

ORIGINAL RESEARCH

# How Providers, Health System Leaders, and States Can Work Together to Align Disparate Policy Efforts to Address Health-Related Social Needs: Learning from North Carolina

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Keywords: Brianna Van Stekelenburg, Katie Huber, Yolande Pokam Tchuisseu, Rebecca Whitaker, Raman Nohria, Andrea Thoumi, Michelle Lyn, Robert Saunders, Will Bleser, health related social needs

<https://doi.org/10.18043/001c.141086>

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## North Carolina Medical Journal

Vol. 86, Issue 2, 2025

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### BACKGROUND

Under the Biden Administration, policy authorities and programs working to address health-related social needs (HRSNs) expanded across the United States. Despite major investments and initiatives to address HRSNs, they are still largely disparate from one another.

### METHODS

We conducted qualitative research to study North Carolina's HRSN landscape from 2020 to 2023, drawing on interviews with 22 individuals from 10 local HRSN initiatives and previous research collected on the service provision of North Carolina's Medicaid waiver demonstration pilot program to address HRSNs.

### RESULTS

For all states, payers, health systems, and providers, North Carolina demonstrates the archetypes of major policy authorities and programs that can and are being used to address HRSNs. However, we identify challenges that cut across them, including sustainability, operational barriers, and silos between sectors, and we draw implications for providers, health system leaders, and state policymakers looking to expand and align disparate health policy efforts to address HRSNs.

### LIMITATIONS

We acknowledge several limitations. First, participants in our qualitative research study did not represent all HRSN initiatives in North Carolina; however, we made significant efforts to capture diverse perspectives and major initiatives in the state. Second, we examined one state's approach to addressing HRSNs, which has lessons for other states; therefore, the generalizability of our findings depends on other states' contexts.

### CONCLUSIONS

As many states are currently prioritizing a whole-person approach to care for their residents, learning from North Carolina is critical to building a more effective and financially sustainable approach to address HRSNs.

## Introduction

Nationally, there is progress and interest across health payers and policymakers in using health payment and delivery reforms to address unmet health-related social needs (HRSNs) to improve whole-person health.<sup>1</sup> Social drivers of health (SDoH) affect health utilization, access to health and social services, and health outcomes. Addressing individual unmet HRSNs is one whole-person strategy, with historic federal investments, authorities, and requirements,<sup>2-7</sup> that can potentially improve costs, outcomes, and equity in health and social service sectors (sometimes with a financial return-on-investment).<sup>8,9</sup>

Of all payers, Medicaid in particular has represented one of the most significant policy opportunities to pay for and address HRSNs. This program can specifically support a lower-income, traditionally marginalized population with notable HRSNs.<sup>1,10</sup> Medicaid has used several powerful delivery reform and financing mechanisms to cover new and expanded HRSN services, including through Section 1115 waivers,<sup>11</sup> state Medicaid plans, managed care programs, and Medicaid Accountable Care Organizations and flexibilities.<sup>1,12</sup>

However, Medicaid is only one payer in a state, and given the shifting policy landscape, it is even more important to consider alternative strategies. States seeking to effectuate holistic change should consider ways to work with providers and health system leaders to align shared visions and goals while coordinating to address HRSNs across payers and health systems caring for populations outside of Medicaid. For example, Medicare Advantage (MA) has substantial authorities for providing HRSN supplemental benefits, including through Special Supplemental Benefits for the Chronically Ill (SSBCI) and Value Based Insurance Design (VBID). These different social needs programs can operate independently, even within the same payer, overseeing multiple authorities or payer types.

Therefore, across payers, there are notable opportunities for alignment and coordination where state leadership can play an important role. First, many authorities leverage payment and delivery flexibilities afforded through capitated and value-based payment (VBP) models, enabling health providers to coordinate across health and human service sectors—sometimes in collaboration with community-based organizations (CBOs). Second, many authorities share similar challenges, including how to scale interventions from a young evidence base, incomplete and inaccurate data on sociodemographic and HRSNs, and a lack of established or standardized cross-sectoral technology.<sup>1,13</sup> The shared challenges provide common footing for stakeholders to mutually benefit from state-led collaborative efforts.

In this paper, by examining North Carolina's HRSN landscape, we aim to draw implications for provider, health system, and state leadership looking to expand and align disparate health policy-led efforts to address HRSNs. North Carolina has the most expansive Section 1115 waiver program in the country to address HRSNs, the Healthy Opportunities Pilots (Pilots). North Carolina also built one of the most expansive programs to address pandemic-related HRSNs.<sup>14-16</sup> Some argue that North Carolina is a national leader in addressing HRSNs across all payers beyond Medicaid.<sup>17-20</sup>

But still, many of these efforts are disconnected, affording opportunities to think through how providers, health system leaders, and state policymakers can work together to coordinate and align different efforts while fostering innovation in those that are market-driven. Examining North Carolina as a state provides a holistic look at what major mechanisms can be used to address HRSNs and provides an opportunity to share challenges that cut across disparate health policy efforts.

