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Integrating Health and Social Care

From Fragmented Pilots to Universal Community Infrastructure

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About this Paper

Over the past decade, Atrómitos has worked alongside state agencies, health systems, payers, philanthropic funders, and community-based organizations engaged in the practical work of integrating health and social care. From designing and operationalizing community-based social care networks to analyzing the policy framework that shapes them, our team has been on the ground throughout the long arc of this work, including its setbacks.

The events of 2025 and early 2026 have brought the structural fragility of the current approach into sharp relief. The 2025 Budget Reconciliation Act, P.L. 119-21 (OBBBA), tightened federal authority that has underwritten most of the country's recent integration progress; CMS rescinded its Health-Related Social Needs Framework guidance and ended the federal match for Designated State Health Programs; and North Carolina, home to the most rigorously evaluated state Medicaid social care program in the country, suspended its Healthy Opportunities Pilots after a state budget impasse, less than seven months after CMS approved a five-year federal renewal. The integration infrastructure the country has built over the past decade is real, valuable, and demonstrably effective for the populations it reaches. It is also reversible within a single budget cycle and gated in ways that exclude residents who need it.

This paper aims to provide a clear, post-2025 articulation of existing models, their capabilities and limitations, the current requirements of the OBBBA-era policy environment, and what a more durable design would entail. It draws on Atrómitos' direct engagements, including work with Community Care of the Lower Cape Fear, Inc. (CCLCF) on the design and operation of its NC HOP Network Lead Entity role, post-waiver sustainability planning, and its new universal residency-based Social Care Network.

The intended audience includes state and federal policymakers, health system and payer leadership, philanthropic funders, and the community-based organizations and coalitions that will do the work, regardless of the financing environment. The argument and the moment are consequential.

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Acronyms and Defined Terms

ACH. Accountable Community for Health

AHC. Accountable Health Communities (CMMI Model, 2017–2023)

CBO. Community-based organization

CCO. Coordinated Care Organization (Oregon)

CCLCF. Community Care of the Lower Cape Fear, Inc. A regional collaborative based in southeastern North Carolina. CCLCF served as the Network Lead for North Carolina's Healthy Opportunities Pilots in the southeastern (Region 5) region, contracting with credentialed human services organizations to deliver HRSN services to enrolled Medicaid members from March 2022 through the July 1, 2025, program suspension.

CHW. Community health worker

CIB. Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CMS guidance vehicle)

CIE. Community Information Exchange

DSHP. Designated State Health Program

DSIP. Designated State Investment Program

D-SNP. Dual Eligible Special Needs Plan (Medicare Advantage plan for individuals dually enrolled in Medicare and Medicaid)

HARP. Health and Recovery Plan (NY Medicaid specialty managed-care product for adults age 21 and older with serious mental illness or significant substance use disorder)

HCBS. Home and Community-Based Services

HOP. Healthy Opportunities Pilots (North Carolina)

HRSN. Health-related social need

HSO. Human services organization (term used in NC HOP for participating community-based service providers)

ILOS. In Lieu of Services and Settings (Medicaid managed care)

IPPS. Inpatient Prospective Payment System (Medicare hospital payment system; CMS issues an annual IPPS final rule)

MCO. Managed Care Organization

MTP. Medicaid Transformation Project (Washington state)

NHCE. New Hanover Community Endowment

NL. Network Lead (NC HOP regional contracting entity)

NYHER. New York Health Equity Reform 1115 Waiver Amendment

OBBBA. 2025 Budget Reconciliation Act, P.L. 119-21 (OBBBA; signed July 4, 2025)

PCHI. Pathways Community HUB Institute

PMPM. Per member per month

RHTP. Rural Health Transformation Program (OBBBA Section 71401)

ROOTS. Rural Organizations Orchestrating Transformation for Sustainability (NC ROOTS; the regional hub network implementing North Carolina's Rural Health Transformation Program)

SCN. Social Care Network

SDOH. Social determinants of health

SSBCI. Special Supplemental Benefits for the Chronically Ill (Medicare Advantage)

STC. Special Terms and Conditions (the CMS document governing the terms of an approved Section 1115 demonstration, including its expiration date)

USCDI. U.S. Core Data for Interoperability

I. Executive Summary

Every existing U.S. integration model is structurally limited, and the integration infrastructure the country has built is reversible within a single budget cycle or a change of Administration. Events in 2025 made these two problems clear.

The first problem: **Structure**. The uninsured, the undocumented, the near-poor, and rural and tribal residents receive integration only by accident. The same applies to many moderate-income working families, to people with chronic conditions whose insurance does not include connected access to a social care network, and to family caregivers who need a knowledgeable navigator to identify, qualify for, and arrange services that their own coverage will not coordinate.[1]

The second problem: **Durability**. In 2025, CMS rescinded the federal Health-Related Social Needs Framework, ended the federal match for Designated State Health Programs and Designated State Investment Programs, and Congress enacted OBBBA, which tightened Section 1115 budget neutrality and established federal Medicaid work requirements that all states must implement by January 1, 2027.[2,3] Additionally, North Carolina, home to the most evaluated state Medicaid social care program in the country, suspended its Healthy Opportunities Pilots (HOP) in July 2025 after a state budget impasse, even though federal authority remains in effect through December 2029.[4]

A residency-based, blended-finance community social care infrastructure available to every resident as a matter of community membership, with Medicaid as one of several revenue sources rather than the single point of failure, must be the future of integrated health and social care. The financing mix needs to combine Medicaid, Medicare Advantage Special Supplemental Benefits for the Chronically Ill (MA-SSBCI), hospital community benefit redirected toward regional Social Care Network (SCN) pools, state non-Medicaid revenue, employer-sponsored access, private pay on a sliding scale, and philanthropic anchor funding.

The choice is no longer whether to integrate health and social care, but how. The country can keep rebuilding it from time-limited fragments every five years, or it can build the missing layer as durable public infrastructure. The goal is wellbeing: the conditions that allow a person, a family, and a community to flourish.

II. The Imperative: Why Integration, Why Now

The United States cannot improve population health within the medical system. The country spends more than 16 percent of its national output on health care, more than any peer nation, and ranks last or near last among high-income countries on most measures of population health.[5] Life expectancy is shorter, maternal mortality is higher, and the gap between the longest- and shortest-lived Americans, grouped by race, ethnicity, and geography, widened from 12.6 years in 2000 to 20.4 years in 2021.[6] The County Health Rankings model attributes roughly 20 percent of population health to clinical care; the remaining 80 percent is determined by social and economic factors, health behaviors, and the physical environment.[7] **The country has organized its single largest sector around the smaller share of the problem, and the consequences are visible in nearly every measure of how its residents fare.**

Figure 1. Determinants of Population Health

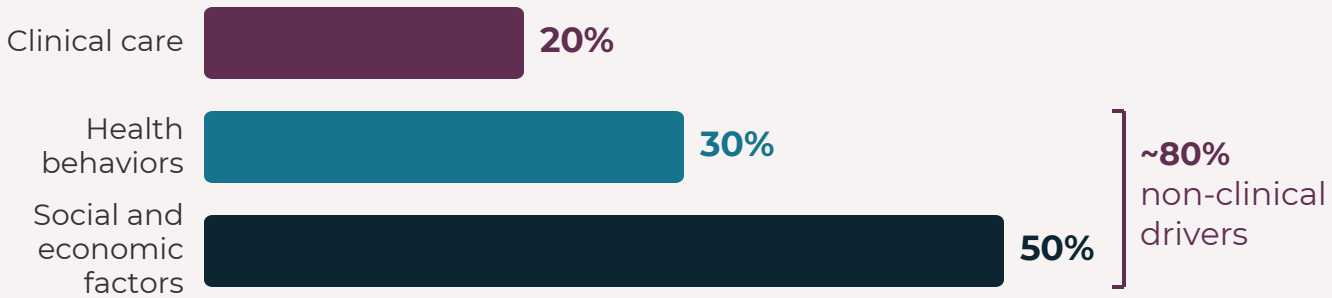


Figure description: Horizontal bar chart with three bars showing the share of health outcomes. Clinical care (quality of and access to healthcare services): 20%. Health behaviors (tobacco, alcohol, diet, physical activity, sexual behavior, sleep): 30%. Social and economic factors (income, economic security, housing, food, education, transportation, social support, physical environment): 50%. A bracket labels the behavioral and social categories together as approximately 80% non-clinical drivers. Source: County Health Rankings and Roadmaps (UWPHI/RWJF); Hood et al., Am. J. Prev. Med. 50(2):129–135 (2016).

Two terms, distinguished

Two terms must be distinguished because they are too often used interchangeably. Public health frames these upstream conditions as the **social determinants of health**: the population-level conditions of housing, income, education, neighborhood, and discrimination that shape exposure to risk and access to opportunity. The health care delivery system increasingly uses the narrower term **health-related social needs** to describe the individual-level circumstances arising from those determinants that a clinical encounter can identify and address: housing insecurity, food insecurity, lack of reliable transportation, intimate partner violence, or social isolation. **Determinants describe the conditions; needs describe their manifestations**. A serious integration agenda must address both by investing in upstream conditions while building a system that meets the downstream needs of the people in front of clinicians today.

Wellbeing as the outcome of interest

The case for integration is often made on the grounds of cost, utilization, or quality. Instead, the outcome of interest must be wellbeing: the conditions that allow a person, a family, and a community to flourish. Healthy People 2030 made wellbeing an explicit national priority for the first time, and the choice was not rhetorical.[8] Life expectancy and disease prevalence, while necessary measures, are insufficient to describe how a population is doing; an integration agenda anchored only in clinical or financial metrics will underperform.

Wellbeing is not a soft frame. It carries the moral case (avoidable suffering matters in itself), the clinical case (people who are housed, fed, connected, and safe respond differently to medical treatment), and the economic case (the spending consequences of unmet social needs are real, even when individual interventions do not pencil out as cost-neutral in the short term).

Why now

Between 2023 and 2025, four forces converged, making 2026 a pivotal moment. The first, the post-pandemic Medicaid unwinding, has moved millions of people through coverage transitions and revealed how dependent the country's nascent integration infrastructure is on continuous Medicaid enrollment.[9] Programs that work well for members who are enrolled long enough to receive services struggle to reach members in motion (i.e., those experiencing enrollment churn).

The second, OBBBA, enacted July 4, 2025, tightened Section 1115 budget neutrality by requiring CMS Chief Actuary certification for new or renewed demonstrations on or after January 1, 2027 (measured against federal Medicaid savings only); it also established federal work requirements for ACA-expansion adults that, under the CMS implementation guidance issued December 8, 2025, all states must implement no later than January 1, 2027, paired with new 6-month eligibility redeterminations for the affected population. Section 1115 cannot waive these requirements. The consequence for integration networks is direct. Enrollees who lose Medicaid coverage during the implementation window or in the new six-month redetermination cycles also lose access to HRSN services delivered through Medicaid-anchored networks. Coverage churn becomes a structural feature rather than an exception, undermining the continuous enrollment that integrated programs depend on to deliver multi-month interventions.[10]

The third, the spring 2025 retrenchment of CMS guidance, included the March 4 rescission of the November 2023 and December 2024 Health-Related Social Needs Framework Informational Bulletins and the April 10 termination of the federal match for Designated State Health Programs and Designated State Investment Programs. These vehicles grew from approximately $886 million in 2019 to $2.7 billion in 2025, and that funding underwrote the public health, workforce, and data infrastructure on which integration efforts in eight states relied.[11]

The fourth is the most concrete illustration of the structural fragility: North Carolina suspended its Healthy Opportunities Pilots on July 1, 2025, less than seven months after CMS approved a five-year federal renewal running through December 9, 2029. HOP did not go dark because the federal government withdrew; it went dark because a single state legislature, in a single budget cycle, declined to appropriate the matching funds.[12]

These conditions raise the stakes of the choice facing policymakers. The United States is integrating health and social care. That work is already underway nationwide, much of it carried out by community-based organizations on a shoestring. The question is whether the country will 1.) build integration into durable public infrastructure, available to every resident as a matter of community membership, or 2.) continue to assemble it from time-limited fragments that leave residents behind.

