Investing in Health:
Essential Infrastructure to Sustainably Address DOH

I. The Charge

The Biden Administration has pledged to "take a department-wide approach to the advancement of equity," including an "examination of ways to address the social determinants of health." Health disparities exist independently from, but are substantially compounded by, drivers of health (DOH) – the socioeconomic, environmental, and behavioral factors that drive 80% of health outcomes. Addressing DOH is central to efforts to improve health, advance health equity, and reduce health care costs.

Investing in Health: A Federal Action Plan outlines seven strategies to accelerate scalable, sustainable integration of DOH into the health care system. This brief is the final in a series of three which draws from the Federal Action Plan – as well as essential feedback provided by state and federal policymakers and national and community leaders in health and healthcare – describing specific policy changes that could be deployed by the Centers for Medicare & Medicaid Services (CMS) under existing authority within the next one to two years.

The focus of this document is on the development of essential infrastructure to sustainably address DOH; it builds on prior documents on the integration of DOH into systems of measurement and accountability and alignment of financial incentives to invest in health. Taken in isolation, the recommendations outlined in each document falls short: scalable, sustainable efforts to address DOH require integration into payment models and measurement systems, *and* the infrastructure to close the integration gap between the health care and social services sectors.

II. The Strategy: Build Essential Infrastructure to Sustainably Address DOH

Health care providers and payers are increasingly screening patients for DOH needs using standardized screening tools and navigating them to resources, but are up against the "last mile" problem – lack of sufficient infrastructure and resources to address DOH needs once they have been identified.

It is now the norm for states to require Medicaid managed care plans to screen members for DOH and refer them to services and for most U.S. hospitals and physician practices to screen for at least one health related social need. A number of Center for Medicare & Medicaid Innovation (CMMI) models and participating entities have functionally incorporated DOH screening and navigation data into their quality frameworks and care plans for beneficiaries (see Figure 1). More broadly, incorporating screening and referral for social needs is also part of CMMI's recently published Strategy Refresh.

And yet, investments in DOH infrastructure necessary to connect beneficiaries to the services and supports necessary to address their health related social needs are lagging behind. DOH infrastructure is the bridge between the current clinically centered health care system and an integrated health and social services network with the data, workforce, and community capacity needed to deliver on the promise of Investing in Health.

Figure 1. DOH "Adoption" by multiple CMMI models

	Does CMMI Model Include DOH (Formally or Functionally)?			
Model (link to evaluation)	**Screen**	**Navigate**	**Required to Screen/Navigate**	**DOH Measures**
Accountable Health Communities (AHC)	Yes	Yes	Yes	Yes
Comprehensive Primary Care Plus	Yes	Yes	Yes (Track 2)	**No**
Maryland Total Cost of Care Model	Yes	Yes	Yes (Track 2)	**No**
State Innovation Models (SIM) Round 2	Yes	Yes	Yes (varies by state)	**No**
Next Generation ACO	Yes	Yes	No	**No**
Comprehensive End-Stage Renal Disease (ESRD) Care Model	Yes	Yes	No	**No**

CMMI's Accountable Health Communities (AHC) Model is emblematic of this "last mile" problem. While over a third of the 482,967 AHC-screened beneficiaries reported at least one health related social need (HRSN), only 14% of those who completed a year of navigation had any of their HRSNs documented as resolved. In addition, racial and ethnic minorities were over-represented among beneficiaries that screened positive.

Barriers to integration between health care and social services sectors to bridge the "last mile," include:

- **Limited Data Sharing:** Access to data necessary to identify and address health related social needs and track population health outcomes is limited; for many social services organizations, underinvestment has greatly hindered development of IT infrastructure, and existing platforms and standards are generally siloed across health and human services providers.
- **Separate Funding Streams, Inadequate Payment:** Health care and social services sectors have different payment models, administrative expectations, and reporting requirements. For example, Medicaid will pay for transportation to a medical appointment to monitor a patient's diabetes, and will pay for assessments and referrals to identify food insecurity which can exacerbate the condition, but will not pay for the transportation to a food bank to address the food insecurity. In addition, efforts to pay for social interventions have not covered the full start up or operational costs necessary to produce improved outcomes.
- **Lack of Investments in Infrastructure and Capacity Building:** Lack of capacity-building funds and ongoing support to advance integration can stall and complicate efforts. Reliance on episodic