## Methods

We conducted qualitative research to study North Carolina's HRSN landscape from 2020 to 2023. To better understand initiatives addressing HRSN across North Carolina, we launched interviews with 22 individuals from 10 initiatives in North Carolina focused on addressing HRSNs in partnership with health systems. To our knowledge, this study captures the large majority of major HRSN initiatives in the state. We identified potential interviewees by reviewing online information on HRSN initiatives, the 77 MA plan products offered in North Carolina for the 2023 enrollment year, and application materials for the Pilots' Network Leads (the entities responsible for overseeing the program's regional HRSN networks).<sup>21,22</sup>

We used a robust, consensual, team-based qualitative research approach to analyze content and synthesize lessons learned from key informant interviews. Interviews followed a semi-structured guide to learn about initiatives addressing HRSNs across North Carolina. Key informant interviews were recorded. The synthesis process included drafting research memos for each interview, debriefing with our multi-disciplinary research team to reflect and expand on findings and reconcile differences in interpretation, and workshopping findings with our study team. Through this process, we identified distinguishing features of initiatives that we categorized into archetypes, as well as challenges and lessons learned that were common across initiatives.<sup>23-25</sup>

The synthesis process utilizes both deductive reasoning (identifying themes within the *a priori* potential theme areas) as well as inductive reasoning (emergently developing new categories of themes). These systematic methods, recommended in the qualitative research field, help to improve the replicability and generalizability of our findings.

## Results

### ***North Carolina: A Model of Health System-led Efforts to Address Health-Related Social Needs at Scale***

North Carolina is noted as expansive in its approach to addressing HRSNs, aiming to enhance whole-person well-being and improve health outcomes across payers through major mechanisms led by or in partnership with the health delivery system. After reviewing different mechanisms, we identified 5 major archetypes for providers, health system leaders, and state policymakers to consider: Medicaid Section 1115 waivers; organizations sustaining proposed cross-sectoral efforts despite not receiving Section 1115 waiver funds; organizations that sustained pandemic-related programs to address HRSNs after funding cessation; commercial payers with initiatives focused on addressing HRSNs; and other local government or health system-led initiatives addressing HRSNs.

North Carolina state agencies have direct influence over the health policy levers of the first 3 archetypes. First, the state leads the \$650 million Medicaid Section 1115 waiver Pilots program to address 29 different HRSNs at scale, which launched in March 2022 after a year-long infrastructure building period. The Centers for Medicare & Medicaid Services (CMS) recently approved North Carolina's request for a 5-year extension and expansion of the Pilots aimed at improving whole-person care. The approval granted permission for the state to expand services statewide and broaden eligibility to include beneficiaries in Tailored Plans and Child and Specialty Family Plans, pregnant people, people with at least 1 chronic condition (rather than 2 or more), and pre-release services for justice-involved populations.<sup>26</sup> While Section 1115 waiver programs are experimental in nature and approved by CMS on a case-by-case application basis, Medicaid Managed Care further gives authority to address HRSNs through in-lieu-of-services (part of their capitated rate) or value-added services (beyond capitated rate). Second, when the state designed the Pilots, they competitively selected 3 regional CBO network hub organizations ("Network Leads") across the state from 9 applicants. The application required substantial work, and some organizations started building new infrastructure before the announcement of selected applicants. Some of the non-selected organizations found ways to continue the enhanced HRSN work they proposed for the Pilots. Third, the state leveraged Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to create a pandemic-related HRSNs program similar in design to the Pilots but on a smaller scale.<sup>15</sup> While that program wound down in 2022 as CARES Act funding depleted, some of the regional grantees sustained their work through new mechanisms.

The last 2 archetypes move beyond authorities that the state has direct influence over to where providers and health system leaders have more influence on aligned design. Regarding the fourth archetype, commercial

plans can offer HRSN services to compete in the private market for employer or individual choice. MA plans are included in this archetype, which provides avenues for commercial payers to pay for services that more indirectly address HRSNs with federal dollars. We examined the 77 MA plan products offered for the 2023 enrollment year in North Carolina.<sup>21</sup> While 66 offered basic supplemental benefits addressing HRSNs, often tied to a specific health condition, we spoke with representatives of 4 plans from 3 MA organizations that offered more expansive and innovative supplemental benefits designed to address HRSNs (e.g., non-medical transportation and flex cards to pay utilities).

Finally, the fifth archetype includes one-off local initiatives, such as those led by local health systems or universities, focused on cross-sectoral partnerships to address HRSNs. Providers arguably have the most influence on this archetype, which is the most ad hoc, creating opportunity for providers to drive alignment. We summarize these 5 archetypes in [Table 1](#), with more detail in Appendix A.