The country must choose the first.

Figure 2: Key Federal and State Policy Actions, 2024 - 2027

Figure description: *Vertical timeline of 13 policy events from December 2024 through March 2027. Dec 10, 2024: CMS approves NC HOP 1115 renewal for a new 5-year term. Mar 4, 2025: CMS rescinds HRSN Framework CIBs (Nov 2023 and Dec 2024). Apr 10, 2025: Federal match ended for Designated State Health and Investment Programs. Jul 1, 2025: NC Healthy Opportunities Pilots services suspended. Jul 4, 2025: OBBBA enacted (P.L. 119-21), tightening 1115 budget neutrality and adding work requirements. Dec 8, 2025: CMS issues work-requirements CIB; Jan 1, 2027, implementation deadline set. Dec 29, 2025: $50B Rural Health Transformation Program state awards announced. Apr 21, 2026: Governor Stein releases FY2026-27 recommended budget (fully funds Medicaid rebase). Jun 1, 2026: CMS issues Medicaid work requirements Interim Final Rule (CMS-2454-IFC). Jul 2026: signed FY2026-27 budget restores HOP with $25M nonrecurring (vs. $80M requested). Dec 31, 2026: CalAIM 1115 STC expiration date. Jan 1, 2027: Medicaid community engagement requirements take effect. Mar 31, 2027: NY Health Equity Reform (NYHER) 1115 STC expiration date. Source: CMS, NCDHHS, NC Office of State Budget and Management, California DHCS, NY DOH.*

III. The Evidence Base for Integration

The scale of unmet need

The integration agenda rests on a factual premise: unmet social needs are widespread among the populations that publicly financed health systems serve, and those needs are causally linked to worse health outcomes and higher costs. The evidence on prevalence is unambiguous. Food insecurity affected approximately 13.5 percent of the population in the most recent national estimate, and housing insecurity ranged from approximately 9 to 20 percent depending on race, ethnicity, and the definition used; both indicators are consistently elevated among low-income, dual-eligible (Medicare and Medicaid), and pediatric populations.[13] Prevalence is markedly higher among Medicaid enrollees and populations served by federally funded community health centers, where rates of one or more unmet needs are well above the national average.[14] The pandemic widened the already wide gradients. By 2024, food insecurity and housing instability had returned to, or surpassed, pre-pandemic levels for low-income households, and the housing affordability crisis had become a public health concern in much of the country.[15] These are the conditions a serious integration agenda must engage.

What the outcome evidence shows

The evidence base for integrated social care is now robust enough to justify policy action. Studies of medically tailored meal delivery for patients with diet-sensitive chronic diseases have shown reductions in hospital admissions, emergency department visits, and total medical spending, with the strongest effects among patients with congestive heart failure and diabetes complicated by socioeconomic risk.[16] Trials of structured community health worker programs have demonstrated improvements in clinical outcomes, patient experience, and Medicaid spending. The IMPaCT model now has more than a decade of replicated trial evidence.[17]

Evaluations of permanent supportive housing for high-utilizing adults experiencing homelessness, including Medicaid populations, continue to show reductions in inpatient and emergency utilization; evidence on whether public-sector total costs fall at or near the cost of the housing intervention itself is mixed, with the strongest offsets concentrated among the highest-utilizing subgroups, with rigorous trials generally showing smaller cost effects than earlier pre/post-test studies.[18] Where integration is structured as a paid service delivery rather

than as referral alone, Medicaid social care networks have shown reductions in inpatient and emergency care, particularly among members enrolled long enough for the intervention to take effect. The NCDHHS and Cecil G. Sheps Center evaluation of North Carolina's Healthy Opportunities Pilots, released in 2026, found measurable reductions in cost and utilization for enrolled members, with the largest effects among members receiving multiple service categories over time and reported per-member medical savings (net savings, inclusive of the cost of services and administrative overhead) of approximately $164 per month across 31,597 enrollees from March 2022 to November 2024, driven by significant reductions in emergency department visits and hospital admissions and a corresponding shift to outpatient care.[19]

What the evidence does and does not say about cost and return on investment

The evidence does not support the claim that all social care interventions are cost-saving. Some are. Some are not. Some are cost-neutral yet produce better outcomes. Some are the right thing to do regardless.[20] A mature policy framework holds all of these together. Framing the integration agenda as a cost-savings agenda is a strategic mistake.

The cost-savings framing has too often shaped what is funded, evaluated, and sustained. The evidence supports four claims taken together.

- First, integrated social care interventions improve outcomes for the people they reach.
- Second, some interventions in some populations reduce total costs or shift costs to lower-acuity settings.
- Third, savings frequently accrue outside the originating payer and over horizons longer than a single waiver period.
- Fourth, the populations with the greatest unmet need are not, on average, those with the highest baseline medical spending; targeting interventions to maximize Medicaid return on investment alone leaves the highest-need populations behind.

Taken together, these four claims counsel against financing designs that treat integration as an activity paid for exclusively by Medicaid: capping the payer base at Medicaid caps the reachable population, and optimizing for Medicaid-specific return directs investment toward the subset of enrollees expected to generate the largest Medicaid savings rather than the subset with the greatest unmet need.

What the equity evidence shows

Average effects can mask unequal reach, and the population subsets least represented in published trials of social care interventions are also the populations least well served by the integration models that have so far emerged. A 2022 SIREN review of HRSN intervention studies found that BIPOC, rural, and tribal populations are systematically underrepresented in study samples. When reached, these populations often experience smaller average effects, which the study authors attribute to under-resourced delivery rather than to differential intervention efficacy.[21] A growing body of work on community data governance and Indigenous data sovereignty persuasively argues that equity in integration cannot be retrofitted; it must be designed into governance, data, contracting, and rate-setting from the outset.[22] These are not concerns about the margins of an integration agenda. These are concerns about whether the agenda is aimed correctly in the first place.

Wellbeing measurement

What should integrated health and social care be measured against? Wellbeing is the right answer because every alternative measure addresses a narrower question.

Moreover, measuring wellbeing is now feasible. Healthy People 2030 has established formal national wellbeing objectives, anchored by OHM-01 (Overall Well-being). Most states have also implemented the CDC's optional Behavioral Risk Factor Surveillance System (BRFSS) modules on life satisfaction and emotional support in recent cycles, enabling state-level surveillance. The Harvard Human Flourishing Program's Global Flourishing Study, with initial findings published in 2024 and 2025, offers cross-national comparison data.[23]

Early evidence from integration programs indicates that residents report improved self-rated wellbeing, stronger community connections, and reduced stress, outcomes that utilization data cannot capture. Basing integration policy and evaluation on wellbeing is the most accurate framework for this work and is supported by an existing measurement infrastructure.

IV. Policy and Programmatic Context

The federal authority that built the country's current integration infrastructure was withdrawn in 2025. The OBBBA-era environment that replaced it requires a fundamentally different design: less dependent on Section 1115 demonstration cycles and DSHP-anchored state authorities, and more reliant on multi-source financing and durable pathways.

Federal authorities, baseline

Over the past decade, the federal framework for integrating health and social care expanded through three main authorities. First, HRSN screening expectations were embedded in federal inpatient and outpatient quality programs, and parallel accreditation expectations were codified for hospitals.[24] Second, Medicaid provided two primary authorities. The Section 1115 Medicaid demonstration authority was the workhorse: HRSN waiver approvals were issued to roughly a dozen states under the prior administration.[25] The Medicaid In Lieu of Services and Settings framework, codified procedurally in the April 2024 Medicaid Managed Care Final Rule, allows managed care organizations to substitute social care services for state plan services when actuarially sound and consistent with the underlying benefit.[26] Third, adjacent authorities round out the federal toolkit:

- 1915(c) and 1915(i) home- and community-based services;[27]
- Medicare Advantage Special Supplemental Benefits for the Chronically Ill;
- CMS Innovation Center's ACO REACH and Shared Savings Program equity provisions,[28] and
- tax-exempt hospital community benefit, governed by the § 501(c)(3) community-benefit standard (Rev. Rul. 69-545, in force since 1969 and reported on Form 990, Schedule H), continues to fund adjacent investment.[29]

The 2025 federal retrenchment

Three federal actions in 2025, described in Section II, reset the integration baseline: CMS' March 4 rescission of the Health-Related Social Needs Framework Informational Bulletins, the April 10 termination of the federal match for Designated State Health Programs and Designated State Investment Programs, and the July 4 enactment of OBBBA (P.L. 119-21). Of the three, OBBBA has the enduring operational implications. Four of its provisions, detailed below, shape the post-2025 environment for the design of state integration.

First, Section 71119 of OBBBA imposes federal work requirements on ACA-expansion adults aged 19–64: 80 hours per month of work, qualifying community service, a work program or job training, half-time enrollment in education, or a combination of these. Per CMS implementation guidance issued December 8, 2025, every state must implement the requirements no later than January 1, 2027, though states may begin earlier. CMS followed with an interim final rule (CMS-2454-IFC) on June 1, 2026, and states must complete outreach to affected enrollees by summer 2026. The requirements are paired with new 6-month eligibility redeterminations for the affected population and $200 million in Government Efficiency Grants distributed across states and the District of Columbia ($100 million divided equally and $100 million allocated based on the proportion of affected enrollees as of March 31, 2025). HHS may grant good-faith compliance extensions, but not beyond December 31, 2028, and Section 1115 cannot waive the requirements.[30]

Second, Section 71118 tightens Section 1115 budget neutrality: each new or renewed demonstration on or after January 1, 2027, must be certified budget-neutral by the CMS Chief Actuary, measured against federal Medicaid savings only. The constraint on HRSN waiver design is sharp. Waivers that previously could justify federal investment through long-horizon savings (for example, housing stability reducing inpatient utilization over multiple years) or through spillovers to non-Medicaid systems (housing, criminal justice, schools, workforce) now must demonstrate federal Medicaid savings within the demonstration period and within the federal Medicaid budget boundary. Many of the strongest social-care interventions do not produce that pattern of savings within that timeline; renewal economics will exclude them unless the Chief Actuary's methodology evolves to account for spillover and long-horizon effects.[31]

Third, Section 71121 of OBBBA establishes a new 1915(c) HCBS category for individuals who do not require an institutional level of care, with $50 million in FY2026 appropriated for CMS implementation and oversight and $100 million in FY2027 appropriated for state grants; services under the new category begin July 1, 2028. Unlike the other three provisions, this one expands integration options. 1915(c) historically required an institutional level of care, a restriction that excluded most working-age adults with HRSN needs. The new category opens a federal vehicle for community-based services for people who do not need institutional-level care.[32]

