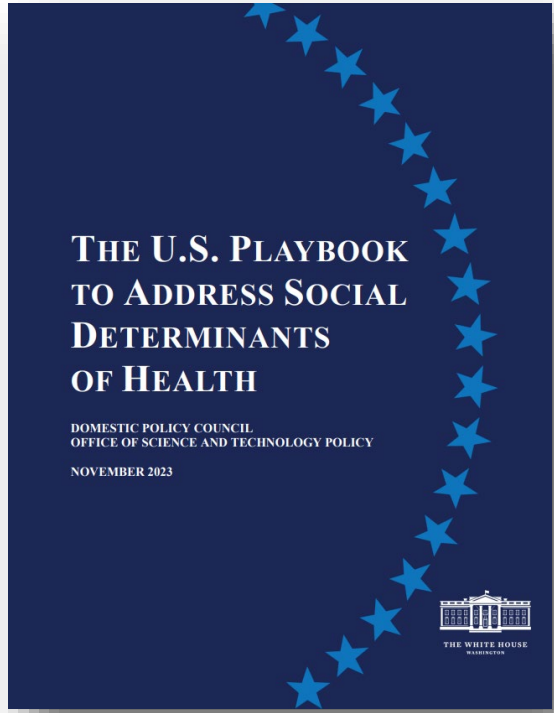
CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION



Cross-Agency Plans and Coordination

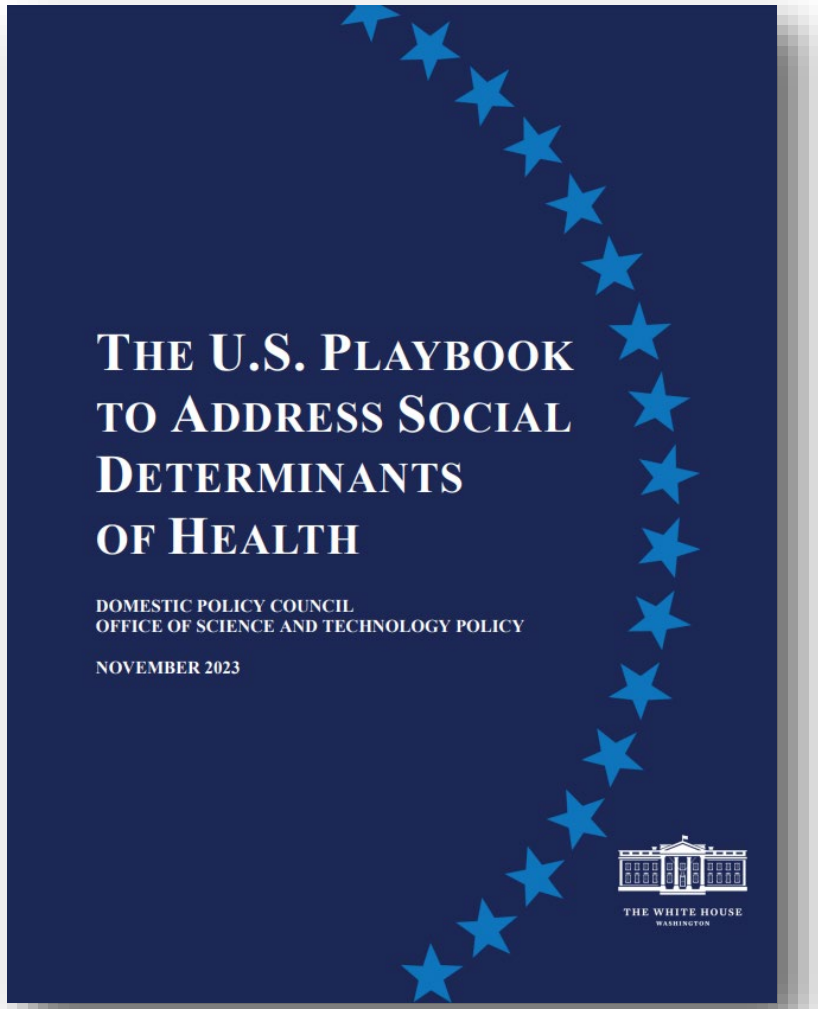






WHITE HOUSE CONFERENCE ON **HUNGER, NUTRITION, & HEALTH**

The White House Social Determinants of Health Playbook



The White House released the first ever U.S. Playbook to Address Social Determinants of Health (SDOH) to initiate a comprehensive strategy for addressing SDOH across federal agencies and sectors.