There are key contextual points that facilitate this work. In many ways, North Carolina may be generalizable to other states. For example, these initiatives were developed across bipartisan lines, indicating they could work in a range of political and policy contexts. At the same time, North Carolina's participation in numerous policy models and multi-stakeholder initiatives that help facilitate the array of HRSN policy initiatives makes it unique from many other states. As a notable example, North Carolina is participating in a federal CMS Innovation Center Model, Integrated Care for Kids (InCK), to advance whole-family integrated care through Medicaid and is currently considering CBO partnerships.<sup>27</sup> North Carolina is also participating in the CMS-supported Health Care Payment Learning & Action Network's State Transformation Collaborative, where North Carolina is focused on aligning quality measures, improving data sharing infrastructure, and enhancing health equity data to enable advanced, coordinated care models.<sup>28,29</sup> Additionally, North Carolina is heavily focused on the integration of Medicaid and Medicare, including equitable and coordinated access to social health needs.<sup>30</sup> Finally, North Carolina became the first state with a statewide contract on a cross-sectoral, closed-loop referral system technology platform, NCCARE360.<sup>15</sup> The platform is mandatory for the Pilots (and handles HRSN service invoicing) but is optional for other providers and health systems to use outside of the Pilots for HRSN screening and referrals.

Table 1. Major Archetypes Addressing Health-Related Social Needs in Partnership with the Health Delivery System in North Carolina

| Archetypes                                                                                                                                             | Example                                                                                                      | Financing Source                                                                                          | Program Details                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Archetype 1:</b><br>Medicaid Section 1115 waiver                                                                                                    | NC Healthy Opportunities Pilots (Pilots)                                                                     | Medicaid                                                                                                  | <ul style="list-style-type: none"> <li>The Pilots demonstration program is a cross-sectoral pilot program led by NCDHHS that is funding health care and community-based social service providers to address HRSNs of eligible Medicaid beneficiaries.</li> <li>Medicaid Managed Care plans can also offer, on a more limited basis, some HRSN services through general in-lieu-of services or value-added services authorities.</li> </ul>                                                                                                                                                                                                                                                                                                              |
| <b>Archetype 2:</b><br>Organizations sustaining proposed cross-sectoral efforts despite not receiving Medicaid Section 1115 waiver demonstration funds | NC Community Action Association (NCCAA)<br>Piedmont Triad Regional Council (PTRC)                            | Grants, foundations<br>MA plans, Medicare (for diabetes classes), state and county human service agencies | <ul style="list-style-type: none"> <li>NCCAA often partners with other organizations, including commercial payers, to provide SDoH services.</li> <li>PTRC developed a community hub model to coordinate referrals, track outcomes, and build capacity across health systems, public health, and social services. PTRC invested in building the community health worker (CHW) workforce to meet the expectations of health system partners. PTRC participates in the federal Community Care Hub National Learning Community.</li> </ul>                                                                                                                                                                                                                 |
| <b>Archetype 3:</b><br>Organizations that sustained pandemic-related programs to address HRSNs after funding cessation                                 | 7-Cs Committee<br>Duke Health                                                                                | Grants, county government, Foundation for Health Leadership and Innovation (FHII)                         | <ul style="list-style-type: none"> <li>Duke Health, continuing work for which it received COVID-19 funds to address HRSNs, SDOH, and health disparities, acts as a neutral convener to bring together a regional network of CBOs, CHWs, and health systems (WakeMed, UNC, Duke) across 7 counties (Durham, Wake, Franklin, Warren, Vance, Granville and Nash) on a monthly basis.</li> <li>The regional network is working to identify the type of role it can serve to support regional stakeholders.</li> </ul>                                                                                                                                                                                                                                       |
| <b>Archetype 4:</b><br>Commercial payers with initiatives focused on addressing HRSNs                                                                  | Blue Cross Blue Shield NC<br>Humana, Aetna, and WellCare                                                     | Free market business<br>Federal funds (Medicare)                                                          | <ul style="list-style-type: none"> <li>Blue Cross Blue Shield NC has several initiatives focused on addressing HRSNs, including initiatives in transportation, housing, and access to foods, and has also prioritized improving how HRSN data is captured and shared across health systems.</li> <li>Several MA plans in NC are using SSBCI to offer innovative supplemental benefits to address HRSNs of the chronically ill population. Examples of these innovative supplemental benefits include non-medical transportation, flex cards for utilities, and services to address loneliness.</li> <li>Participation in the VBID program also allows plans to pay for similar services to SSBCI, but to a broader population.</li> </ul>               |
| <b>Archetype 5:</b> Other local government or health system-led initiatives addressing HRSNs                                                           | Whole Community Connection (WCC)<br>Guilford County-Cone Health Partnership<br>Advocate Health/Atrium Health | UNC, Kenan Charitable Trust<br>American Rescue Plan Act funds, Cone Health Advocate Health/Atrium Health  | <ul style="list-style-type: none"> <li>WCC supports NC leaders with community-academic partnerships for health equity.</li> <li>The Guilford County-Cone Health partnership identifies community-informed solutions to address SDOH and improve health equity.</li> <li>Advocate Health is launching the new Advocate National Center for Health Equity to more intentionally provide support for HRSNs and health equity across its networks. Atrium Health, which operates under Advocate Health in the Southeast, focuses on partnerships with community organizations to assist with efforts related to food access, affordable housing, and employment, including a community resource hub and a housing instability plan in Charlotte.</li> </ul> |