Fourth, Section 71401 of OBBBA establishes the Rural Health Transformation Program, a $50 billion fund distributed across FY2026–FY2030 at $10 billion per year. Half of the funds are distributed equally among approved states, and the other half is allocated based on rural health needs and proposed impact. On December 29, 2025, CMS announced state awards under the program, with North Carolina receiving $213 million for the first year.[33] The program is a meaningful new infusion of federal dollars for rural delivery-system transformation; like the Section 1115 demonstrations it parallels, it is also time-limited, with no statutory continuation beyond FY2030. North Carolina, with its $213 million FY2026 award, in May 2026 named five hub-lead organizations (Impact Health, Trillium Health Resources, Vaya Health, UNC Hospitals, and Access East) to coordinate care across the state's six Medicaid regions, with regional structures that echo the HOP Network Lead model and that are designed to carry HRSN coordination into some of the same rural communities HOP had reached. Under the terms of the federal RHTP award, however, ROOTS Hub funding is structured strictly as an infrastructure investment: the funds can be used to build care-coordination systems, conduct needs assessments, and support workforce development, but cannot be used to pay directly for food, transportation, or housing repair services. NC ROOTS is therefore the closest near-term continuation of HOP's coordination infrastructure, but cannot replace HOP's direct service funding; the hubs must rely on separately funded programs to deliver the services that the coordination is designed to support. The program is also time-limited (FY2026–FY2030), structured as a demonstration rather than a durable statutory authority, so any state that uses RHTP to stand up integration capacity will face the post-FY2030 sustainability problem that AHC and similar demonstrations already illustrate.[34]

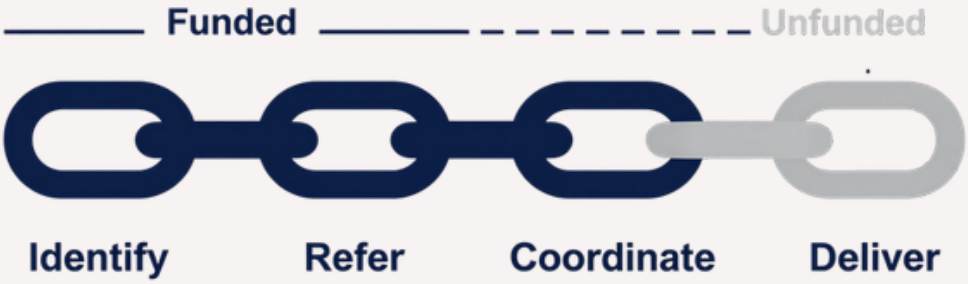
What still works

In the wake of these federal changes, four authorities continue to provide a working foundation for integration. ILOS remains a viable pathway for Medicaid-covered HRSN services where the 2024 Final Rule's procedural and rate criteria are met. SSBCI continues for Medicare Advantage members with chronic conditions. State authority (1115, 1915, state plan amendments, MCO contracting, and state-only programs) remains, subject to federal review. Tax-exempt hospital community benefit, philanthropic capital, and several other federal funding streams continue and remain underleveraged.[35] Existing 1115 HRSN approvals remain in force through their terms; the open question is what their renewal experience will be in the post-OBBBA environment.

V. The Current Landscape: How the U.S. Has Tried to Integrate

Every integration model the United States has built is structurally gated. Each has produced value within its own design; each fails at least one structural test for universal community infrastructure. The service chain has four functions: identifying, referring, coordinating, and delivering the HRSN service, and each must be paid for; a model that funds the earlier functions but stops before delivery leaves the resident's need unmet, and delivery is the link most often missing. **The pattern is consistent: where a model can serve every resident, it does not fund delivery; where it funds delivery, it cannot serve every resident.**

Graphic I: Four Functions of the Integrated Social Care Service Chain



Universal Access	✓	✓	✓	X	Does NOT fund delivery
Gated Access	✓	✓	✓	✓	Services paid for if eligible

Graphic Description: A four-link chain represents the service chain: Identify, Refer, Coordinate, and Deliver. The first three links are funded; the fourth (Deliver) is unfunded. Below, two rows compare access models: 'Universal Access' funds Identify, Refer, and Coordinate but does NOT fund Deliver. 'Gated Access' funds all four but only for eligible individuals. No existing model achieves both universal access and funded delivery.

Health-system-led integration

Health systems have built social-care infrastructure inside their own delivery networks, anchored on hospital community-benefit dollars, integrated-delivery-system revenue, and, in some cases, employed physician groups. The model is exemplified by Kaiser Permanente's Thrive Local platform, which embeds CBO referral and navigation within Kaiser's integrated care; by Geisinger's Fresh Food Farmacy program, which provides medically tailored food to diabetic patients in the Geisinger system; and by similar programs at Intermountain Health, CommonSpirit, RWJBarnabas, and other integrated delivery networks.[36]

These programs braid hospital community-benefit spending (under the § 501(c)(3) community-benefit standard, Rev. Rul. 69-545), integrated-delivery-system surplus, employed-clinician quality incentives, and, where applicable, the system's own health-plan revenue. The strengths are real: an aligned chart, a single clinical and financial system to coordinate within, and rapid implementation. The primary limit is clear: access stops at the system's catchment. A patient discharged to a community where the system has no clinical presence loses access to social services. A second limit is financial. Health-system social-care infrastructure rests on the underlying business case for community benefit and integrated-delivery-system surplus, both of which can shift with policy changes, tax status reviews, or margin pressure. When the business case changes, the social-care infrastructure built on it is among the first programs reduced or withdrawn, even within an existing catchment, and even when the catchment population still needs it.

Payer-led integration

Payer-led models place integration within a health plan rather than a health system. Highmark Health's Social Care Network in Pennsylvania and West Virginia, UnitedHealthcare and Humana's SDOH programs, and the SDOH initiatives operated by Elevance, Centene, and Aetna all sit in this category. Funding rides on the plan's underlying contracts: commercial premium dollars, Medicare Advantage capitation (often through Special Supplemental Benefits for the Chronically Ill), Medicaid managed-care capitation in states where the plan holds MCO contracts, or some combination of these.[37]

The contracting and payment infrastructure is mature, and plans can move quickly within their covered population. The structural limit is membership: the integrated services stop at the plan's book of business. A member who churns from a Medicaid managed care plan to an employer-sponsored plan or to no

coverage at all loses access to the integration, whatever the underlying need. A second limit is benefit volatility. Plan-level social-care offerings are discretionary and renegotiated at the annual bid cycle, especially Medicare Advantage Special Supplemental Benefits for the Chronically Ill: a benefit available in one plan year can be reduced or withdrawn in the next, even for members who remain enrolled. The HealthScape Advisors 2026 supplemental-benefit landscape analysis documented exactly this contraction across multiple plan portfolios.[38]

State Medicaid-anchored networks

State Medicaid-anchored networks are the most evaluated U.S. integration models. They share three design features: they contract with and pay community-based organizations for service delivery; they restrict access to Medicaid enrollees (or certain sub-populations within Medicaid); and they are financed through Section 1115 waivers or the In Lieu of Services and Settings (ILOS) framework.

The state-by-state examples below illustrate the design variations within the category: Arizona, California, Massachusetts, New York, North Carolina, Oregon, Washington, and a grouping of smaller-scale state programs and Accountable Communities for Health.

Arizona's Housing and Health Opportunities (H2O) Program operates within the AHCCCS 1115 waiver framework, integrating housing support services into Medicaid for members experiencing homelessness. H2O is notable for its structured service design process: new service types are piloted, evaluated for outcomes, and either standardized or retired.[39]

In California, CalAIM Community Supports establishes the state's social care framework within Medi-Cal managed care under the ILOS model. Medi-Cal MCOs partner with CBOs to provide fifteen Community Supports, such as housing transition services, recuperative care, medically supportive food, sobering centers, and asthma remediation, with service-specific rates published by DHCS.[40] Two distinct points about CalAIM should not be confused. First, since CalAIM Community Supports are integrated into Medi-Cal managed care, the state intends to continue Enhanced Care Management (ECM) and Community Supports under managed care contracting authority alone in the CalAIM renewal that takes effect in 2027, without requiring renewed 1915(b) waiver authority for those services.[41] Second, the five-year, $1.85 billion PATH initiative that funded provider capacity building for ECM and Community Supports is concluding as the transition from Whole Person Care and the Health Homes Program is

completed; DHCS is exploring alternative pathways to sustain Medical Respite capacity in the post-PATH environment.[42]

In Massachusetts, the Flexible Services Program is the social-care arm of the MassHealth Medicaid ACO program. Launched in January 2020 under the 2017 Section 1115 waiver renewal as a fixed-pool DSRIP-funded program (approximately $149 million statewide), the program was extended into the current MassHealth ACO contract cycle (April 1, 2023, through December 31, 2027) under the 2022–2027 waiver renewal with modified rules. MassHealth ACOs deliver nutrition and housing supports to medically and socially high-risk ACO enrollees through partnerships with Social Service Organizations, subject to per-member spending caps and service-specific maximums.[43]

In New York, the NYHER 1115 waiver amendment (approved January 9, 2024, effective through March 31, 2027) directs approximately $3.7 billion specifically to nine regional Social Care Networks ($3.16 billion for HRSN services and $500 million for SCN infrastructure) — the SCN-specific carve-out within NYHER's roughly $7.5 billion total waiver value, which also funds hospital, workforce, and other non-SCN investments — led by SCN Lead Entities that contract with CBO networks to deliver HRSN services to Medicaid and Health and Recovery Plan (HARP) enrollees.[44] SCN billing began in January 2025. New York's scale is unmatched: more than one million Medicaid members had been screened for health-related social needs through the SCN program as of June 2026. The 2027 renewal will be the second major OBBBA budget-neutrality test for an HRSN-heavy waiver.[45,46]

In North Carolina, the Healthy Opportunities Pilots (HOP) operate under the state's Section 1115 demonstration, with three regional Network Leads contracting with credentialed human services organizations (HSOs) to deliver housing, food, transportation, and services addressing interpersonal violence and toxic stress to qualifying Medicaid managed care enrollees.[47] HOP's service fee schedule and per-service rates, set by NCDHHS in 2022 and updated through 2024, have become a national reference for what Medicaid is willing to pay for specific social-care services.[48] HOP services were suspended on July 1, 2025, when the state legislature failed to appropriate matching funds consistent with CMS' December 2024 renewal.[49] After nearly a year of suspension, North Carolina's first full budget since 2023, introduced at the end of June 2026 and signed into law by Governor Stein on July 7, 2026, restores HOP with only $25 million in nonrecurring funds, roughly a third of the approximately $80 million the regional Network Leads had requested. Program leaders have cautioned that the year-long freeze has already degraded the delivery infrastructure, with drivers leaving for other work and

participating farms are scaling back. That a program with documented per-member savings could be frozen for a year and, even in the enacted budget, revived only as one-time money at a fraction of the requested amount is a direct illustration of the reversibility this paper describes: gated, budget-cycle financing leaves even proven social-care programs structurally fragile. An Impact Health economic analysis of statewide HOP spending across all three regions, published via CCLCF in May 2026, found that the program's $247 million in HOP service investment generated approximately $384 million in total business activity across North Carolina—an additional $0.55 in economic activity for every service dollar invested—supporting nearly 3,000 jobs and generating more than $125 million in wages and labor income statewide.