The Playbook outlines strategic actions addressing both SDOH and HRSNs at both community and federal levels grouped into three pillars:

- Pillar 1: Expand Data Gathering and Sharing
- Pillar 2: Support Flexible Funding for Social Needs
- Pillar 3: Support Backbone Organizations

Pillar 1: Expand Data Gathering and Sharing

	Actions	Description/Details
1.1	Establish a centralized federal data working group.	Established by OMB and housed within the Executive Office of the President, the SDOH Data Working Group will lead SDOH data collection management, as well as interoperability policy development and implementation, across federal programs.
1.2	Improve responsible and protected exchange of individual sensitive health information across federal agencies.	The HHS, HHS Office for Civil Rights, and the HHS Office of the National Coordinator for Health IT (ONC) will continue their support and coordination of interoperability through rulemaking and guidance.
1.3	**Align federally administered programs to support SDOH information exchange and closed-loop referrals.**	Encourage the adoption of standards and non-proprietary, open application programming interfaces (e.g., HL7 Fast Healthcare Interoperability Resource (FHIR), Gravity Project) to collect and exchange SDOH data.
1.4	Improve capacity of backbone organizations to make effective referrals.	The Administration for Community Living (ACL) and ONC provide technical assistance (e.g., training, sharing best practices, governance models, streamline workflow processes for closed-loop referrals) to community organizations.
1.5	Reduce data gaps to serve those at increased risk of disparate health outcomes.	• The finalization of the SDOH Clinical Care FHIR Implementation Guide. • The Enterprise-wide Veteran Social Determinants Health Framework Integrated Project Team will evaluate the collection of SDOH data, encourage interoperability, and identify best practices. • The National Science and Technology Council's Environmental Justice Subcommittee was launched and will prepare an Environmental Justice Science, Data, and Research Plan.
1.6	**Strengthen SDOH data collection and sharing across programs for Medicaid beneficiaries.**	CMS will encourage the adoption of existing demographic data standards and collection. CMS also published data briefs analyzing demographics for Medicaid and CHIP enrollees to identify disparities and improve policy design.
1.7	Illuminate disparities in localities with significant SDOH burden.	The CDC will release SDOH data from the Behavioral Risk Factor Surveillance System SDOH/Health Equity module by September 2023, which will then be added to a health surveillance databased called Population-level Analysis and Community Estimates of Health (PLACES). The PLACES' small area estimates of public health measures are expected to be published by Summer 2024.
1.8	Connect veterans to needed social services.	The cross-agency Assessing Circumstances and Offering Resources for Needs (ACORN) initiative will screen veterans for HRSNs and recommend focused interventions based on individual needs. There are 25 VA medical centers using ACORN, with plans to add 15 to 20 more in Fiscal Year (FY) 2024.

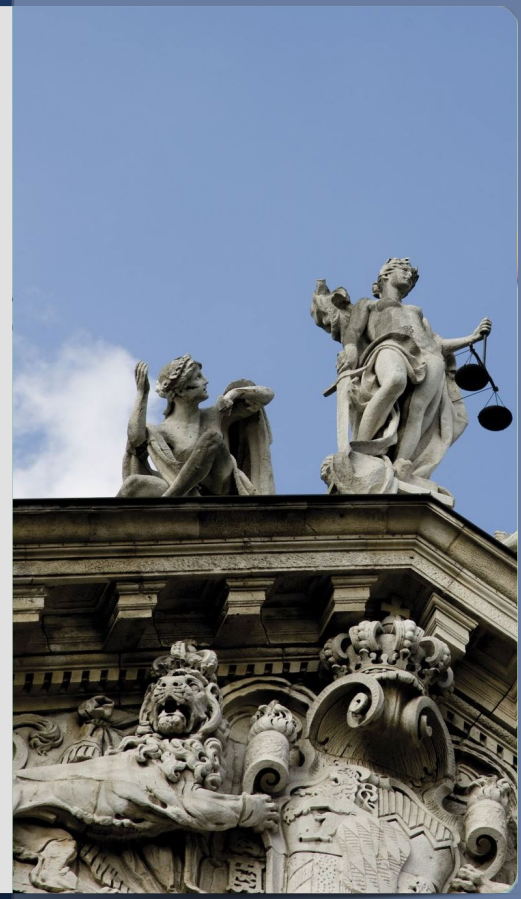
Pillar 2: Support Flexible Funding for Social Needs