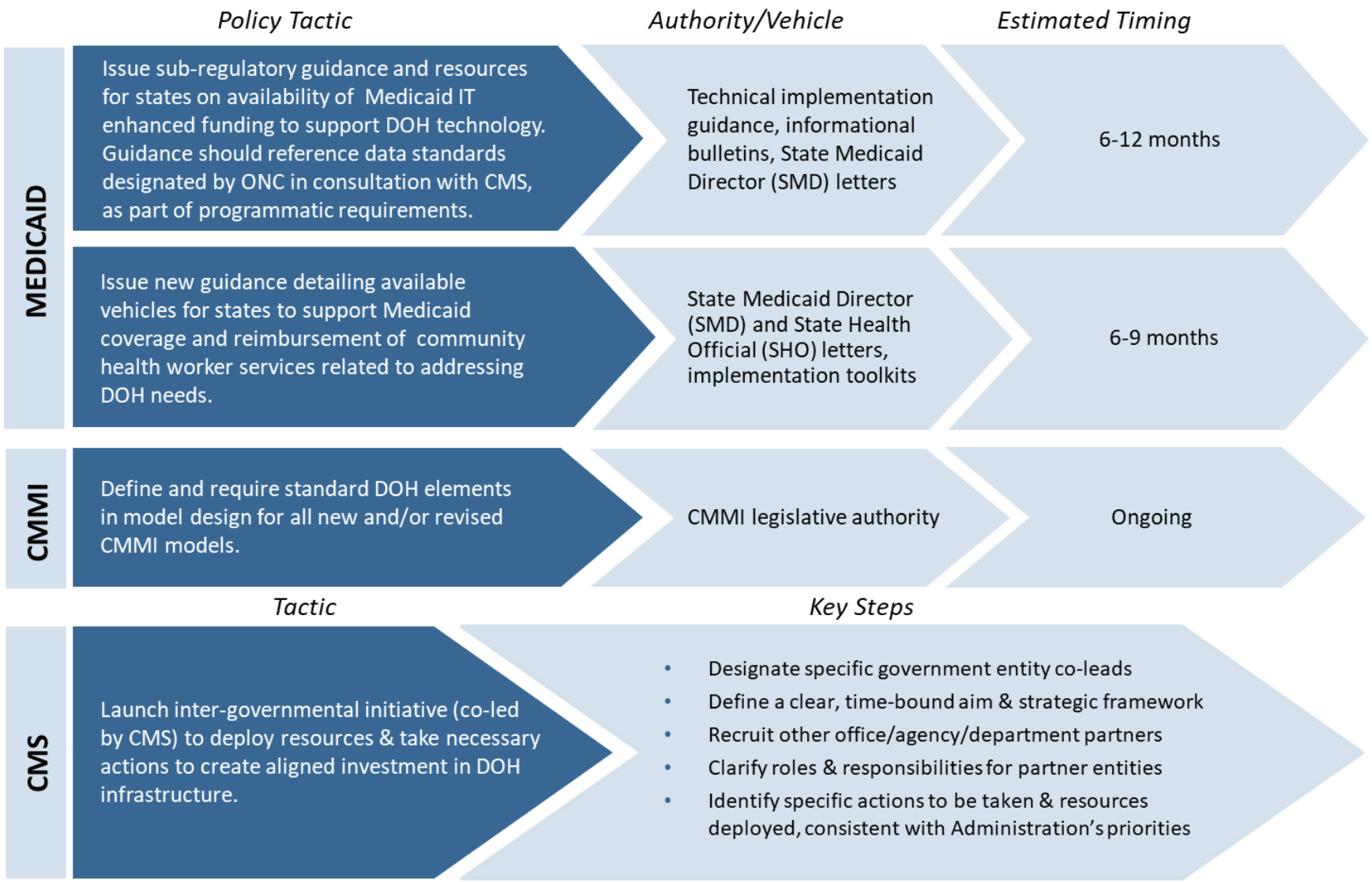
grant funding and expectations for short-term, "same pocket" returns on investment create barriers to sustainability.

- **Uncertainty in Policy Environment:** Concern that government and industry interest in addressing DOH could be a passing fad leaves providers in both sectors "torn between investing in tomorrow's promising innovations or continuing to maintain the essential safety net for today."
- **Structural Inequities:** Community based organizations (CBOs), particularly those led by people of color, currently don't have the power to redesign systems or change the structural inequities that result in health disparities.
- **Lack of Alignment Around Outcomes.** Population-level goals can help ensure that investments align to improve health outcomes; a proliferation of disparate investments risks diffusing the impact and undermining support and sustainability of interventions to address DOH.