In Oregon, Coordinated Care Organizations (CCO 2.0) operate as regional public-private Medicaid managed care entities responsible for physical, behavioral, and oral health care for assigned Oregon Health Plan members, with HRSN services authorized under the state's Section 1115 demonstration (renewing on September 30, 2027). CCOs allocate a defined share of capitation to community investment and SDOH spending, with funds flowing through the CCO to community partners.[50]

In Washington, the Medicaid Transformation Project 2.0 (MTP 2.0, approved by CMS on June 30, 2023, running through June 30, 2028) authorizes up to $1.5 billion over five years for HRSN services and up to $270 million for HRSN infrastructure. Covered HRSN services include home modification and asthma remediation, nutrition supports (medically tailored meals, nutrition counseling, pantry stocking, fruit and vegetable prescriptions, and short-term grocery provision), medical respite, housing transition navigation services, up to six months of rent assistance or temporary housing for clinically and socially eligible enrollees, and Care Management, Outreach, and Education (social needs navigation). These HRSN services reach the entire Apple Health population through two authorities: the in lieu of services (ILOS) authority for managed-care enrollees and the demonstration fee-for-service authority for the fee-for-service population. Service administration is distributed across multiple entities rather than being centralized. The state's nine regional Community Care Hubs, operated by Accountable Communities of Health (ACHs), administer the Care Management, Outreach, and Education service and connect members to other authorizing entities. A statewide Native Hub for Tribal communities is in development under MTP 2.0 but has not yet launched as of mid-2026; in the interim, HCA's Office of Tribal Affairs is performing some navigation functions. Nutrition supports and home modifications are managed through the Area Agencies on Aging and the Department of Social and Health Services; housing

services flow through the Foundational Community Supports (FCS) program; medical respite remains managed by the Medicaid managed care organizations (MCOs).[51]

New Jersey, New Mexico, and Hawaii each operate state-specific HRSN authority within their 1115 demonstrations, with smaller scale and shorter operational histories.[52] Accountable Communities for Health (ACH) initiatives in California, Washington, Minnesota, and Vermont are also state Medicaid-anchored in financing terms: they are multi-stakeholder governance bodies that integrate public-health, clinical, and community partners and that increasingly serve as the regional administrative entity for Medicaid HRSN service delivery (most visibly in Washington, where the ACH-anchored Community Care Hubs administer the Care Management, Outreach, and Education service [the community-based care-coordination service under MTP 2.0]).[53]

The strengths of this category are substantial: braided financing through Medicaid, formal CBO networks, evidence-grade evaluations, and the operational discipline that comes from contracting at scale. The structural limit is, again, eligibility: by design, these networks reach only the state's Medicaid enrollees (Washington ACHs braid non-Medicaid funding to extend Community Hub social-needs navigation to non-Medicaid residents, though Medicaid remains the bulk of their funding), often with additional qualifying conditions or risk gates layered on top. Benefits do not reach the uninsured, the privately insured, the Medicare-only population, or those churning out of Medicaid. Further, the 2025 retrenchment has made the durability problem acute rather than theoretical.[54,55]

Federal demonstrations

The federal demonstration category extends beyond a single program.

The CMMI Accountable Health Communities (AHC) Model, which ran from 2017 through April 30, 2023, produced one of the largest evidence bases on screening and navigation in the field. Across its six-year run, AHC contracted with regional bridge organizations to screen Medicare and Medicaid beneficiaries for five core HRSNs (housing instability, food insecurity, transportation, utilities, and interpersonal violence) and connect high-risk beneficiaries to community resources.[56] Two structural features of AHC shape how its evidence transfers. First, the model was restricted to Medicare and Medicaid populations, so its navigation infrastructure was never designed to serve commercial or uninsured patients. Second, it was time-limited; when CMMI closed the demonstration in April 2023, no successor authority replaced it, and the bridge-organization layer dissolved unevenly. Some bridge organizations absorbed the HRSN navigation into the

hospital community-benefit programs or Medicaid managed-care contracts, and continued operating. Some secured limited continuation funding under state Section 1115 or state-plan authority. Others wound down HRSN navigation within twelve months because no successor revenue source emerged.[57]

Three other CMMI demonstrations addressed HRSN within distinct populations and authority structures. The Integrated Care for Kids (InCK) Model, running from 2020 through 2026 in seven states,[58] placed HRSN screening and risk-stratified case management for food insecurity and unstable housing within child- and family-centered integrated care. Because InCK is structured as a cooperative agreement, CMMI funds underwrote model design and integration infrastructure rather than direct service payment; the services themselves were paid through existing Medicaid and CHIP authority.[59] The Maternal Opioid Misuse (MOM) Model, a ten-state demonstration[60] wrapped housing, transportation, childcare, and interpersonal-violence services around pregnant and postpartum Medicaid beneficiaries with opioid use disorder.[61] The Making Care Primary (MCP) Model, launched July 1, 2024, in eight states,[62] built in HRSN screening, social-risk payment adjustments, and a planned 10.5-year performance period; CMS' March 12, 2025, cancellation cut the model off at twelve months, eliminating HRSN payment streams that participating primary-care practices had been preparing to use, and offers an instructive precedent for what happens when a federal demonstration window closes mid-cycle.[63]

Three forward-looking CMMI demonstrations carry HRSN requirements into the remainder of the decade. The Transforming Episode Accountability Model (TEAM), a mandatory model running January 1, 2026 through December 31, 2030, applies to acute-care hospitals in 188 randomly selected core-based statistical areas, roughly 700–741 hospitals nationwide, and, as finalized in August 2024, required HRSN screening (food, housing, transportation, utilities) for each Medicare beneficiary at the episode-trigger admission across five surgical episode categories, with referral to primary care and community resources. In the FY2026 IPPS final rule (effective October 1, 2025), however, the Administration removed TEAM's HRSN screening and health-equity reporting requirements, retaining only the primary-care referral. This rollback is consistent with the broader federal retrenchment described above (the rescission of the HRSN Framework guidance and the wind-down of designated state health program funding) that is steadily dismantling federal support for HRSN screening, referral, and service payment.[64] The Enhancing Oncology Model (EOM), running July 1, 2023, through June 30, 2030, and currently enrolling more than 40 oncology practices across two enrollment cohorts (the original cohort, since reduced by attrition, plus a second cohort of seven practices added in July 2025), requires

parallel HRSN screening for all participants in each performance period.[65] The AHEAD Model (discussed separately below) incorporates equity and HRSN components into its state total cost-of-care framework.[66] As originally designed, TEAM and EOM together would have required HRSN screening at acute-care and oncology touchpoints for a substantial share of the Medicare fee-for-service population through 2030. With TEAM's requirement now rescinded by the Administration, EOM remains the principal CMMI model mandating HRSN screening. The same constraint that limited AHC applies here: what happens to that screening infrastructure when the models conclude will depend entirely on whether successor authority is in place at the time.[67]

Three consistent limits run through the federal demonstration category. First, eligibility is restricted to Medicare and Medicaid populations, so the navigation infrastructure on which these models are built is not designed to serve commercial or uninsured patients. Second, authority is time-limited; none of these models has a permanent statutory home. Third, and most consequential for integration design, none of these CMMI demonstrations directly funds the social services themselves. AHC paid for screening and navigation; InCK pays for model design and integration infrastructure; MOM pays for care coordination and clinical services, with social-service costs absorbed by state-cooperative-agreement budgets or existing Medicaid authority; MCP added social-risk payment adjustments to primary-care payment but did not pay for housing or food; EOM requires HRSN screening and referral (as did TEAM, until the FY2026 IPPS final rule removed its requirement) but neither pays for the referred services; and AHEAD applies an equity overlay to a total-cost-of-care framework but does not itself reimburse social services. The services-payment lever, in other words, lives in Section 1115 "in lieu of services" authority, the pathway used in HOP, CalAIM, NYHER, MTP, MA Flexible Services, Oregon's CCO HRSN program, AHCCCS H2O, NJ FamilyCare, NM Turquoise Care, and HI QUEST Integration, not in the CMMI demonstration authority.[68]

Hub and care-coordination models

The Pathways Community HUB Institute (PCHI) Model is a nationally certified, outcome-based care coordination framework. Regional Pathways Community HUBs (PCHs) serve as neutral network conveners, contracting with Care Coordination Agencies, community-based organizations that hire and supervise community health workers (CHWs). CHWs conduct in-home visits, assess residents against 21 standard Pathways spanning housing, food, employment, prenatal care, and related social risk domains, and are reimbursed only when a

Pathway goal is verifiably met (a closed Pathway). As of 2025, certified PCHs operate in more than a dozen communities, primarily in the Midwest, Mid-Atlantic, and South. The model has produced strong evidence on maternal and infant outcomes and is well-suited to risk-targeted enrollment.[69] The structural limit is that, by design, PCHI is population-targeted with risk-based individual enrollment; it is not residency-based, and it is not designed to serve every member of a community.

Vermont Blueprint for Health and the AHEAD Model

Vermont is included as its own category because it is the only U.S. state operating an HRSN-relevant integration model anchored on multi-payer financing rather than on Medicaid alone. The Vermont Blueprint for Health, established in 2006, reached statewide implementation through a phased rollout under Act 128 (2010–2013) and continues today as the longest-running multi-payer advanced primary care and Community Health Team framework in the country. Blueprint supports advanced primary care and Community Health Teams alongside Patient-Centered Medical Homes in each Health Service Area, providing care coordination, behavioral health support,[70] and social care navigation through multidisciplinary staffing distributed across the state. Blueprint operates two payment streams, jointly contributed by Medicaid, Medicare, and the major commercial insurers in Vermont: a PCMH support payment (Medicaid approximately $4.65 PMPM and commercial payers approximately $3.00 PMPM, as of recent reports) and a separate PMPM contribution supporting the Community Health Teams.[71]

Vermont's separate All-Payer ACO Model (VTAPM) was a CMMI demonstration that ran from January 1, 2017, through December 31, 2025, and was operated principally through OneCare Vermont. VTAPM established statewide multi-payer global-budget and risk-based ACO contracts and incorporated the Blueprint infrastructure without replacing it; CMS did not renew VTAPM at its scheduled conclusion.[72] The successor framework, the AHEAD Model (States Advancing All-Payer Health Equity Approaches and Development), continues multi-payer alignment across six participating jurisdictions organized in cohorts;[73] Cohort 1 (Maryland) began January 1, 2026; Vermont participates in Cohort 2 (with Connecticut and Hawaii), whose performance period begins January 1, 2028; and Cohort 3 (Rhode Island and New York's downstate counties), also beginning January 1, 2028. For Vermont, specifically, AHEAD continues the multi-payer transformation work that Blueprint and VTAPM jointly built; the Blueprint

infrastructure itself persists independently of AHEAD's performance period.[74]

Two features make Vermont central to this paper's argument. First, because Medicare and commercial payers continue to contribute to Blueprint alongside Medicaid, the framework is partially insulated from the kind of federal Medicaid retrenchment that has driven events in 2025; single-payer-dependent state programs lack that insulation. Second, Rhode Island and Maryland operate related state-level all-payer constructs (Maryland under the Total Cost of Care Model), but Vermont is the longest-running and most documented U.S. precedent for multi-payer integration financing.

Information, referral, and closed-loop infrastructure

Information-and-referral and closed-loop infrastructure can be grouped into three tiers, distinguished by the services each entity provides and the funding it processes. The first tier comprises pure information-and-referral; the second comprises community information exchanges with closed-loop tracking and community data governance; and the third comprises commercial referral platforms with optional payment processing. The three tiers are sometimes conflated, but their institutional and financial structures differ, and these distinctions matter for SCN design.

