1. **What specific SDOH challenges have you seen to have the most impact on health?**
RESPONSE—
    - **Affordability**—One of the primary challenges for patients is affording the care they need to get and stay well. Affordability challenges have wide impact on a person's health, including their ability to afford routine prescription drugs or buy small-dollar nonmedical items and services that could lead to better health, such as fees that are required for housing applications or car repairs.
    - **Low health care literacy—**Health care is inherently complex and can prove intimidating to individuals most susceptible to social determinants. A person's health literacy may be influenced by their education, income levels, ethnicity, age and more. The impact of low-health literacy is far reaching and can adversely impact a person's care and treatment.
    - **Access to care—**While overall access to care is a challenge for individuals who are already impacted by adverse external factors, it is particularly acute for specialty care, dental care, long-term care and behavioral health.
    - **Transportation—**Getting to and from doctors' appointments and pharmacies is an issue in lower-income and rural communities, especially for older Americans. A lack of reliable transportation also impacts a person's ability to access community resources that may be available to them.
    - **Affordable housing—**Across all communities, this is the most frequently-cited challenge individuals face.
    - **Food insecurity—**Tens of millions of Americans struggled to have access to nutritionally-sound food before the pandemic. But the public health emergency around COVID-19 only exacerbated the problem, especially as unemployment grew and wages disappeared. As highlighted by the advocacy organization Feeding America, food insecurity disproportionately impacts persons of color across the U.S.

What areas have changed most during the COVID-19 pandemic?
RESPONSE—
The COVID-19 pandemic and subsequent public health emergency has only added to the challenges that low-income and disadvantaged individuals face.

- **Behavioral health**—Instances of increased anxiety, stress and depression associated with the pandemic underscored the frayed behavioral health safety net, and increased feelings of isolation and loneliness.
- **Preventive care**—Many people sidelined routine preventive care, posing severe long-term health risks if conditions go undetected.
- **In-person check-ins**—Community health workers, for instance, were not able to meet with individuals in their home or at their provider's office. Phone and video chats largely replaced in-person visits, but also highlighted challenges around a lack of equipment (e.g., smart phones,

tablets or computers), access to WI-FI and a lack of understanding or comfort with using that equipment once in place.

- **Food insecurity**—Some disadvantaged individuals were not able to shop for groceries during the quarantine, and several ACHP health plans report experiencing more requests for food from their low-income members.

2. **What types of gaps in care, programs and services serve as a main barrier in addressing SDOH in the communities you serve? What approaches have your organization, community, Tribal organization, or state taken to address such challenges?**

RESPONSE—

- **Gaps in Medicaid/CHIP coverage—**Millions of low-income individuals experience a two-to-five-month gap in Medicaid and CHIP coverage each year, in part because they may not realize that they have to reapply for the benefit. Coverage interruptions worsen health outcomes and lead to avoidable hospitalizations or emergency room care.
    - **Solution—** One ACHP member implemented a *"Do Not Get Dropped"* campaign, which provides Medicaid and CHIP enrollees a 60-day notice, typically through the mail, that alerts them that they must file for a coverage redetermination. Health plan customer service staff then work with that member to ensure they do not experience a gap in coverage.
    - **Solution**—ACHP and its members support ***continuous enrollment*** policies that ensure low-income individuals have a full 12 months of coverage for Medicaid and CHIP enrollees.
- **Gaps in race and ethnicity reporting—**Today, efforts to drive improvements in health equity are greatly hampered by a lack of data requirements when reporting on a person's race or ethnicity. This is especially problematic in government health programs, including Medicaid.
    - **Solution—**Variation across Medicaid programs provides major barriers to delivering better, more equitable outcomes across all patient populations. Providing minimum standards on how race and ethnicity is reported would improve outcomes in Medicaid and other government programs.
- **Lack of service partners—**Many rural communities lack the resources to provide help for low-income individuals, including nonmedical transportation options access to the internet or online services, "food deserts" where healthy options are limited and a shortage of acute care and mental health providers.
    - **Solution—**One ACHP member works to identify individuals with specific social needs and then helps to connect them with available community resources. The health plan offers a number of supplemental benefits, such as access to a tele-nutrition program that provides a registered dietician who can help plan—and arrange for delivery--of healthy and affordable meals.
- **Undocumented immigrants**—Undocumented immigrants are not eligible for Medicaid, CHIP or Affordable Care Act coverage. Medicaid can pay for emergency services for those who otherwise would qualify for Medicaid coverage but for their immigration status. For households with mixed-immigration status, this creates a major barrier for accessing government aid and very often individuals that are uninsured end up relying on charity care.

- **Solution**—Community outreach. One ACHP member developed and nurtured relationships with various local stakeholders that, in turn, target high risk populations and connect them with local enrollment assistors.