Federal action is needed to address these challenges. Investment in DOH infrastructure – IT, workforce, and upfront investment in community capacity – are required to advance this integration, address DOH, advance health equity, lower health costs, and improve health outcomes.

Figure 2 outlines a set of four specific recommendations that CMS could take within its current regulatory authority in the next two years to move forward on building the essential infrastructure to sustainably address DOH. These recommendations align with CMS' recently published strategic vision for the Medicaid program, which centers on advancement of equity and whole-person care, including health related social needs.

Figure 2. Recommendations for building the essential infrastructure to sustainably address DOH



❖ *Medicaid:* Issue sub-regulatory guidance and resources for states on availability of Medicaid IT enhanced funding to support DOH technology. Guidance should reference data standards designated by ONC in consultation with CMS, as part of programmatic requirements.

Adoption of Community Information Exchanges (CIE) – IT systems that facilitate data sharing and integration of health care and social services providers to address DOH – is increasing nationwide. However, emerging CIEs in places such as San Diego, King County in Washington, and Nebraska draw upon a patchwork of funding to operate – limited financing/payment opportunities and lack of national standards remain significant barriers to scaling CIEs.

Under the current statutory and regulatory framework, state Medicaid agencies can receive federal funding for Medicaid IT and associated activities, and much of it at an enhanced federal matching level (75% or 90% federal match). In January 2021 guidance, CMS highlighted availability of federal Medicaid IT funding for data integration and sharing to identify individuals with DOH needs and link them to appropriate medical and social support services. To receive enhanced federal funding, states must demonstrate that their proposed or operational systems satisfy a series of conditions, including that costs be allocated to ensure Medicaid pays its "fair share" and that investments align with federal standards, such as those designated by the Office of the National Coordinator for Health Information Technology (ONC). CMS has discretion in what it determines to be Medicaid's "fair share" in allocating Medicaid IT costs, but it is currently unclear how these rules apply in the context of CIE.

In July 2021, ONC updated the United States Core Data for Interoperability version 2 (USCDI v2), a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange, to support the standardized electronic exchange of DOH data classes. While electronic health records are currently the predominant use case for USCDI, adherence to the standards will be key to exchange DOH data across a variety of health and social services systems and settings. ONC has indicated that it intends its standards to "be broadly reused across use cases, including outside of patient care and patient access" and CMS is supportive of this goal.

As ONC's interoperability standards mature and are adopted more broadly across sectors, linking Medicaid IT funding to use of ONC's standards can accelerate adoption and interoperability in electronic exchange of DOH data.

CMS should seed development of DOH IT infrastructure and capacity aligned with national standards by providing guidance and resources on Medicaid IT enhanced funding to support DOH technology and reference data standards designated by ONC in consultation with CMS, as part of programmatic requirements. This should include clarifying guidance allowing Medicaid to serve as a catalyst and finance the principal share of CIEs initially, with additional funding partners engaged over time.

❖ *Medicaid:* Issue new guidance detailing available vehicles for states to support Medicaid coverage and reimbursement of Community Health Worker services related to addressing DOH needs.

Community Health Workers (CHWs) are trusted members of their community who bridge the gap between health care and social services sectors. CHW interventions have shown to reduce

hospitalizations and generate cost savings. A CMMI Health Care Innovations Awards evaluation found that, out of six types of innovation system delivery components assessed, innovations using CHWs was the only type associated with substantial savings ($138 per beneficiary per quarter).

The Administration is investing in hiring and training of CHWs to support response to the COVID-19 pandemic; this essential workforce can be redeployed after the pandemic to address DOH needs across the health system. Demand for CHWs is projected to grow by 14% by the year 2030 and efforts to develop national standards for recruiting, employing, and supervising CHWs are underway.

Several Medicaid authorities support coverage and reimbursement of CHW services, including managed care contracts, Medicaid state plans, and 1115 waivers. Despite the availability of options to reimburse for CHW services through Medicaid, state uptake has been limited.

CMS should issue new guidance detailing available vehicles for states to support coverage and reimbursement of CHW services related to addressing DOH needs through Medicaid and allowing states flexibility in defining their roles and responsibilities to ensure their success.