First tier: information-and-referral. 211 nationally is a network of approximately 200 community-based nonprofits operating under a single FCC-designated three-digit dialing code, granted in 2000. Each local 211 is an independent nonprofit with its own board and resource database, coordinated nationally through United Way Worldwide. The free public tier of Findhelp falls in the same tier, providing a directory and self-service referrals without payment processing. Funding flows through United Way contributions, state and county contracts, and (for free Findhelp) a freemium revenue model. Neither pays CBOs to deliver services.[75]

Second tier: community information exchanges with closed-loop tracking and community data governance. 211 San Diego's Community Information Exchange layers a shared longitudinal client record, bidirectional electronic referrals, and outcome tracking onto standard 211 information-and-referral, with community governance of data sharing and consent. The Chicago Regionwide CIE operates a similar model. NCCARE360 is the statewide North Carolina closed-loop referral network, structured as a public-private partnership between NCDHHS and the

Foundation for Health Leadership and Innovation, with United Way of NC supporting CBO engagement, and NC 211 contributing the resource database. NCCARE360 runs on the Unite Us platform (procured by NCDHHS).[76]

Third tier: commercial referral platforms with optional payment processing. Unite Us and Findhelp are commercial technology vendors that sell referral platforms. Other commercial platforms active in this tier include WellSky (Social Care Connect), CareConvene, Holon Solutions, and PCE Systems; Unite Us and Findhelp have the largest footprint in Medicaid-anchored HRSN programs as of 2025, but the vendor landscape is broader and interoperability across platforms remains limited. Several of these platforms have added integrated payment infrastructure to process reimbursements to CBOs on behalf of their underlying funders. Unite Us provides the underlying platform for NCCARE360, for several NY SCN Lead Entities, and for selected pilots elsewhere; Findhelp powers HRSN service delivery for MassHealth ACOs as of January 2025. In every case, the underlying funding source is the program (the 1115 waiver, the managed-care contract, philanthropy), not the platform vendor. The distinction between payment processing and a funded service model matters. Tier-three vendors have lowered the operational friction of moving dollars to CBOs, but they have not solved the structural problem of who provides the underlying funding and on what terms.[77,78]

Across all three tiers, the strengths are real: open or near-open access, powerful capabilities for visibility and referral, and an increasingly sophisticated infrastructure for closed-loop tracking. But none of these entities is itself a service funder. The category has built a powerful infrastructure for visibility, referrals, and reimbursement, but it has not closed the gap in funded services.[79]

Coalition-, community-, and faith-based delivery

The organizations in this category of integration models are those that most often serve the populations the rest of the integration system overlooks.

The Camden Coalition, free clinic networks, and faith-based health networks are trust-rooted, often locally embedded, and frequently serve as the front line for marginalized communities. The federally supported Community Care Hubs (organized by ACL in partnership with the CDC) represent a distinct model: they contract with payer organizations and fund CBOs within their networks to deliver the HRSN service, placing them in the gated quadrant of Figure 3 that pays for the HRSN service itself, though their population reach depends on payer-contract eligibility rather than open community-wide residency.

As of early 2026, the Community Care Hub National Learning Community, launched in November 2022, continues to support a network of more than 70 regional CBO hubs operated by the Center of Excellence to Align Health and Social Care at USAging. The framework is more flexible than a Medicaid-only SCN and is among the most promising scaffolds for residency-based reach. However, its near-term future is uncertain: ACL was eliminated and restructured in 2025, as part of the HHS reorganization, with its programs distributed across the existing Administration for Children and Families (ACF), CMS, and ASPE.[80] No successor federal sponsor for the Community Care Hub National Learning Community has been announced yet.

These are the organizations performing the integration work that the rest of the system cannot, and they are being asked to do more of it with less. The financing model has not kept pace, and unless it does, the country's residency-based scaffold will continue to operate on a project-by-project basis rather than as durable infrastructure.

The structural pattern

Across all these categories, the pattern is consistent. No existing model fully occupies the upper-right quadrant of Figure 3: open access to every resident of the service area, with payment for the HRSN service itself through a contracted CBO network. The country has built fragments of social care infrastructure, in real numbers and with real outcomes, but it has not built a comprehensive social care infrastructure.

Figure 3. Typology of U.S. Social Care Integration Models

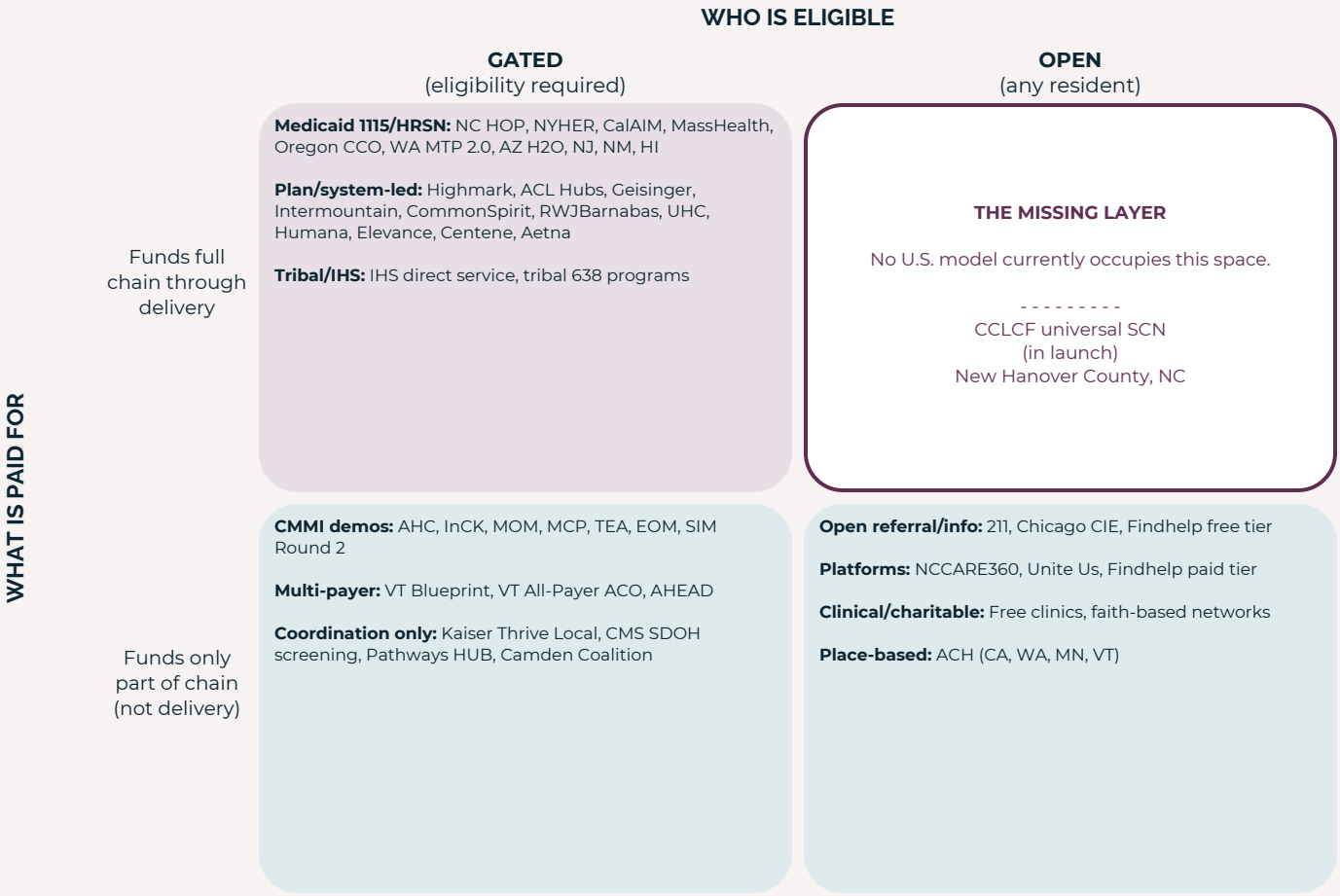


***Figure description**: Two-by-two matrix classifying U.S. integration models on two axes. The horizontal axis, who can be served, runs from Gated (insurance or eligibility required) on the left to Open (any resident) on the right. The vertical axis, what is paid for, runs from funds only part of the chain, not delivery, at the bottom to funds the full chain through delivery at the top. The service chain is identifying need, referring, coordinating, and delivering services; delivery is the link most often missing. Upper-left (gated; funds the full chain through delivery): Medicaid 1115 and HRSN programs (NC HOP, NYHER, CalAIM, MassHealth, Oregon CCO, WA MTP 2.0, AZ H2O, and NJ, NM, and HI programs); plan- and system-led models (Highmark Health, ACL Hubs, Geisinger, Intermountain, CommonSpirit, RWJBarnabas, and the national health plans UnitedHealthcare, Humana, Elevance, Centene, and Aetna); and Tribal/IHS integration (IHS direct service and tribal 638 programs). Upper-right (open; funds the full chain through delivery): The Missing Layer. No U.S. model currently occupies this space of open access plus funding the full chain through delivery, but a dashed marker labeled CCLCF universal SCN (in launch), New Hanover County, NC, indicates that Community Care of the Lower Cape Fear, formerly a Network Lead under NC HOP, is building a separate universal, residency-based SCN, the first model entering this space. Lower-left (gated; funds only part of the chain, not delivery): CMMI demonstrations (Accountable Health Communities, Integrated Care for Kids, Maternal Opioid Misuse, Making Care Primary, Transforming Episode Accountability, Enhancing Oncology Model, and the historical SIM Round 2); multi-payer alignment (Vermont Blueprint, Vermont All-Payer ACO, and AHEAD); and coordination and navigation only (Kaiser Thrive Local, CMS hospital SDOH screening mandates, Pathways Community HUB, and Camden Coalition). Lower-right (open; funds only part of the chain, not delivery): open referral and information systems (211 national and 211 San Diego CIE, Chicago Regionwide CIE, and Findhelp free tier); referral and payment platforms that are infrastructure rather than funders (NCCARE360 and Unite Us, Unite Us Social Care Payments, and Findhelp paid tier); open-access clinical and charitable providers that deliver clinical care but not HRSN social-service delivery (free clinics and faith-based networks); and place-based community health collaboratives that coordinate rather than centrally deliver (Accountable Communities for Health in CA, WA, MN, and VT). Source: Atrómitos analysis; RTI International, CMS Innovation Center, and cited program documentation.*

VI. The Gap: Why the Patchwork Falls Short, and Is Falling Apart

The cumulative effect of structural gating is that the residents in need of integration receive it only by accident, if at all. There are four structural gaps that create access gaps: eligibility gating, funding fragility, budget-neutral compression, and CBO sustainability.

Eligibility gating

Eligibility gating is not one constraint but a stack of them, applied in series. Figure 4 traces the stack from the full U.S. population at the top down to the population reached.[81]