3. Are there other federal policies that present challenges to addressing SDOH?

RESPONSE—

- **Uncertainty around telehealth—**Under the COVID-19 public health emergency, federal health agencies relaxed antiquated restrictions on the use of telehealth. The ability for individuals to easily access care over the telephone or through video services has been a lifeline for those in rural and disadvantaged communities. ACHP and its members strongly support the permanent extension of these flexibilities, which would allow Americans to continue to access care in the safest, most convenient and effective ways via telehealth.
- **Data sharing and interoperability—**Health privacy laws, such as HIPAA, can be a roadblock to data exchange efforts. That's because community organizations, which play an important role in bridging disadvantaged individuals with important medical and nonmedical resources, have been subject to strict guidelines often become a barrier to sharing personal health information. Congress should consider ways to modernize flexibility for community organizations under HIPAA.
- **Lack of residential care coverage—**Under current rules, CMS does not cover residential care for substance treatment or licensed clinical professional counselors who treat substance use disorder.
- **Federal Beneficiary Inducement regulations—**The federal Beneficiary Inducement Statute (BIS) is in place to prevent health care organizations from providing remuneration to patients in Medicare and Medicaid in a way that would steer them to a particular provider. While the statute's intention is good, interpretation of the statute has nevertheless become a barrier when health plans want to provide their members with certain SDOH services who are enrolled in Medicare or Medicaid. Congress should work with federal health agencies to provide greater leeway in how the BIS is interpreted.
- **Federal policies related to the Institutes for Mental Disease (IMD)—**IMDs are medical facilities that diagnose, treat and care for persons with mental diseases, including substance use disorders. Currently, federal policies limit the number of days an individual can receive treatment. These types of treatment centers are very often the hub for addressing a person's social needs. Moving individuals out of an IMD before they are ready has an adverse effect on that person's health as well as the social fabric to help them get better.

4. Is there a unique role technology can play to alleviate specific challenges (e.g., referrals to community resources, telehealth consultations with community resource partners, etc.)? What are the barriers to using technology in this way?

RESPONSE—

- **Telehealth—**As noted in Question 3 and elsewhere in our response, ACHP and its members support extending the telehealth flexibilities granted under the COVID-19 public health emergency. ACHP supports extending those flexibilities to create greater access to specialists, remote monitoring and community resources.
    - **Barriers—**Data sharing needs to improve so that information can flow more freely across different care coordination platforms.
    - **Broadband--** ACHP strongly supports efforts to fully fund the expansion of broadband not just to rural communities, but also to underserved urban areas.

5. **Where do you see opportunities for better coordination and alignment between community organizations, public health entities, and health organizations?**

RESPONSE—

- **Data standardization and exchange**—This is especially important with regards to race, ethnicity, provenance of information and ability for individual consumers, patients and members to submit and update their information.

What role can Congress play in facilitating such coordination so that effective social determinant interventions can be developed?

RESPONSE—

- **Implementation and operations**—Congress can authorize demonstration projects and funding for implementation research. It's important for lawmakers to understand that the operational portion of these demonstrations is the mak- it or break-it phase for social determinant interventions. Additionally, Congress should consider strengthening the Affordable Care Act's requirement for providers to conduct regular Community Health Needs Assessments (CHNA), which are severely underused in practice. More rigorous requirements could incentivize collaboration among different organizations.

6. **What potential do you see in pooling funding from different sources to achieve aligned goals in addressing SDOH? How could Congress and federal agencies provide state and communities with more guidance regarding how they can blend or braid funds?**

RESPONSE—

- In 2019, ACHP convened a strategic roundtable discussion across its membership to discuss and develop strategies to invest in social needs innovation. Much of the conversation centered on how to pool available state and federal funding, as well as private investment, to expand data collection, community outreach and capacity building. *ACHP would welcome the opportunity to share the important results and next steps from that conversation with the Caucus.*

  The upshot of that discussion is the recognition that funding must come from a variety of sources. An ACHP member in Pennsylvania, for instance, partnered with a Pittsburgh-based organization that received funding from the U.S. Department of Housing and Urban Development to develop a program that provides housing for the chronically homeless. Another ACHP member partnered with a California-based tech company that helps build out community networks to address social needs.

  Congress should consider the following—

  - **Fully fund Medicaid's Home and Community Based Services (HCBS) programs**. Many of the solutions for those with social needs are housed within the Medicaid program. Home and Community Based Services allow for those individuals who receive Medicaid benefits to receive medical and nonmedical services in their homes or at community centers.
  - **Expand HCBS criteria—**Specifically, ACHP members identified a need for Congress to expand Section 1915(i), which outlines state options in defining criteria based on a person's needs. If the person meets the criteria, then they can receive acute care, skilled-nursing services and a range of nonmedical supports in their home or at a

community center. Congress should expand Section 1915(i) so that more patient populations are eligible to meet to the criteria.

7. **How could federal programs such as Medicaid, CHIP, SNAP, WIC, etc. better align to effectively address SDOH in a holistic way? Are there particular programmatic changes you recommend?**

RESPONSE—

- **Improve data collection, standardization and sharing.** As mentioned in previous responses, improving data collection is central to virtually all aspects of improving social determinants of health. Several states are developing state-level partnerships to share information among social services and Medicaid. The federal government should take a lead role in collecting and sharing the learning processes, operational components and other organizational improvements from the states. The federal government should also incentivize other states to take similar steps.