Note. Pilots = NC Healthy Opportunities Pilots; NCDHHS = North Carolina Department of Health and Human Services; HRSNs = health-related social needs; MA = Medicare Advantage; SDoH = social drivers of health; CHW = community health worker; CBO = community-based organizations; VBID = value-based insurance design

## Discussion

### ***Challenges That Crosscut Disparate Health Policy Efforts to Address Health-Related Social Needs***

Although there are myriad initiatives working to address HRSNs and integrate social services with the health delivery system, there are many challenges. Some of these challenges are not new, echoing those noted in the literature. However, some relate to new policy authorities where contextualization is useful, and we illustrate real-world examples of how these challenges play out in North Carolina. As we interviewed stakeholders across the archetypes noted in [Table 1](#), three sets of challenges crosscut all initiatives. First, current health policy efforts to address HRSNs are often disconnected and siloed within states—sometimes within single health systems or provider organizations. This can make it difficult to know comprehensively what efforts are occurring, what services are being provided, which populations are being served, where there may be duplication or uncoordinated gaps, and whether disparities are being reduced. A critical part of this challenge stems from the lack of standardized screening tools, making data exchange across sectors difficult and impacting service delivery. Second, further complications arise from a general lack of available funding, lack of flexibility in available financing, and/or the need to weave different funding streams together to provide services. Third, even when significant funding is available, there are operational and logistical barriers to implementing cross-sectoral programs to address HRSNs, some of which relate to new authorities or major demonstration programs. These challenges can inhibit any given cross-sectoral partnership, and even the potential for whole-system success, ultimately hindering equitable service provision to populations in need. However, they also provide a common ground for identifying opportunities for statewide coordination. These opportunities are summarized in [Table 2](#).

### ***Lack of Communication and Coordination Forums Across Stakeholders Working to Address Health-Related Social Needs***

From speaking with a wide variety of North Carolina initiatives, 3 primary communication and coordination challenges emerged. First, there is not a common cross-effort coordination forum spanning healthy policy levers and initiatives to address HRSNs, especially when different funding sources are involved. There are several structural reasons for this. Sometimes there is a lack of communication between different archetypes within one organization based on the line of business (e.g., between a commercial payer's groups overseeing a local MA plan and a Medicaid Managed Care plan). In addition, there are major differences in levels of funding and power between health and social service organizations. The health system typically has high capital compared to those providing services (e.g., CBOs), and there are incentives for health systems to screen and refer patients, but many current initiatives

Table 2. Summary of Challenges that Cross-cut Disparate Health Policy Efforts to Address Health-Related Social Needs (HRSNs) in North Carolina

| Challenge Domain                                                                                                              | Key challenges                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Lack of communication and coordination forums across stakeholders working to address HRSNs                                    | <ul style="list-style-type: none"> <li>• Lack of a common, cross-effort coordination forum, sometimes even within the same organization, when different funding sources are involved.</li> <li>• No standardized tools or approaches to address HRSNs in collaboration with the health system.</li> <li>• Young, experimental cross-sectoral technology platforms to facilitate cross-sectoral HRSNs work that rarely have functionality to “close the loop” after referrals are made or to house important data.</li> </ul>                                                                                    |
| Issues with sustainability, financing, and the flexibility of financing                                                       | <ul style="list-style-type: none"> <li>• Disparate health system financing mechanisms to address HRSNs, each with different timelines, reporting requirements, delivery models, legal and regulatory restrictions.</li> <li>• CBOs historically operate through a variety of insufficiently resourced grants and financing mechanisms, threatening capacity-building potential and the ability to sustainably integrate with the health system.</li> <li>• Cessation of one-time COVID-19 pandemic-related funding that improved local capacity to address HRSNs threatens current system financing.</li> </ul> |
| Operational and logistical barriers for implementation of new health-related social support services authorities and programs | <ul style="list-style-type: none"> <li>• Some authorities to address HRSNs through the health delivery system are relatively new, so lessons are developing and uptake is low.</li> <li>• Eligibility criteria for many existing or new authorities are strict and labor-intensive, challenging uptake and the communication of benefits to people.</li> </ul>                                                                                                                                                                                                                                                  |

Note. HRSN = health-related social needs; CBO = community-based organization

(with some notable exceptions) do not include the funding for CBOs to provide services. Additionally, different populations have varying social service needs and may be served by different types of health care and CBO providers, which further complicates communication and coordination.

A second major issue is a lack of standardization in tools and approaches to address HRSNs.<sup>1</sup> Part of this challenge stems from the use of a decentralized approach to address HRSNs. Across payers, there are often different processes for screening for unmet needs, leading to differences in what data are collected and how they are formatted and stored. This makes data sharing across organizations and sectors difficult, which complicates efforts to track uptake and quality of services, and also leads to increased provider burden. Further, the lack of standardization in collecting and sharing HRSN data across organizations and sectors leads to challenges in providing patient-centered care and improving outcomes. On the delivery side, the current approach to screening and referrals draws clear lines between health and social service providers (e.g., health care workers think their job is complete after a referral is executed), causing a lack of understanding about the work that continues following a referral (e.g., connection with the appropriate resources) and the need for follow-up after screening to ensure those needs were met. Finally, CBO infrastructure varies by geography, further complicating what HRSNs people have and what services are available. These contexts could be improved through system-wide coordination.