Figure 4. Eligibility Gating: From Total Population to Served

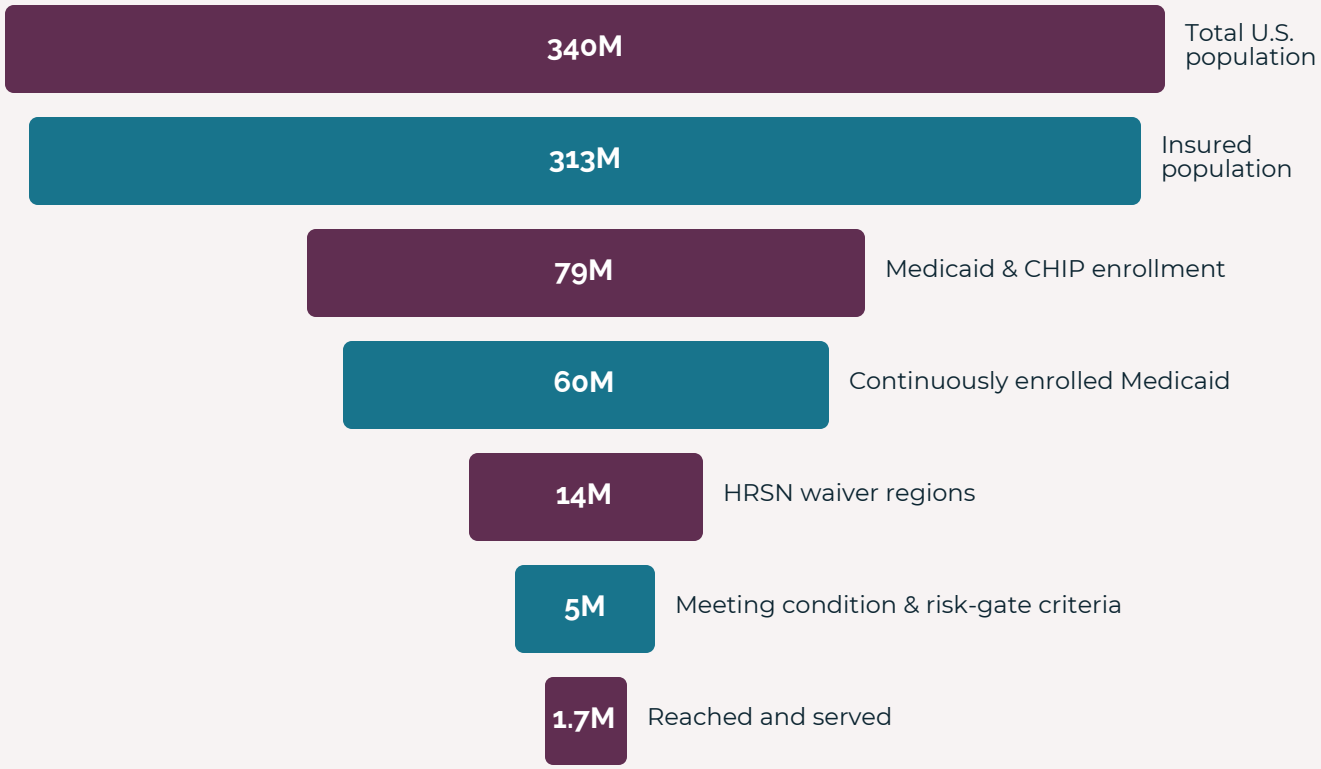


Figure description: *Cascading bar chart showing population narrowing across seven tiers, from the total U.S. population to those reached and served. 340 million: Total U.S. population (2024 Census Bureau). 313 million: Insured population (~92% covered, KFF/U.S. Census, 2024). 79 million: Medicaid and CHIP enrollment (Dec 2024 CMS data, ~78.8M). 60 million: Continuously enrolled Medicaid (post-PHE unwinding; projected OBBBA churn). 14 million: Medicaid managed care in HRSN waiver regions (HRSN-approved 1115 pilot states). 5 million: Meeting condition and risk-gate criteria (program-specific eligibility gate). 1.7 million: Reached and served across active programs. Bar widths use square-root scaling. Source: U.S. Census Bureau (2024); KFF; CMS; NCDHHS, NY DOH, DHCS, WA HCA, MassHealth, OHA; Atrómitos analysis.*

The **insurance gate** excludes residents without continuous qualifying coverage: the uninsured (roughly 27 million people in 2024), undocumented residents and members of mixed-status households, gig workers without coverage, and people in coverage gaps during transitions. The payer gate restricts most existing networks to a single insurance type, typically Medicaid, which leaves Medicare-only, commercial, and ACA-marketplace residents outside Medicaid-anchored SCNs. The payer gate falls on the moderate-means working family managing eldercare or childcare strain, the employer-insured caregiver of a parent with dementia, the rural commercial subscriber whose plan has no community-based contracting, and the chronically ill ACA-marketplace enrollee whose plan does not coordinate non-medical services.

The **geographic gate** restricts integration to residents of an approved pilot region: HRSN-approved 1115 waivers typically do not cover the whole state (Washington's MTP 2.0 is a notable statewide exception), and rural and tribal communities are disproportionately outside approved geographies.

The **demonstration-term gate** imposes a temporal restriction: programs run for the term of the federal authority (typically 5 years), and infrastructure does not uniformly survive termination, as the post-AHC and post-MCP experiences have shown.

The **condition-and-risk gate** is the most familiar: most Medicaid-anchored SCNs require a qualifying physical or behavioral health condition plus a documented social risk factor, which excludes residents who have unmet social needs but do not meet the medical-risk threshold (a common circumstance among young families, working-age uninsured, and many rural and tribal residents).

And the **reach gate**, which is too often invisible in policy analysis, captures the gap between eligibility and successful enrollment: residents who are eligible but never identified, screened, referred, or successfully connected to the service.[82,83]

Each gate, alone, looks reasonable. Stacked, they exclude the residents with the greatest unmet need.

But the stack still understates the problem. Every gate above assumes the resident is already in the system in some way (enrolled in a program or covered by a payer with a network) and excludes them at some stage. A second, larger population is outside the system altogether: their insurance is not connected to any social-care network, so their social needs are never identified or screened,

and they remain invisible to the current integration apparatus. Identified-but-excluded need and unidentified need are distinct problems, and durable, residency-based infrastructure must address both because payer-anchored screening alone reaches neither.

Funding fragility

Most integration infrastructure rides on time-limited demonstrations, philanthropic grants, or annually appropriated state programs. The events of 2025 have moved this fragility from theoretical to acute. The DSHP and DSIP wind-down on April 10, 2025, the CMS HRSN guidance rescission on March 4, and the NC HOP funding lapse and service suspension on July 1 each illustrate the pattern. CBOs cannot sustain workforce, data, and service capacity on three- to five-year cycles, nor can they survive program suspensions. North Carolina's case is especially instructive: federal authority for HOP runs through 2029, yet service delivery has been dark for nearly a year because the state-level appropriation has not arrived.[84]

Budget-neutrality compression

OBBBA's tightened 1115 budget-neutrality requirements, which require Chief Actuary certification at each renewal and a federal claw back for noncompliance, collide with the realities of social care financing. Savings often accrue beyond the waiver period and outside Medicaid. This is a structural threat to HRSN waivers as currently designed. Even programs with documented per-member savings, like North Carolina's HOP, may have difficulty meeting budget-neutrality scrutiny when the savings horizon extends beyond the five-year waiver period. The first major test will arrive at the California CalAIM renewal at the end of 2026 (the demonstration expires December 31, 2026, and is in active CMS renewal negotiation through 2026), with New York's Social Care Networks renewal (waiver expires March 31, 2027) following close behind.[85]

CBO sustainability

Even when payment is in place, rates often fail to cover indirect costs and data infrastructure, and smaller, BIPOC-led CBOs are systematically disadvantaged. They are also the most exposed to funding contractions: the first organizations to close in any retrenchment are those operating on the thinnest margins, and those are disproportionately the organizations serving the populations the rest of the system misses. Integration that relies on community organizations to absorb the indirect and infrastructure costs of the work falls short of the standard of durable public infrastructure.[86]

Net effect: the missing layer

These four structural gaps describe a system of fragments, not infrastructure. The fragments cannot deliver the universal outcomes that the evidence shows integration can produce. The 2025 retrenchment is not a temporary headwind; it is a stress test, and the patchwork will not survive it.

The country must build the missing layer in Figure 3: a universal, residency-based, community-wide social-care infrastructure that serves every resident of a region regardless of insurance status, contracts with and pays a CBO service-delivery network, and is financed by enough sources to ensure its sustainability.

VII. A Path Forward: Universal Community-Wide Social Care Networks

For the purposes of this paper, a Social Care Network (SCN) is a regional network of contracted community-based organizations that identify, refer, coordinate, and deliver payable Health-Related Social Needs services to residents under a unified contracting, intake, and payment structure. All four functions must be funded: a network that pays for identification, referral, or coordination but not for delivery leaves the underlying need unmet, and a network that funds delivery without funding identification, referral, and coordination cannot reliably connect residents to the service. This is distinct from coordination-only networks (e.g., Washington's Accountable Communities of Health, which coordinate across organizations and administer social-needs navigation but do not fund delivery of the full set of HRSN services) and referral-only networks (e.g., 211 information-and-referral hotlines), each of which funds part of the chain but not the whole.

A residency-based, blended-finance social care network is the missing layer the United States must build over the next decade. The design is not speculative; the operating components and financing sources exist, and the policy environment makes the work both more difficult and more necessary.

A public-infrastructure analogy

Public libraries, public health departments, 911, and public transit share three properties. They are residency-based: anyone within the service area can use them. They are durable: their financing is not contingent on annual approval of demonstrations. And they are not gated by who pays.

None of these systems is perfect; all of them are real, and most people encounter them as part of community membership rather than as benefits earned through eligibility. The country built these systems because it decided at some point that they were too important to leave to administrative discretion or market forces. The country is at the same threshold now.

Design principles

A universal community-wide social care network rests on six design principles, each paired with a structural mechanism that makes it real rather than aspirational. They are addressed here roughly in the order a network would need to resolve them: who can use it and what gets paid for, how data moves and who governs it, how it is financed durably, how governance ensures it serves everyone equitably, and how its service catalog stays current with the evidence.

PRINCIPLE 1: RESIDENCY-BASED, INSURANCE- AND STATUS-BLIND ACCESS

Any resident of the service area can use the network regardless of insurance status, income, or background, with financing drawn from multiple sources and enrollment that remains open rather than capped by waiver slots or a fixed budget-year headcount. This principle answers directly to the eligibility gating problem documented in Section VI: a network anchored to residency rather than to a single payer's enrollment file cannot, by construction, exclude the moderate-means working family, the employer-insured caregiver, or the ACA-marketplace enrollee described there, because eligibility is not payer-defined in the first place. The mechanism is a regional governance entity, modeled in spirit on the Lead Entity structure in New York's Social Care Networks or the Network Lead role in NC HOP, but with its eligibility scope expanded to all residents of the region and a contracting structure that does not depend on any single Medicaid waiver for its legal or financial existence.

PRINCIPLE 2: A FUNDED SERVICE CHAIN

Identification, referral, coordination, and delivery are all paid for, not one function at the expense of the others. A network that pays for identification, referral, or coordination but not delivery leaves the underlying need unmet, and a network that funds delivery without funding the earlier functions cannot reliably connect a resident to the service. The mechanism is a rate structure that funds every link in the chain: contracted community-based organizations deliver services under rate floors that cover indirect costs rather than only the marginal cost of the service itself; screening, referral, and coordination are funded as distinct, billable functions alongside delivery rather than treated as unfunded overhead that

CBOs must absorb, and shared infrastructure, workforce training, data systems, and administrative capacity are funded across the network rather than by each CBO alone.

PRINCIPLE 3: CLOSED-LOOP, RESIDENT-GOVERNED DATA

Data and consent are fundamental structural challenges in U.S. social-care integration, not mere technical afterthoughts. The field has yet to address them comprehensively. Five distinct issues compound this complexity, each requiring a different solution: whether a referral closes the loop, whether consent is meaningful, who governs the data, how much is collected, and how well it is secured.

The first is interoperability. Closed-loop referral platforms have multiplied without converging on shared standards, so a referral initiated in one state, payer, or platform does not transfer cleanly to another. USCDI v3 SDOH data elements and Gravity Project standards offer a path, but adoption is uneven, and there is no federal requirement that platforms interoperate.[87] USCDI v3 is the federally required core data set for certified health IT; the Gravity Project is the HL7 FHIR community building shared coding for HRSN screening, assessment, goals, and interventions. Together, they establish a common vocabulary and data model that closed-loop referral platforms can adopt to exchange social-care information across EHRs, payers, and CBOs.