Specifically, next steps include:

- Issuing new guidance, building off the January 2021 State Health Official Letter (SHO), detailing all available vehicles for states to support coverage and reimbursement of CHW services related to addressing DOH needs through Medicaid.
- Providing states with models for implementation, tools, and templates to support use of CHWs in addressing DOH needs:
    - Examples of state approaches (including CHW training guidelines, CHW scope and responsibilities, CHW reimbursement approaches and levels)
    - Successful models for integration of CHWs into care team
    - Model state plan amendments (SPAs)
    - Managed care contract language

❖ *CMMI: Define and require standard DOH elements in model design for all new and/or revised CMMI models.*

CMS and CMMI leadership have articulated their vision for the next decade, including key strategic objectives to (1) drive accountable care; (2) advance health equity; and (3) partner to achieve system transformation. Achieving CMMI's strategic objectives requires broadening the Total Cost of Care (TCOC) frame, which defined the first decade of CMMI, to focus on *Total Cost of Health* (TCOH). A TCOH frame explicitly addresses the impact of both clinical factors and DOH, such as access to healthy food and safe housing, on health costs and outcomes, through the lens of racial equity.

As only ~20% of health outcomes and associated costs are linked to clinical care, any CMMI model that does not address DOH leaves potentially significant savings off the table. As a result, a TCOH approach – which integrates DOH and stratifies by race/ethnicity – is more likely to reduce racial/ethnic disparities; enable future CMMI models to achieve actuarial certification; and contribute to the longevity of the Medicare Trust Fund.

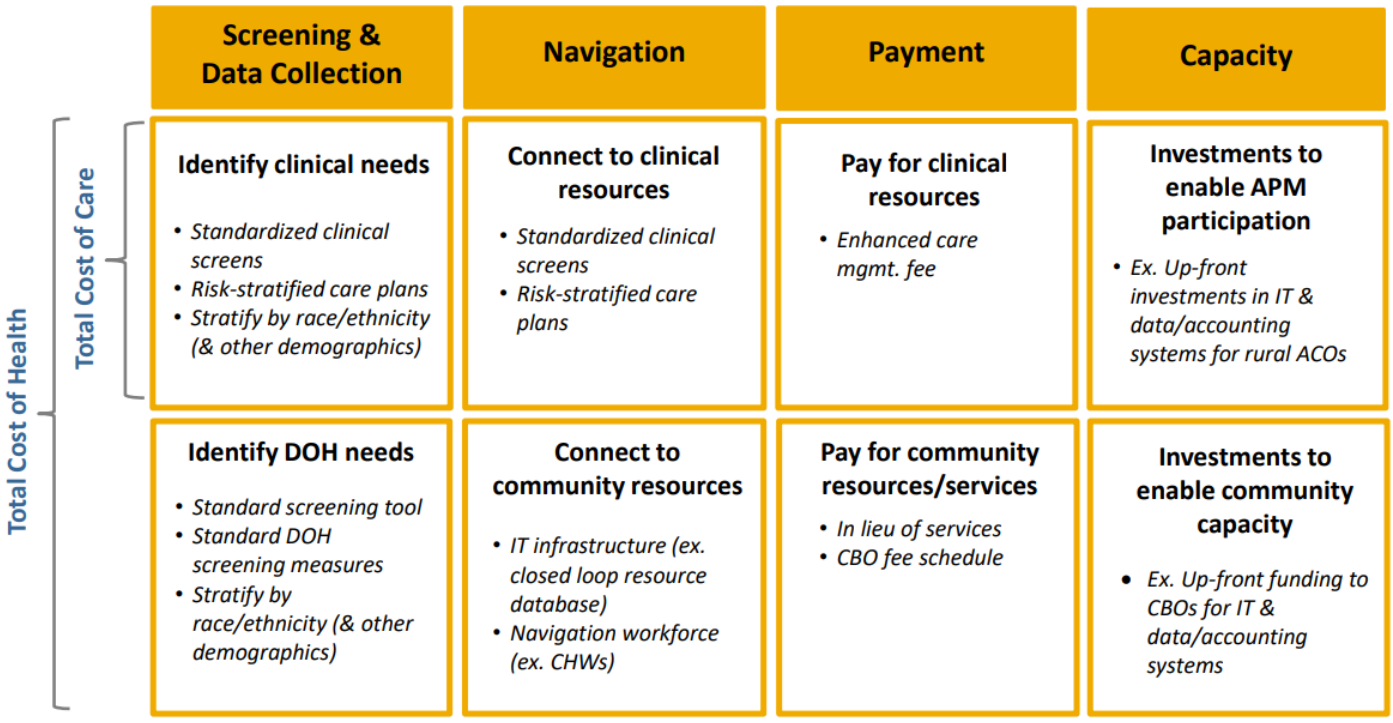
CMMI has two sets of learnings to draw from for building a TCOH approach.