	Actions	Description/Details
2.1	**Enable use of Medicaid funds for SDOH investments.**	The Medicaid and CHIP HRSN Framework and accompanying CMCS Informational Bulletin (CIB) guided states to utilize allotted funding to more effectively address SDOH.
2.2	**Increase payment for assessing and addressing SDOH.**	The Calendar Year 2024 Medicare Physician Fee Schedule Final Rule resulted in separate Medicare payment and coding for SDOH risk assessments.
2.3	**Reduce barriers to using grants to address HRSNs.**	OMB and HHS will review and revise funding and data reporting processes to reduce barriers for potential grantees.
2.4	Improve the accessibility of HHS grant funding.	The HHS Office of the Assistant Secretary of Financial Resources (ASFR) will conduct a user experience study to: (1) Identify root causes and solutions beyond Grants.gov, and (2) Create a detailed roadmap of best-in-class user experience for grant applications.
2.5	Support expanded nutrition assistance through coordination with health and social care service programs.	Increase enrollment to food assistance programs (e.g., WIC, SNAP, free and reduced school meals) across federal agencies (e.g., ACL, Food and Nutrition Service (FNS), CMS, USDS) by braiding funding, providing financial, educational, and technical support.
2.6	**Use data to foster hospital and health insurer investments in SDOH.**	CMS is offering financial incentives for addressing HRSNs: upfront payments, social risk adjustment, benchmark considerations, and payment incentives for actions taken to address SDOH such as screening for social needs.
2.7	**Support high value hospital community benefits spending.**	"In December 2022, the Internal Revenue Service (IRS) updated the instructions to Schedule H (Form 990). These instructions offer hospitals direction on reporting their activities as community benefits and community-building programs.
2.8	Incorporate health equity guidance into CDC's non-research notice of funding opportunity (NOFO) template.	CDC revised the NOFO template to include scientifically proven health equity approaches and SDOH interventions.

Pillar 3: Support Backbone Organizations

	Actions	Description/Details
3.1	Provide training and technical assistance to community care hubs through a National Learning Community.	The National Learning Community, consisting of nearly 60 hubs across 32 states, will provide technical assistance, improve information and resource exchange, offer consulting with subject matter experts, and offer training (e.g., billing, coding, network administration).
3.2	**Award new funding to support community care hubs.**	ACL, with CDC, provided $5.5 million in discretionary funding to the national Center of Excellence for technical support and collaboration of hubs and health care organizations.
3.3	Support backbone organizations through HHS Health Resources and Services Administration's (HRSA) Early Childhood Comprehensive Systems Program.	The program will support systems development to provide equitable access to social and health services during the prenatal period to age three.
3.4	Support backbone organizations through the HHS Administration for Children and Families (ACF) Children's Bureau.	ACF promotes service coordination through community-based primary prevention demonstration grants.
3.5	Build backbone organizations to strengthen at-risk neighborhoods through the Choice Neighborhoods program.	In FY 2022, the Choice Neighborhood program received $180 million in implementation funds to aid communities by expanding housing, supporting local businesses, and improving social care provided by backbone organizations.
3.6	Seed backbone organization infrastructure by **enhancing access to legal services for patients at health centers.**	HRSA, alongside technical assistance organizations, will offer training on legal service integration in health care.
3.7	**Expand and disseminate SDOH-related research resources and training opportunities.**	The HHS National Institutes of Health (NIH) Community Partnerships to Advance Science for Society (ComPASS) Program allocated funding for a Coordination Center in FY 2023 and plans to allocate funding for five Health Equity Research Hubs in FY 2024.
3.8	Inform backbone organization work through targeted research.	The USDA will research the linkage between SDOH, nutrition security, and health and economic outcomes to influence backbone organizations' agendas.
3.9	Increase technical assistance and build capacity of backbone organizations to support communities, including with environmental justice needs.	The Federal Interagency Thriving Communities Network was established to support urban, rural, and Tribal communities with localized technical assistance and capacity-building resources.