Third, while some cross-sectoral technology platforms help identify local organizations that provide services to patients with HRSNs and facilitate referrals, it is uncommon for those technology systems to be able to follow-up on referrals or house the financial and encounter data CBOs need to receive

payment for their services—or for health care organizations to track progress. Two-way communication between health care organizations and CBOs is important to both understanding and addressing the needs and outcomes of patients, and to reducing communication breakdown and improving coordination of services. North Carolina’s NCCARE360 platform, developed through a public-private partnership as a statewide cross-sectoral, closed-loop referral system, is designed to address many of these problems. NCCARE360 is used in the Pilots and by almost all North Carolina health systems outside of the Pilots, but challenges to broader uptake and implementation remain.<sup>15,22</sup> There is opportunity for providers and health system leaders to align HRSN strategies around NCCARE360 to minimize statewide fragmentation of technological and screening approaches. Technology related to enrollment for public programs also plays into this, as North Carolina has separate enrollment platforms for different programs which are not currently integrated into NCCARE360. People may lose eligibility for one program, and neither they nor the state may know of eligibility for other programs or local resources to address HRSNs.

### ***Issues with Sustainability, Financing, and the Flexibility of Financing***

Currently, services to address HRSNs are funded through many mechanisms, contributing to challenges in system-wide coordination. In North Carolina, this includes funding through CMS, including through Medicare (e.g., MA plans) and Medicaid (e.g., Section 1115 waivers, CMS Innovation Models); employers (e.g., commercial employer-sponsored insurance plans); one-off federal funds (e.g., CARES Act funding); local county governments (Duke Health’s 7 C’s); research grants; and health system internal investments (e.g., Cone Health). Different funding sources have varying timelines, reporting requirements, delivery models, and legal and regulatory restrictions, which can make alignment challenging.

Further, while there are many potential funding sources, CBOs often have difficulty finding sustainable sources of funding for aspects of their HRSNs work. Many CBOs operate on extremely thin margins, funded through a variety of sources, threatening the maintenance of their data infrastructure, ability to pay administrative costs, and efforts to build capacity related to integrating their work into health delivery systems.<sup>22,31</sup> Not dissimilarly, health systems also encounter difficulties financing aspects of their HRSNs work such as the organizational changes needed to implement HRSN services, particularly if there is an impact to clinical workflows.

The use of one-time funding from COVID-19, and the allowed flexible usage of funds, was critical in setting up and bolstering infrastructure to address HRSNs.<sup>15</sup> However, these funds are time-limited and often targeted towards specific supports, making it important for states to develop a strategy to

coordinate across sectors, weave funding together to sustain programs and infrastructure, and consider coordinating plans to support programs after funding cessation.

### ***Operational and Logistical Barriers for Implementation of New Health-Related Social Support Service Authorities and Programs***

Even when funding is available, there are many operational and logistical barriers to implementing cross-sectoral programs to address HRSNs. There is a body of literature on this topic, but we highlight 2 new examples we learned through interviews.

First, the spread of MA SSBCI offered new abilities to address HRSNs through MA in local North Carolina settings. SSBCI offers supplemental benefits to address HRSNs to MA beneficiaries that have 1 or more complex chronic conditions. However, uptake has been slow, as made evident in studies, as well as in our scan of public North Carolina MA plans.<sup>32</sup> Interviewees noted that the adoption of SSBCI may be limited due to operational and logistic barriers, including strict claims-based criteria to qualify beneficiaries, balancing clear communication to members on the availability of SSBCI benefits with the risk that beneficiaries will not qualify, implementation of care coordination, and strict rules about vendor oversight.<sup>33</sup>

Similarly, enrollment in the Pilots was slower than originally anticipated.<sup>17</sup> This stemmed from several reasons, including delays in program launch due to COVID-19, but also the complexity associated with implementing a large-scale, novel, cross-sectoral program and building the partnerships and infrastructure.<sup>17</sup> Low community awareness about the Pilots, combined with a time-consuming enrollment process, also contributed to slower uptake of Pilot services early on. NC Medicaid has implemented several strategies to increase enrollment in the Pilots and the uptake of services, including paying CBOs for grassroots enrollment efforts and developing targeted marketing to increase awareness.<sup>34</sup>

### **Conclusion**

Across the United States, there has been an uptick in initiatives working to address HRSNs and SDoH, pointing to a movement led by providers, health systems, and states that focuses on the delivery of whole-person care and the integration of physical, behavioral, and nonmedical drivers of health. New funding mechanisms have helped drive the increase in initiatives (e.g., guidance on the expanded use of Medicaid funds for HRSNs, new MA authorities, commercial payers seeing the importance of addressing HRSNs, and ability for COVID-19 funds to be used to set up critical infrastructure). While many initiatives are forming, there are still challenges with sustainability, operational barriers, and silos between sectors. For providers,

health systems, and state leaders to make progress on addressing HRSNs and the challenges often seen within those initiatives, there is a need to coordinate and align disparate health policy efforts to achieve a common vision for addressing HRSNs and improving health equity. We draw challenges and opportunities from North Carolina—a state with an expansive infrastructure to address HRSNs, but where coordination across authorities and efforts could improve system-wide progress.