The second is consent. The legal frameworks for sharing social-care data across health, public health, and social services are inconsistent, and many programs default to either over-collection (relying on broad blanket consents that residents do not meaningfully understand) or under-sharing (refusing to share data even where the resident has authorized it), because the legal posture is unclear. HIPAA, 42 CFR Part 2, FERPA, and state-specific social services privacy laws apply in different combinations to different services, creating a patchwork that disproportionately burdens residents with the consent question.[88]

The third is community data governance. In practice, residents and the communities they belong to have the least authority over how their data is used. Indigenous data sovereignty frameworks and the CARE Principles for Indigenous Data Governance (Collective benefit, Authority to control, Responsibility, Ethics) offer a more defensible model, and the FNIGC OCAP® principles (Ownership, Control, Access, Possession) in the Canadian context offer a related framework, but neither set has yet become dominant practice in U.S. social-care integration outside Tribal jurisdictions.[89] The CARE Principles, developed by the Global

Indigenous Data Alliance, frame data governance around collective benefit to the community that the data describes, authority to control how the data are used, responsibility for how the data are managed, and ethics in their collection and reuse; OCAP® articulates the corresponding rights of First Nations to own, control, access, and possess information about themselves and their communities; in both cases the framework moves data governance authority from the holder of the platform to the community that the data are about.

The fourth and fifth issues are linked. Data minimization is rarely the default; many platforms collect more identifying and sensitive data than the service requires, on the theory that it might be useful later, creating exposure without commensurate benefit. Breach and re-identification risk compound that exposure: social-care data combined with healthcare data is among the most sensitive personal information held about a person, and the security investments at many small CBOs are not commensurate with that sensitivity.

A serious universal SCN must address all five at the design stage: shared data standards (USCDI v3, Gravity Project, and FHIR HRSN profiles), enforceable interoperability requirements, layered and meaningful consent processes, community data-governance bodies with real authority, data-minimization defaults, and security investments scaled to data sensitivity. Together, these make the network's data closed-loop in operation and resident-governed in ownership: a referral that does not connect to a service is a referral that did not happen, and residents, not the platform or the payer, own and govern the information collected about them.

PRINCIPLE 4: DURABLE, MULTI-SOURCE FINANCING

A public funding anchor sized to keep the network operating across budget cycles, independent of any single payer's continued participation, is required. North Carolina's experience, discussed in Section VI's funding-fragility problem, is the clearest illustration of what happens without it: federal 1115 authority for HOP runs through 2029, yet service delivery went dark for over a year because a single state legislature failed to appropriate matching funds in a single budget cycle. A durable design does not depend on any one payer, state legislature, or federal demonstration term remaining intact; it draws revenue from Medicaid, Medicare Advantage supplemental benefits, hospital community benefit, state revenue, employer contributions, philanthropy, federal grants, and private pay, so that the loss or disruption of any single source reduces, rather than eliminates, the network's operating capacity. The comparison of how existing programs finance HRSN services and a proposed financing architecture built on this principle is developed in the Cross-program financing comparison below.

PRINCIPLE 5: EQUITABLE COMMUNITY GOVERNANCE

Equitable community governance has three components: reach, trust, and community voice. The first is reach: even where networks exist, they do not consistently reach BIPOC, immigrant, rural, and tribal residents at population-equivalent rates, in part because outreach, screening, and enrollment processes are designed around populations that engage the conventional healthcare system. The second is trust: residents with experience of immigration enforcement, child-welfare intervention, criminal-legal-system contact, or discriminatory clinical care have well-founded reasons to be cautious about a system that requests sensitive social information and shares it across agencies. Trust, once eroded, is slow to rebuild, and a network that has compromised its trust with a community will not recover it within a single waiver cycle. The third is community voice in governance: who decides what services the network offers, what data it collects, what rate floors it sets, and which populations it prioritizes. When these decisions are made by the state Medicaid agency or the SCN Lead Entity without meaningful community-level representation, the network drifts toward the dominant payer's priorities rather than those of the residents it is supposed to serve. The mechanism is structural: BIPOC-led, tribal, and rural CBOs are first-class participants in governance, not afterthoughts; the entity is accountable to the residents it serves rather than only to its largest payer, and is best held by a local, community-connected nonprofit with a community-representative board; and outcome and equity accountability are built in through public reporting on reach, including unequal reach.[90,91]

PRINCIPLE 6: EVIDENCE-BASED SERVICE SCOPE

A universal SCN also needs a defensible answer to a question every existing program has answered differently: which services belong in the catalog. The programs surveyed in Section V converge on no common core: NC HOP funds four domains (housing, food, transportation, and services addressing interpersonal violence and toxic stress); CalAIM funds fifteen Community Supports; New York's SCNs and Washington's MTP 2.0 each define their own service lists; and AHC's five HRSN domains (housing instability, food insecurity, transportation, utilities, and interpersonal violence) set the federal baseline that several state programs still track. Rather than adopt any one program's list wholesale, a universal SCN should scope its initial catalog to the domains with the strongest outcome evidence assembled in Section III: housing stability and navigation, medically tailored food and nutrition supports, transportation, care coordination and CHW-delivered navigation, and interpersonal-violence and toxic-stress services. Domains with thinner evidence, such as broader income supports or legal services, belong in a mature network's catalog only as the

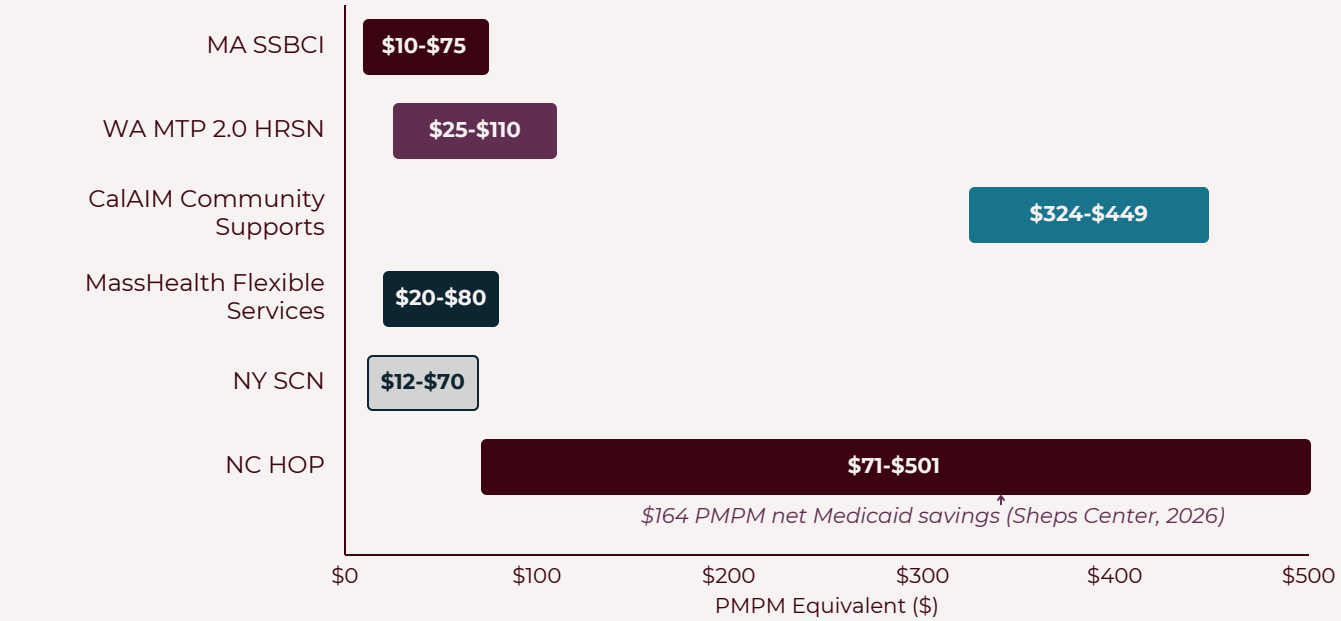
evidence-base and the financing mix develope, not by default at launch. Scope decisions apply across the full service chain established earlier in this section: identification, referral, coordination, and delivery together, because a service added to the catalog without funding the earlier functions will not reach the resident who needs it.

The scope set at launch cannot be allowed to calcify, and two precedents already discussed in this paper point to the mechanism. Arizona's H2O program pilots new service types, evaluates them for outcomes, and either standardizes or retires them (Section V); CCLCF's planned Innovation Lab is designed to develop, pilot, evaluate, and standardize new SDOH services in collaboration with medical providers, payers, and CBOs (Section VII).[92] A universal SCN should generalize both into a standing design principle: a governance body, not a single payer or administrator acting unilaterally, reviews the service catalog on a fixed cycle tied to the network's own contract or budget cycle rather than to any single payer's, applies a pilot-evaluate-standardize-or-retire pathway to every candidate service, and publishes the resulting menu and rate changes rather than adjusting them administratively and without notice, the failure mode already documented in the Medicare Advantage supplemental-benefit contraction discussed in Section V. The review body should include the community-representative governance established above as a design principle in its own right, so that additions and retirements track resident need and published evidence rather than a payer's cost pressure in a given budget year. Without this mechanism, a service catalog fixed at launch drifts from the evidence within a few years of the program's opening, and a catalog changed unilaterally by whichever payer holds the largest share of network revenue reproduces, at the level of a single program, the durability problem this paper identifies at the federal and state level.

Cross-Program Financing Comparison

Programs that fund HRSN services use different financing structures, and a clean per-member-per-month band that spans them does not exist in the public record. The fairer comparison, summarized in Figure 5, places each program in the units its own documentation uses.[93] The takeaway is structural: financing for HRSN services takes multiple, incommensurable forms, and a universal SCN’s per-resident cost should be derived on a program-by-program basis rather than from a single cross-program PMPM band.

Figure 5: HRSN Service Financing Across Programs and Payer Type



Programs use different units; ranges are Atrómitos PMPM derivations from published sources.

Figure description: *Horizontal bar chart comparing per-member-per-month (PMPM) equivalent financing ranges. MA SSBCI: $10-$75 PMPM (estimated actual utilization, not benefit caps; MedPAC Oct 2024). WA MTP 2.0 HRSN: $25-$110 PMPM. CalAIM Community Supports: $324-$449 PMPM. MassHealth Flexible Services: $20-$80 PMPM. NY SCN: $12-$70 PMPM. NC HOP: $71-$501 PMPM; annotation notes $164 PMPM net Medicaid savings (Sheps Center, 2026). Programs use different units; ranges are Atrómitos PMPM derivations from published sources. Source: NCDHHS, California DHCS, NY DOH, WA HCA, MassHealth, MedPAC (Oct 2024); Atrómitos analysis.*

A universal residency-based SCN serving every resident of a region, not only a Medicaid-enrolled subset, changes the financing math in two important ways. The cost is spread across the full population rather than concentrated on the highest-need subset, so per-resident costs are lower than the per-enrollee rates documented for HRSN-eligible Medicaid programs. The revenue base must also be diversified across non-Medicaid sources by design, since not all residents are enrolled in Medicaid. Figure 6 presents a proposed financing architecture for a universal residency-based SCN: a design in which Federal Medicaid is one of eight revenue sources rather than the single point of failure. Vermont Blueprint for Health, the only U.S. model with documented multi-payer HRSN-adjacent financing at a statewide scale, demonstrates that multi-payer contribution is achievable; no current SCN program operates with a financing mix this diversified, which is precisely the structural gap that must be closed.