Looking Ahead



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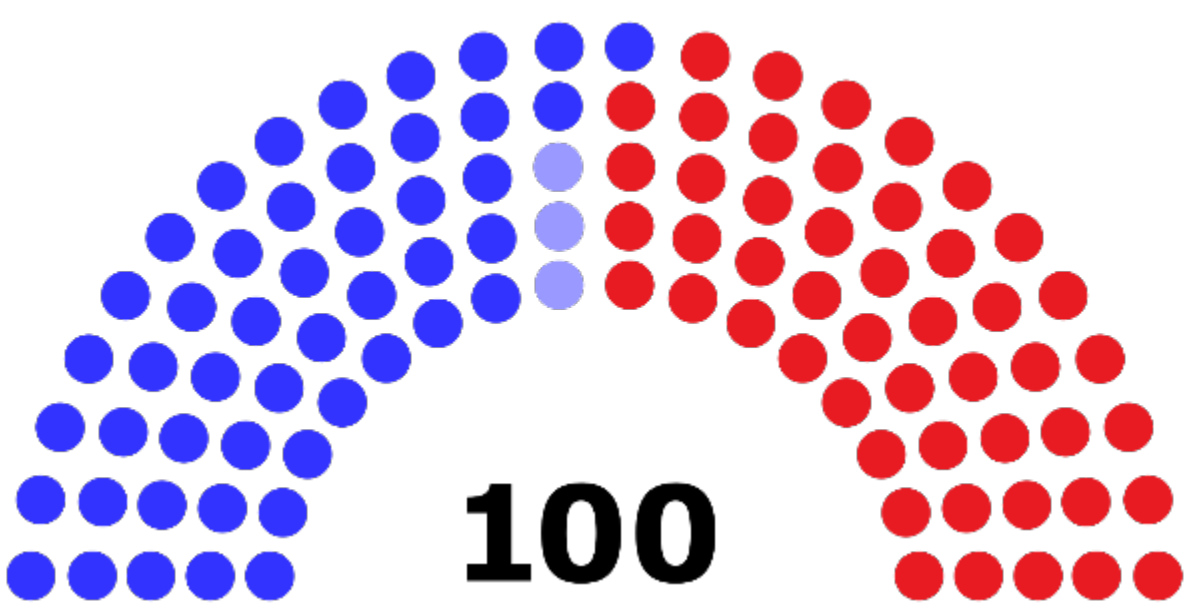
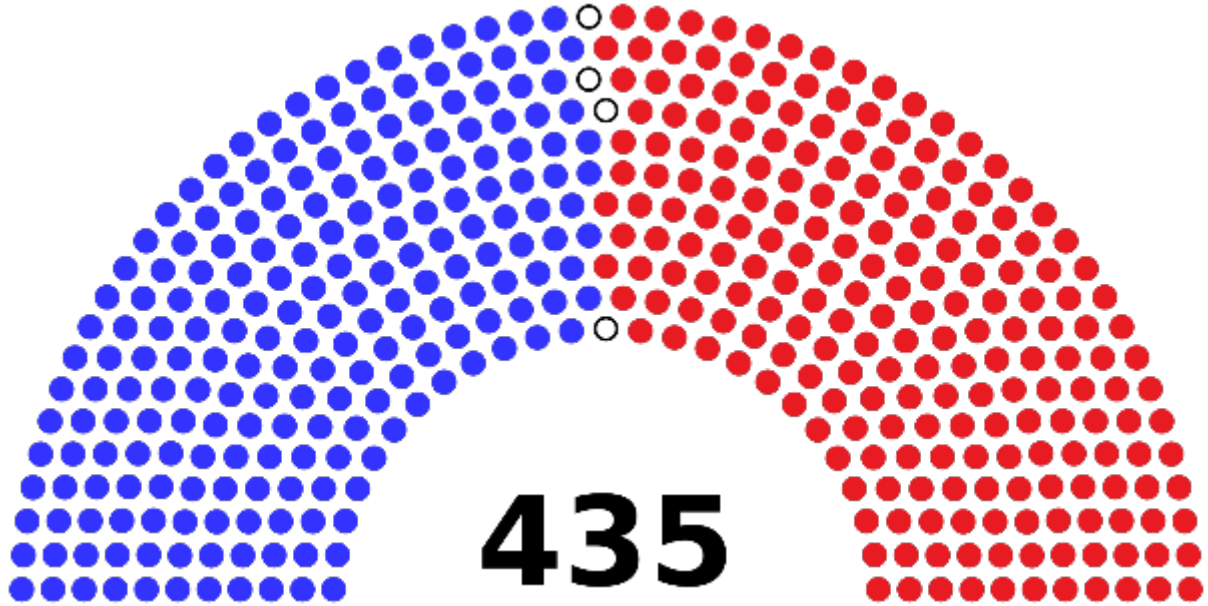
118th Congress: A Partisan Divide