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### ***Financial support***

The authors acknowledge grant support for this work from the Kate B. Reynolds Charitable Trust.

### ***Disclosure of interests***

Brianna Van Stekelenburg does not have any disclosures at this time. Katie Huber previously received speaking fees from the Mountain Area Health Education Center for presenting research on health care transformation to address social needs and health equity. Yolande Pokam Tchuisseu does not have any disclosures at this time. Dr. Rebecca Whitaker is the lead on a Duke-Margolis contract with the NC Department of Health and Human Services Division of Health Benefits to generate and translate evidence to inform the design and implementation of the Department's value-based purchasing (VBP) strategy and with Kate B. Reynolds Charitable Trust to identify strategies to integrate equity in NC Medicaid value-based payment. Dr. Whitaker is a volunteer board member for Care Share Health Alliance, an organization supporting the implementation of the Healthy Opportunities Pilots. Dr. Raman Nohria does not have any disclosures at this time. Andrea Thoumi is an Executive Board Member of LATIN-19 (unpaid affiliation). Michelle Lyn does not have any disclosures at this time. Dr. Robert Saunders has been an external reviewer for The John A. Hartford Foundation, and he is a co-chair for the Health Evolution Summit Roundtable on Value-Based Care for Specialized Populations. Dr. William K. Bleser previously received consulting fees from StollenWerks LLC on health policy delivery system change unrelated to this work, speaking fees from the Mountain Area Health Education Center and from the West Virginia Primary Care Association for presenting research on health care transformation to address social needs and health equity, an honorarium from the Robert Wood Johnson Foundation for assistance reviewing grant proposals unrelated to this work, consulting fees from Merck for research for vaccine litigation unrelated to this work, consulting fees from BioMedicalInsights, Inc. for subject matter expertise on value-based cardiovascular research unrelated to this work, and consulting fees from Gerson Lehrman Group, Inc. on health policy subject matter expertise

unrelated to this work. He serves as Board Vice President (uncompensated) for Shepherd's Clinic, a clinic providing free health care to the uninsured in Baltimore, MD.

Published: June 27, 2025 EDT.



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## Appendix A.

### *North Carolina: A Case Study of Health System-led Efforts to Address Health-Related Social Needs*

#### **ARCHETYPE 1: MEDICAID SECTION 1115 WAIVER**

As part of North Carolina's Section 1115 waiver that shifts the Medicaid program to managed care, the Centers for Medicare and Medicaid Services (CMS) authorized the Healthy Opportunities Pilots (Pilots), a cross-sectoral pilot program that is funding health care and community-based social service providers to work together to address the health-related social needs (HRSNs) of eligible Medicaid enrollees in 3 regions of the state.<sup>14</sup> Up to \$650 million in Medicaid funding is authorized for the Pilots to deliver 29 specific services related to housing, food, transportation, and interpersonal safety and toxic stress that are reimbursed on a set fee schedule. CMS is evaluating the impact of the program on enrollees' health outcomes, health care utilization, and health care costs.

Overall, the program involves cross-sector partnerships among Medicaid Managed Care plans and community-based organizations (CBOs). Three regional Network Lead organizations are responsible for building and supporting networks of CBOs that are contracted to deliver Pilots services. Prepaid Health Plans (PHPs – North Carolina's Medicaid Managed Care Organizations) are responsible for determining enrollees' eligibility for the Pilots, authorizing services, and reimbursing CBOs for service delivery. NCCARE360 is being used to make closed-loop referrals for Pilots services.

CMS recently approved a 5-year extension and expansion of the Pilots aimed at improving whole-person care, including expansion of services statewide and expanded eligibility for beneficiaries.

#### **ARCHETYPE 2: ORGANIZATIONS SUSTAINING PROPOSED CROSS-SECTORAL EFFORTS DESPITE NOT RECEIVING MEDICAID SECTION 1115 WAIVER DEMONSTRATION FUNDS**

Some organizations in North Carolina found ways to sustain progress through other funding sources outside of the Section 1115 Waiver opportunity. These organizations have long histories of cross-sector partnerships that exist outside of the Pilots and were able to build off those partnerships to continue planned work that did not get funded through the Section 1115 waiver. Some invested in infrastructure and technology to build out community hub functionality. Two examples we came across in our research include the NC Community Action Association (NCCAA) and the Piedmont Triad Regional Council (PTRC).<sup>35,36</sup>