First, CMS and CMMI's TCOC and Alternative Payment Models (APMs) have included tools and mechanisms that could be leveraged not only for clinical care, but also to address DOH. Since 2015, the Health Care Payment Learning & Action Network (LAN) has leveraged a strong public-private partnership in the shift from FFS to APMs. LAN population-based payments (Category 4 APMs) can be used to cover a range of preventive health, care coordination, and wellness services, in addition to standard medical procedures typically paid through claims. If the LAN framework were to include payment for (and partnerships with) CBOs to address DOH, it could further accelerate improved outcomes, lower costs, and health equity.

Likewise, currently, all ACOs screen for and measure diabetes in a TCOC frame. Under a TCOH frame, ACOs would also screen and measure diabetics for food insecurity (recognizing that food insecure diabetics cost ~$4,500 more PMPM than diabetics with access to healthy food). This approach also recognizes racial inequities, with Black Americans facing the highest rates of both food insecurity and diabetes. Collected systematically, this member-level DOH data would be critical inputs for actuarial cost projection and risk-adjustment for APMs.

Second, current CMS programs and CMMI models have implemented and tested TCOH elements. The challenge is that these elements are scattered across programs and models; the opportunity now exists to integrate them. CMMI's models to date reveal four key elements to bridge from TCOC to TCOH in future models: (1) Screening and data collection, (2) navigation, (3) payment, and (4) capacity (see Figure 3).

Figure 3. Four key elements to bridge from TCOC to TCOH in future models



It is important to acknowledge the inherent tension in a TCOH approach – while effectively addressing health equity and DOH requires new and sustained investment in communities, improving financial accountability and reducing healthcare costs are at the forefront of state and federal health care policy imperatives and statutorily embedded in CMMI's charge. Moving to TCOH will require fundamental changes to the structure of health and social service systems that cannot be accomplished by focusing on cost alone. Similarly, the success of models cannot only be evaluated based on cost savings. The shift to TCOH will require CMMI, and CMS more broadly, to reframe what success looks like.

To that end, CMMI should integrate DOH elements across its models, while requiring clear DOH outcome goals at a population level for model participants. In doing so, CMMI should provide clear examples of activities and investments that model participants could make to advance model goals (see Figure 4 for specific strategies).

Figure 4. Integrating DOH elements across CMMI models

Element	Key Changes	Experience to Date (Examples)	Where to Begin (Examples)*
Screening & Data Collection	Identify DOH Needs	• Accountable Health Communities • Medicaid state plan services/MCOs	• Implement standard, validated HRSN screening tool • Implement standard DOH measures, stratified by race/ethnicity (*note:* DOH measures on 2021 MUC list)

Navigation	Connect to Community Resources	• Accountable Health Communities
		• Comprehensive Primary Care Plus
		• Maryland TCOC
		• State Innovation Model
		• Medicaid state plan services/MCOs/Waivers
			• Pay for ***CHWs/navigation support*** via:
			  • Medicare enhanced care management fees
			  • Medicaid care coordination funding
			• Pay for ***up-to-date, closed loop referral platform*** via:
			  • Pooled/braided resources from enrollee partners (ex. Medicaid MCOs, community benefit dollars, philanthropy)
			  • Requiring platform as standard element of coordinated care management in state-based & multi-payer models (*e.g.*, SIM design states)

Payment	Pay for Community Resources/Services	• LAN (Category 4)
		• Medicare Advantage
		• Next Gen ACO
		• Comprehensive ESRD Care (CEC)
		• Bundled Payments for Care Improvement (BPCI)
		• Medicaid state plan services/MCOs/Waivers (NC)
			• Pay for ***CBO services/supports*** (ex. healthy food) in model/program budgets via:
			  • MA Supplemental benefits
			  • Medicaid In lieu of services
			  • Prospective population-based payments

Capacity	Investments to Enable Community Capacity	• LAN (Category 4)
		• ACO Investment Model
		• State Innovation Model
		• Maryland TCOC
		• Medicaid MCOs/1115 Waiver
		• Healthy Equity Zones (RI)
			• Invest in ***CBO capacity*** via:
			  • "Advanced payments" to CBOs for infrastructure investments (e.g., IT & data/accounting systems)
			  • Pooled/braided resources from enrollee partners (ex. Medicaid MCOs, enhanced Medicaid IT funding, community benefit dollars, philanthropy)

****DOH model elements already being implemented and/or clinical model elements that could be applied to DOH.***

❖ *CMS:* Launch inter-governmental initiative to deploy resources & take necessary actions to create aligned investment in DOH infrastructure.