Both the House and the Senate are held by incredibly slim majorities. While the House is held by the Republican Party and the Senate by the Democratic Party, both are challenged by the limitations of their narrow margins, such as members who are absent due to illness, death, retirement, or other obligations. Both are also vulnerable to changes in partisan control in the 2024 election.



Senate: 51 D, 49 R



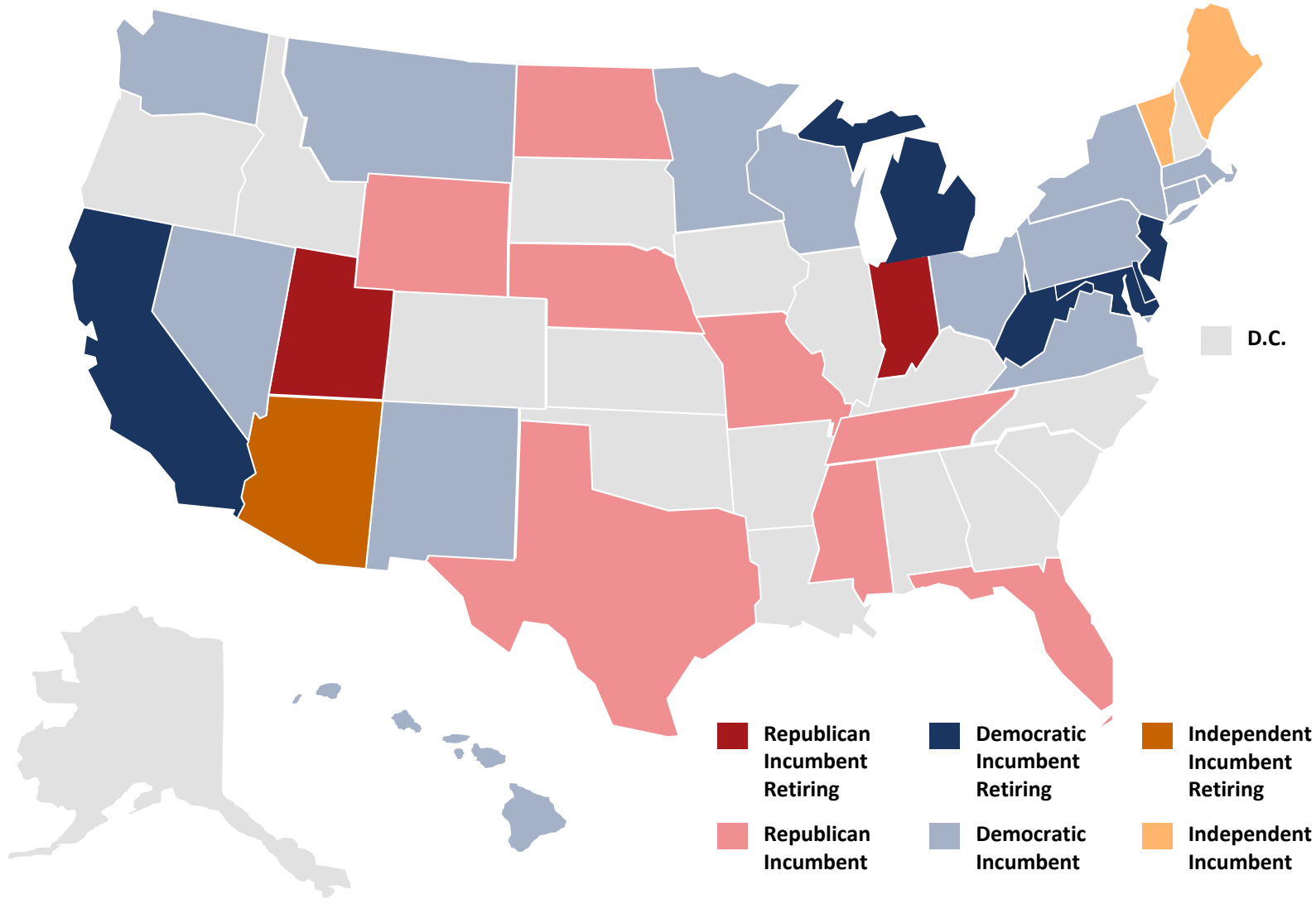
House of Representatives: 213 D, 218 R, 4 vacant