### ***North Carolina Community Action Association (NCCAA)***

Community Action Agencies can be found across the US and receive federal funding to offer specialized programming in local communities to address the root effects of poverty and equip low-income individuals with the tools and potential for becoming self-sufficient. NCCAA has been providing programs and services to address SDoH for nearly 60 years, often partnering with other organizations to provide those services. One such initiative is the Healthy Homes Initiative, which is a partnership between NCCAA and Blue Cross and Blue Shield of NC to provide families with home repairs needed to improve their health and safety.<sup>37</sup>

### ***Piedmont Triad Regional Council (PTRC)***

PTRC is a voluntary association of local governments that serves a 12-county area in Central North Carolina. PTRC applied to participate in the Pilots, but they were not selected during the first competitive application process and turned to other avenues to sustain progress, creating new inroads with both health systems and payers. To continue to sustain efforts, PTRC developed a Community Care Hub Model to centralize intake processes and build capacity across a broad network of community agencies, including health systems, insurers, public health, and social services. Seeing community health workers (CHWs) as essential to the healthcare system in bridging clients with community needs, PTRC invested in building an internal CHW workforce and an information technology (IT) system for managing referrals in order to create a more sustainable interface between the health and social service sectors. PTRC consulted with health system partners to identify initial areas of high need and deployed their CHWs accordingly. They focused in part on hiring bilingual CHWs because of the areas they were directed to serve. PTRC is also one of 58 participants in the federal Community Care Hub National Learning Community.<sup>38</sup>

### **ARCHETYPE 3: ORGANIZATIONS THAT SUSTAINED PANDEMIC-RELATED PROGRAMS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS AFTER FUNDING CESSATION**

Many states used time-limited federal funding that became available in response to the COVID-19 pandemic to address HRSNs, social drivers of health (SDoH), and health disparities. Major sources of initial funding for these efforts included the Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan Act (ARPA). Two examples where organizations sustained pandemic-related programs to address HRSNs after funding cessation include the 7 C's Committee and Duke Health.

## ***7 C's Committee***

Regional networks, both formal and informal, play a critical role in further aligning health and social care services. This section explores the experience of 7 C's, a North Carolina regional network addressing health and social care integration for 7 North Carolina counties—Durham, Wake, Franklin, Warren, Vance, Granville, and Nash—and the role states can play in effectively leveraging these networks. The 7 C's regional network grew out of the effort to support COVID-19 quarantine efforts for North Carolinian residents in these 7 counties. Duke Health, in collaboration with CBOs, the NCDHHS, and CHWs, participated in the NCDHHS COVID-19 Social Support Program to serve its members. The 7 C's regional network persists in spite of funding expiration in February 2021. This committee has intentionally chosen to coordinate as a region to take advantage of interconnected CBO/CHW networks and coordinated capacity. This network operates through continuous relationship building, focusing on health equity and understanding real-time effectiveness.

The current objective of this group is to understand the role the regional network can play in supporting health and social care integration efforts. Possible roles identified include serving to raise awareness and educating members regarding ongoing efforts; taking a lead to design regional strategy with a concrete number of stakeholders; or working with state and regional lawmakers to codify policies that improve regional network effectiveness. States should undertake efforts to identify such regional networks, whether formal or informal, and assist these networks in defining their roles in order to better coordinate stakeholders.

## ***Duke Health Screening for Health-Related Social Needs***

Duke Health started using NCCARE360 in August 2020 as part of the NCDHHS COVID Support Program, with full Electronic Medical Record (EMR) integration of NCCARE360 in January 2021. Duke Health has been conducting systematic HRSN screening since 2017, with current HRSN screening implementation not only within Duke Health's outpatient primary care network, but also at its federally qualified health center, specialty clinics such as endocrinology and psychiatry, and the emergency department. Duke Health also has a case management program called DukeWELL that implements HRSN screening. Duke Health's experience in implementing HRSN screening offers 3 key lessons for states looking to leverage health systems to align health and social care: 1) allow for flexibility in implementation of screening; 2) the lack of integration between social care referral data and EMR data is a major barrier to evaluate real-time effectiveness of screening and referral services; and 3) screening is greatly enhanced when CBOs are funded to have the capacity to serve referrals.

While Duke Health has encouraged screening across the health system to ensure equitable screening, Duke Health has supported screening implementation to be tailored to each screening location.<sup>39</sup> For example, screening itself has been implemented differently; the DukeWELL case management program conducts screening as part of its intake, outpatient primary care and specialty clinics have integrated screening into their online intake questionnaires, and outpatient pediatrics have used a welcome tablet. Another tailored aspect is the individual responsible for following up on referrals. In the outpatient primary care network, a dedicated population health coordinator is responsible for entering referrals into NCCARE360, while Duke Health's FQHC has leveraged a student-led help desk to perform screening and coordinate referrals.<sup>40,41</sup>