Investing in DOH infrastructure requires a "both, and" approach – both immediate, unilateral action by CMS, and inter/intra departmental collaboration. CMS can use its existing resources and authorities to

support and accelerate DOH infrastructure investments as outlined above. At the same time, CMS's efforts (and CMMI's specifically) could be substantially magnified by reinforcing these DOH infrastructure investments with supports available from other divisions within HHS and other federal departments.

Such efforts to align across programs, divisions and agencies have been effective in the past and can provide a blueprint for the work ahead. The Million Hearts Cardiovascular Disease (CVD) Risk Reduction Model is an example of a "both, and" approach, with unilateral action by CMS as well as inter/intra departmental collaboration to achieve a common aim. Million Hearts 2022 – a national initiative co-led by the Centers for Disease Control and Prevention (CDC) and CMS to prevent one million heart attacks and strokes within five years – leveraged contributions from and alignment across not only CDC and CMS but also SAMHSA, ONC, and the Department of Veterans Affairs. Several other programs have demonstrated the impact of intra/inter departmental alignment and braided funding to address DOH, such as Rhode Island's Health Equity Zones, the Administration for Community Living's No Wrong Door Community Infrastructure Grants, and HRSA's Ryan White HIV/AIDS Program.

CMS should launch an inter-governmental initiative to deploy resources and take necessary actions to create aligned investment in DOH infrastructure (see Figure 5). Such coordination should also be leveraged to more effectively support states and other federal grantees in braiding funding to address DOH. For example, mounting evidence indicates that access to stable housing can improve health outcomes and reduce costs for people experiencing or at risk of homelessness. Yet CMS has repeatedly indicated in policy guidance that, while Medicaid may help pay for housing-related services (such as housing navigation), it cannot be used to pay for rent or room and board, even when such payment is explicitly linked to improved health outcomes and reduced costs. Aligning federal investment across health and housing services – and supporting state efforts to do the same – could dramatically improve health outcomes while reducing ED visits, admissions, and inpatient days and overall health care costs.

While CMS can co-lead the effort, other federal partners must also meaningfully engage and collaborate with CMS on the inter-governmental initiative. To help ensure the success of the collaboration, a clear, collective goal and defined outcomes should underpin the initiative. Key next steps include:

- Designate specific government entity co-leads
- Define a clear, time-bound aim & strategic framework
- Recruit other office/agency/department partners
- Clarify roles & responsibilities for partner entities
- Identify specific actions to be taken and resources deployed, consistent with Administration's priorities

Figure 5. CMS should formally partner with other HHS offices and other federal departments to align investments in DOH infrastructure.

		HHS											
Actions	**Notes/Examples**	**CMS/ CMMI**	**CMS/ Programs**	**CDC**	**ONC**	**HRSA**	**SAMHSA**	**ACF**	**ACL**	**HUD**	**USDA**	**OMB**	**DPC**
Provide grant or ongoing funding, including for indirect/admin costs	For CBOs to add/adapt service offerings and acquire administrative capabilities to enter partnerships with providers/payers	X	X	X	X	X	X	X	X	X	X	X	X
Align funding criteria across program areas	OMB could lead development of special criteria for entities that want to braid/blend funding streams	X	X	X	X	X	X	X	X	X	X	X	X
Coordinate/simplify procurement processes to create consistency across programs	Institutionalize learning from COVID rapid-response procurement	X	X	X		X	X	X	X	X	X	X	X
Streamline/align reporting requirements across programs	Reporting criteria should minimize burden, cost and risk across systems	X	X	X	X	X	X	X	X	X	X	X	X
Streamline/align program eligibility	Alignment across programs like SNAP, WIC and Medicaid would increase participation and directly impact DOH		X					X		X	X	X	X
Create common standards for data gathering and reporting	ONC could take the lead in designating standards, but deployment requires adoption/integration across all federal programs	X	X	X	X	X	X	X	X	X	X		X

Note: Chart is illustrative.