2024 Congressional Elections: Senate

There are **33 Senate seats** up for regular election in 2024 – 10 currently held by Republicans, 20 by Democrats, and three by Independents.

Two **special elections** will also be held on November 5, 2024:

- To fill the last two years of the six-year term Ben Sasse (R-NE) was elected to in 2020.
- To fill the final weeks of the six-year term that Dianne Feinstein was elected to in 2018 (ending January 3, 2025).



Possible 2025 Governance Scenarios

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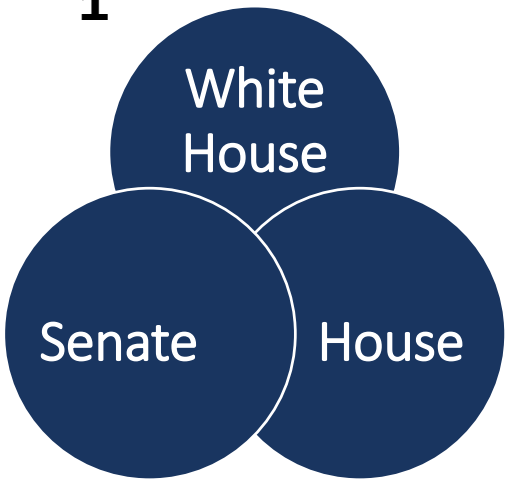

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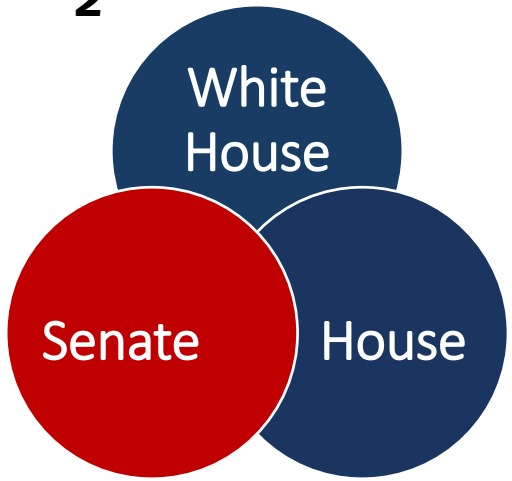

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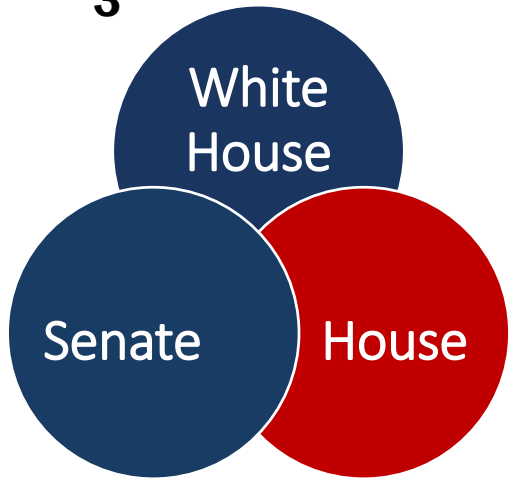