#### **ARCHETYPE 4: COMMERCIAL PAYERS WITH INITIATIVES FOCUSED ON ADDRESSING HRSNS**

##### ***Blue Cross and Blue Shield of North Carolina***

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) is one of North Carolina's largest commercial payers. Recently, they launched several initiatives focused on addressing HRSNs in key areas, including housing, transportation, and access to healthy foods. Current initiatives include the Green and Healthy Homes Initiative to create healthy environments for members, a new clinical study to improve food security with UNC Health, and a prescription-based food purchasing program with Reinvestment Partners.<sup>42-44</sup> Blue Cross NC has also prioritized data as a key focus area after recognizing the challenges that a lack of data sharing across the health care community brings to address HRSNs.<sup>45</sup> They also recently joined the Gravity Project, a collection of payers, providers, and other health care stakeholders to improve how HRSN data is captured and shared across health systems.<sup>46</sup>

##### ***Medicare Advantage Plans Providing Innovative Supplemental Benefits for Addressing Health-Related Social Needs***

Some MA plans in North Carolina are going beyond basic supplemental benefits (e.g., transportation for doctor's visits and gym memberships) by providing non-health related supplemental benefits (e.g., transportation for non-medical needs and pest control). In our scan of public North Carolina MA plans, 4 out of 77 were providing more than basic HRSN-related benefits.<sup>21</sup> These extra supplemental benefits are primarily offered either through the SSBCI or VBID model.<sup>47</sup> While MA plans provide SSBCI benefits primarily based on qualifying health conditions, MA plans participating in the VBID model are able to provide supplemental benefits to enrollees based on both qualifying health conditions and income level.<sup>48</sup> Several MA plans in North Carolina are focused on designing benefits to

meet the shifting needs of members during the course of a year, which could happen outside of the enrollment period, signaling a desire for more flexible benefits. Some of the more flexible benefits offered under SSBCI or VBID include flex cards to use as needed on items such as food, utilities, home health services, and over-the-counter needs; nonmedical transport to senior centers or fitness centers; grocery delivery; a companionship benefit; and home remediation.<sup>49,50</sup>

### **ARCHETYPE 5: OTHER LOCAL GOVERNMENT OR HEALTH SYSTEM-LED INITIATIVES ADDRESSING HRSNS**

Several standalone initiatives have been formed in NC through cross-sector partnerships, including between universities and human services organizations, as well as county governments and health systems. Three examples we came across in our research include the Whole Community Connection, the Guilford County-Cone Health iTeam, and Advocate Health/Atrium Health.

#### ***Whole Community Connection***

Whole Community Connection (WCC)—supported by The University of North Carolina at Chapel Hill (UNC) Office of Interprofessional Education and Practice, UNC Rural, and a gift from the William R. Kenan, Jr. Charitable Trust—is supporting leaders in rural North Carolina through community-academic partnerships to advance health equity.<sup>51</sup> WCC's goal is to provide the initial funding to start academic-community partnerships that implement successful and sustainable programming prioritized and driven by local communities. Previous community partnerships have focused on maternal health, family mental health, peer support for parents with special health care needs, and sexual violence prevention for individuals with developmental disabilities. Partners include UNC faculty in the Eshelman School of Pharmacy, Gillings School of Global Public Health, School of Nursing, School of Social Work, and Department of Geography and Environment. Community partners include a local children's health clinic, a rape crisis and counseling center, and human service organizations advocating for rural capacity building and individuals with developmental disabilities. Projects focus on prevention and improved coordination of resources and community involvement in rural communities.

#### ***Guilford County-Cone Health iTeam***

Since 2020, Cone Health has used human-centered design to transform its approach to health equity through a deeper understanding and partnership with the entire community. This collaborative model helped inspire Guilford County and Cone Health to establish a public-private partnership that leverages human-centered design to identify community-informed solutions to address SDoH and improve health equity.<sup>52</sup> This unique innovation

partnership will go beyond caring for an individual solely in a clinical setting and will work alongside community members to address the root causes and systems that cause inequities in health. This team is in its early stages and is still speaking with the community to determine where to prioritize efforts. This initiative is funded in part by Guilford County's allocation of American Rescue Plan Act Funds.

### ***Advocate Health/Atrium Health***

In December 2022, Advocate Aurora Health and Atrium Health finalized plans to create Advocate Health—the fifth-largest nonprofit integrated health system in the United States.<sup>53</sup> The newly established Advocate Health is launching the Advocate National Center for Health Equity that will operate across Advocate's network, including in North Carolina. This new center will utilize the full resources of the health system to impact health equity by bringing interventions directly to patients and by partnering with community stakeholders to co-design and activate social impact programs. Atrium Health, which operates in the Southeast under Advocate Health, is focused on partnerships with community organizations in a variety of social need areas, including food access, affordable housing, and employment. Atrium Health uses a Community Resource Hub to connect Atrium Health providers, patients, and other residents to a variety of community-based programs and services.<sup>54</sup> Eugene Woods, CEO of Advocate Health, co-chaired a multi-sector effort to address housing instability and homelessness in Charlotte-Mecklenburg, creating the 'A Home for All' strategic framework in 2022 that is now being implemented by the United Way of Greater Charlotte.<sup>55,56</sup>