8. **Are there any non-traditional partners that are critical to addressing SDOH that should be better aligned with the health sector to address SDOH across the continuum from birth through adulthood? What differences should be considered between non-health partners for adults' social needs vs children's social needs?**

RESPONSE—

People with "lived experience," such as doulas and peer-health workers, need to become more fully integrated into care teams. There should be accommodations for the nonclinical nature of these roles, including preparing clinical teams for their inclusion, determining best practices for maintaining the "in-the-field" basis for these roles while also promoting good communication and coordination with overall clinical health teams. *Earlier this year, ACHP published an extensive report called, "A Framework for Advancing Health Equity: ACHP's Action Loops."* Key parts of the report center on "peer-driven interventions" that have proven to be effective for certain populations, including those in Medicaid. ACHP would welcome the opportunity to discuss its framework with Caucus members.

9. **What opportunities exist to better collect, understand, leverage, and report SDOH data to link individuals to services to address their health and social needs and to empower communities to improve outcomes?**

RESPONSE—

See response to Q8.

10. **What are the key challenges related to the exchange of SDOH data between health care and public health organizations and social service organizations? How do these challenges vary across social needs (i.e., housing, food, etc.)? What tools, resources, or policies might assist in addressing such challenges?**

RESPONSE—

One major challenge is the ability to maintain updated and current information and determining who is in charge of the process. And as ACHP has referenced in previous questions, the lack of clear data-sharing protocols and interoperability continues to hinder sharing between health care organizations, public health organizations and social services. Roadblocks to sharing data could adversely impact the identification of health plan members who may be in need of additional aid.

11. **What are some programs/emergency flexibilities your organization leveraged to better address SDOH during the pandemic (i.e., emergency funding, emergency waivers, etc.)? Of the changes made, which would you like to see continued post-COVID?**

RESPONSE—
ACHP members were quick to identify the impact COVID-19 would have on low-income, rural and disadvantaged populations. For a full list of the actions community health plans took to address social determinants during the pandemic, please click here.

12. **Which innovative state, local, and/or private sector programs or practices addressing SDOH should Congress look into further that could potentially be leveraged more widely across other settings? Are there particular models or pilots that seek to address SDOH that could be successful in other areas, particularly rural, tribal or underserved communities?**

13. **Given the evidence base about the importance of the early years in influencing lifelong health trajectories, what are the most promising opportunities for addressing SDOH and promoting equity for children and families? What could Congress do to accelerate progress in addressing SDOH for the pediatric population?**

RESPONSE—
Addressing the maternal health crisis in a holistic way is the best way to start. Doing so means going beyond making sure women do not die during childbirth, and extends to include wraparound approaches that follow the mother and family as the newborn grows. This also includes ensuring the childhood development environment promotes mental, physical and social health. ACHP supports the Black Maternal Health Momnibus Act, which makes critical investments in social determinants of health, provides funding for community-based resources, diversifies the perinatal workforce and more.

14. **Alternative payment models help to measure health care based on its outcomes, rather than its services. What opportunities exist to expand SDOH interventions in outcome-based alternative payment models and bundled payment models?**

RESPONSE—
Current quality measures are insufficient for doing this. Health plans have concerns over simply risk adjusting current measures. More work needs to be done to identify actual quality measures to indicate the impact of the health care entity's role in improving SDOH. Key to any successful approach is the ability to collect data that is standardized, high-quality and that doesn't require significant resources to "clean."

15. **A critical element of transformation, particularly for new models of care, is measurement and evaluation. With SDOH in mind, which are the most critical elements to measure in a model, and what differences should be considered when measuring SDOH outcomes for adults vs children?**

RESPONSE—
Longitudinal measures and impact evaluation will be required. Shorter term impact could be evaluated for specific measures, such as how access to a nutritional diet tracks to instances of diabetes. Health plans and providers, however, should also focus on the impact of preventative measures on long-term health.

16. **How can Congress best address the factors related to SDOH that influence overall health outcomes in rural, tribal and/or underserved areas to improve health outcomes in these communities?**

RESPONSE—

The best approach to these underserved populations is a community-based approach that engages members of the community in defining the "problem" and its resolution. Many ACHP plans hire from those communities specifically for that reason, which has the added bonus of creating economic opportunity where one otherwise might not exist.

17. What are the main barriers to programs addressing SDOH and promoting in the communities you serve? What should Congress consider when developing legislative solutions to address these challenges?

RESPONSE—

First and foremast, the lack of a business case for investment is the main barrier to addressing social determinants of health. Much of this problem extends to the difficulty in obtaining and analyzing data. Having the ability to do an analysis across patient populations, providers, health plans and community organizations is resource-and-time intensive work. Having a way to aggregate data across these platforms could speed the process.

18. Is there any other information you would like to share?

RESPONSE-

The Alliance of Community Health Plans and its nonprofit, provider-aligned members are driven to develop, test and ultimately expand workable solutions to improve health outcomes for people who struggle with adverse social factors. ACHP looks forward to being a constructive partner as the Congressional Social Determinants of Health Caucus begins its work in earnest.

For more information, please reach out to Matt DoBias, mdobias@achp.org