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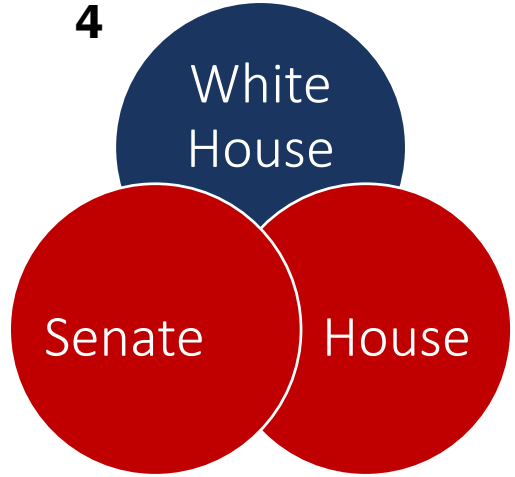

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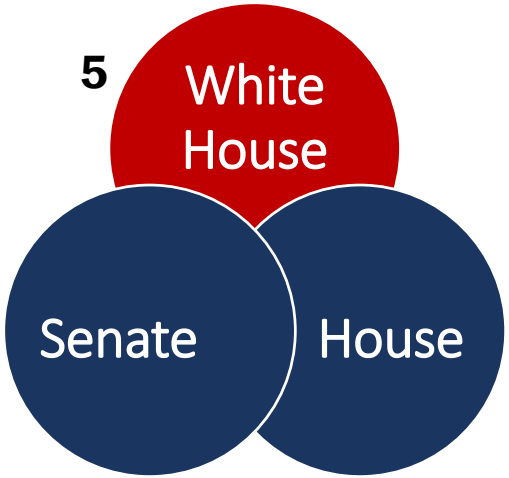

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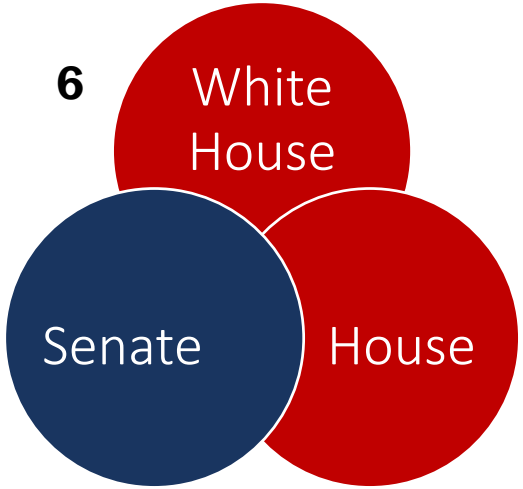

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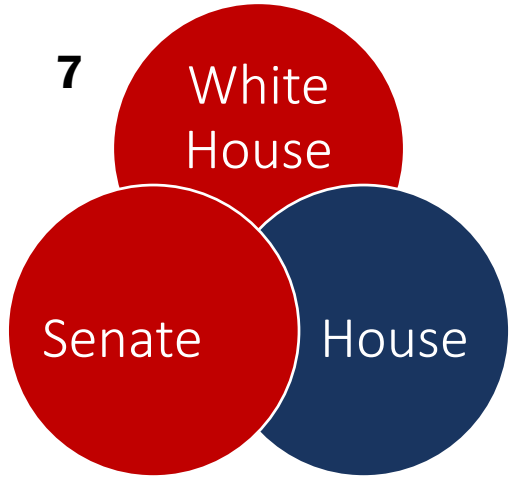

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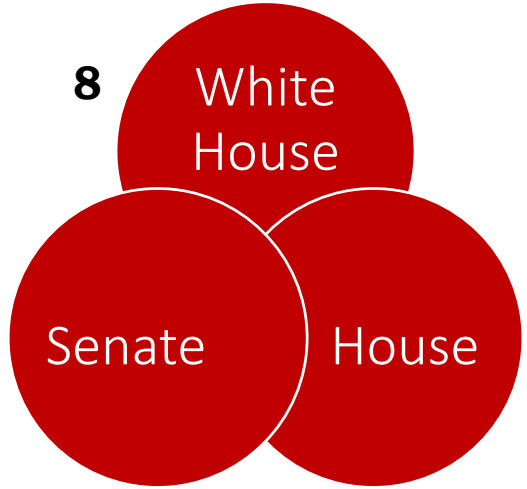

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Laura Pence
Advisor to NASDOH
Director
Laura.Pence@LeavittPartners.com