Figure 6: Proposed Multi-Payer Financing Mix for a Universal SCN

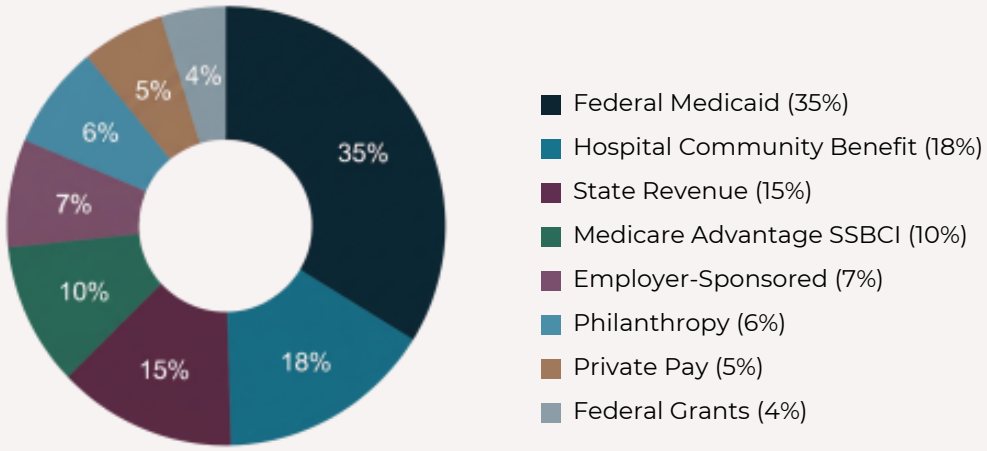


Figure description: *Donut chart showing a proposed multi-payer financing mix for a universal residency-based Social Care Network. Eight funding sources: Federal Medicaid 35%; Hospital Community Benefit 18%; State Revenue 15%; Medicare Advantage SSBCI 10%; Employer-Sponsored 7%; Philanthropy 6%; Private Pay 5%; Federal Grants 4%. Percentages are illustrative target mix for a service area that reaches all residents, regardless of insurance status; the actual mix will vary by market, demographics, and policy environment. Vermont Blueprint for Health is the only U.S. precedent for multi-payer HRSN-adjacent financing at a statewide scale. Source: Atrómitos design analysis.*

A universal SCN should add two further revenue layers that reach residents. The first is employer-sponsored access, either as a benefit included in a self-insured or fully insured group plan or as an employer-purchased add-on operating alongside an Employee Assistance Program. An employer that contracts SCN access for its workforce can extend social-care navigation, food and transportation services, and housing assistance to employees and dependents who would not otherwise have it, with the cost spread across the employer's contribution base. The second is private pay: residents and families paying out of pocket for services not covered by their insurance, on a sliding-scale or flat-fee basis. A private-pay example is the daughter whose elderly parents live out of state, are enrolled in a Medicare Advantage plan that does not participate in the SCN, and need access to medically tailored meals or in-home care coordination: a private-pay layer allows that daughter to purchase the service for her parents from the SCN serving their region. Both layers expand reach and diversify revenue without compromising the core public-anchor financing for residents who cannot pay.[94]

Philanthropic anchor capital is already visible in the SCN buildouts surveyed in this paper, most visibly in the CCLCF transition described below, where the New

Hanover Community Endowment is anchoring the regional SCN's stand-up after the July 2025 HOP suspension.[95] Philanthropy alone is not a sustainable financing solution at scale, but it is essential both as a launch mechanism and as a permanent gap-filler for residents whom no other layer reaches.[96,97]

Two design constraints accompany financing diversification. First, tighter 1115 budget neutrality (and the end of the DSHP and DSIP federal match) means that HRSN-heavy components must be paired with primary care and utilization linkages that can pass CMS Chief Actuary review, and new state revenue sources must be identified up front. Second, the Rural Health Transformation Program offers meaningful near-term funding for rural delivery-system transformation but expires in FY2030; a universal SCN that relies on RHTP must therefore plan for the same kind of post-demonstration transition that the AHC and HOP experiences have already taught the field.

The financing model above is designed to absorb both constraints: diversification is the answer to single-source fragility, and the non-Medicaid revenue layers (Medicare Advantage SSBCI, hospital community benefit, state non-Medicaid revenue, employer-sponsored, private pay, and philanthropic anchor) reduce the sensitivity of the network to any single CMS or state appropriation action.

Case study: Building a universal residency-based SCN after a Medicaid-anchored program collapses

Community Care of the Lower Cape Fear, Inc. (CCLCF) is an example of how an established regional collaborative can pivot from operating a Medicaid-anchored social care program to designing a universal, residency-based SCN.[98] CCLCF served as one of the regional Network Leads under North Carolina's Healthy Opportunities Pilots and is actively building a universal social care network. The transition is anchored by a planning grant from the New Hanover Community Endowment and is currently designed for New Hanover County. In June 2026, the Endowment committed an additional $2.5 million to launch and establish the network, building on its 2025 planning grant. The funder characterized the initiative as having the potential to become "the first Social Care Network of its kind in the United States," one designed to serve every resident regardless of payer source or background. The launch grant is structured for long-term sustainability across four revenue streams: medical payer reimbursements, employer contributions, philanthropic investments, and public funding, which are consistent with the broader diversified, multi-payer financing architecture modeled in Figure 6.[99] The geographic scope of the initial SCN is constrained by the originating philanthropic funder's service area; statewide or multi-county

replication will require additional philanthropic anchors and a broader revenue mix. New Hanover County also falls within Trillium Health Resources' NC ROOTS Region 5. Because ROOTS Hub funding is restricted to infrastructure and cannot cover services, the CCLCF universal SCN is designed to complement, rather than duplicate, the ROOTS Hub now operating in its geographic area.

THE CCLCF UNIVERSAL SCN DESIGN

The design CCLCF developed in response to the structural limits identified in Sections V and VI puts the design principles above into practice and features eight differentiators that distinguish it from prior Medicaid-anchored SCN models, grouped into four functional areas: governance and innovation; service design and delivery; operations and administration; and data and evaluation.

First, the network is residency-based rather than eligibility-based: any New Hanover County resident, regardless of insurance status, economic status, age, race, national origin, or other protected characteristic, will be able to access services. The network will provide approved services based on payer or funder match where available, accept self-pay for non-covered services, and actively work to secure funding for uninsured and financially insecure residents. Regardless of payer match, all residents also have access to health resource navigation to help them identify and connect to the services they need. Second, the network will operate an Innovation Lab, governed by an Innovation Lab Committee, that will develop, pilot, evaluate, and standardize new SDOH services in collaboration with medical providers, insurance carriers, health systems, CBOs, and community leaders. The Innovation Lab's mandate addresses the absence of a service-innovation mechanism that constrained HOP.

Third, the network will bundle services to address root causes rather than single needs (for example, pairing nutrition with health literacy rather than resolving an immediate hunger episode in isolation). Fourth, the network is grounded in local connections: CCLCF was established in 2003 and has more than twenty years of operational presence in southeastern North Carolina, with a CBO network that has collectively delivered more than 99,000 services to New Hanover County residents. Fifth, the network deploys Centralized Network Services (CNS) that consolidate contracting, intake, service-definition management, billing and finance, quality improvement, data tracking and reporting, and privacy and security across all CBOs, significantly reducing administrative overhead and freeing CBO capacity for direct service delivery.

Sixth, the network will operate an enhanced participant-engagement model focused on shared decision-making, strengths-based planning, and closed-loop follow-through, replacing the compliance-driven check-in pattern that HOP revealed to produce limited behavioral change. Seventh, the network embeds data-driven decision-making at every level of operations, including identifying bottlenecks, waste, and opportunities for standardization. Finally, the network treats impact analysis and reporting as a core capture function rather than an afterthought: the Network Lead engages directly with payers and funders through data-sharing agreements to capture clinical claims data that HOP never made available to its Network Leads, and integrates outcome and financial impact analyses into the operational data flow.

FINANCING THE TRANSITION: PHILANTHROPIC ANCHOR, MULTI-PAYER BUILD

CCLCF's financial model is the operational test of the multi-source approach this section advocates. The structure is a declining philanthropic anchor over the first five years, paired with growing network revenue from Network Lead administrative fees tied to transaction volume, calibrated so that the SCN reaches full sustainability by the end of the bridge period. The trajectory is grounded in HOP's documented in-region operational performance, in which network revenue scaled rapidly over the three pilot years before state funding lapsed; the philanthropic anchor in the new model explicitly substitutes for the time-limited Medicaid-only revenue that proved structurally fragile.

Beyond the philanthropic anchor, the multi-payer build includes Medicaid (where Medicaid funding becomes available again through HOP restoration, ILOS arrangements (which require carefully designed eligibility criteria; overly broad eligibility risks cost-effectiveness failures, while overly narrow eligibility limits access) with North Carolina's Standard Plans and Tailored Plan, or any successor Medicaid HRSN authority), Medicare and Medicare Advantage (including SSBCI for chronically ill members and D-SNP arrangements for dual-eligible residents), private commercial plans (including employer-sponsored coverage), Cape Fear HealthNet and Novant Health financial assistance programs for indigent residents, hospital community benefit redirected from individual institutional priorities to regional SCN financing pools, state non-Medicaid revenue where available, and private pay on a sliding scale for residents and families purchasing services outside their insurance coverage.

The model is architected for scale.

WHAT THE CCLCF TRANSITION WILL TELL THE REST OF THE COUNTRY

If CCLCF is successful, it will be the first U.S. example of a universal, residency-based social-care network built on a previously Medicaid-anchored regional infrastructure, with a documented path to sustainability and an established CBO network. The model would demonstrate that the gated-to-universal transition this paper argues for is not only theoretically defensible but operationally feasible at a regional scale, on a five-year financial timeline, with philanthropy serving as a bridge rather than a substitute funder.

If the CCLCF transition encounters obstacles, they will be informative for the rest of the field. Whether the financing model holds, whether the Innovation Lab produces sustained service innovation, whether the Centralized Network Services administrative consolidation delivers the cost reductions projected, whether the data-driven decision-making capacity yields the impact analysis HOP could not produce, and whether the residency-based access model expands reach without diluting service depth are all empirical questions that the next five years will answer.

The 2025 retrenchment showed that integration infrastructure built primarily on federal and state authority can be undone in a single budget cycle. The conclusion is not that those authorities are irrelevant; every layer of public-anchor financing flows through one or the other, but that anchoring durability solely on federal and state action is the strategy that just failed. A universal social care network requires a different theory of change:

- The infrastructure must be in place before the financing solidifies;
- It must draw revenue from multiple sources that no single authority can switch off;
- It must be owned and governed at the community level; and
- It must federate horizontally rather than wait for vertical permission.

VIII. Recommendations

The 2025 retrenchment showed that integration infrastructure built primarily on federal and state authority can be undone in a single budget cycle. The conclusion is not that those authorities are irrelevant; every layer of public-anchor financing flows through one or the other, but that anchoring durability solely on federal and state action is the strategy that just failed. A universal social care network requires a different theory of change:

- The infrastructure must be in place before the financing solidifies;
- It must draw revenue from multiple sources that no single authority can switch off;
- It must be owned and governed at the community level; and
- It must federate horizontally rather than wait for vertical permission.

The recommendations below are organized around four strategic priorities that follow from that theory, followed by a subsection on what federal and state authorities should do to accommodate the build.

Strategic Priority 1: Build first, finance second

The CCLCF transition is doing exactly this: it draws on philanthropic anchor capital from the New Hanover Community Endowment and a multi-payer plan that does not depend on restoration of the HOP appropriation. The pattern is replicable. Community endowments and place-based foundations should anchor three- to five-year stand-up grants for regional SCNs in their geography, using the NHCE/CCLCF template: defined-period launch capital, not an open-ended operating subsidy. Hospital systems should commit at least 25 percent of community-benefit spending to regional SCN financing pools within 24 months. Because community benefit is governed by the flexible § 501(c)(3) standard (Rev. Rul. 69-545) and reported on Form 990, Schedule H, hospitals retain broad discretion to direct those dollars toward regional SCN financing.[100,101]

Strategic Priority 2: Aggregate demand across every payer and private pay

A regional SCN built on a single 1115 waiver dies with that waiver. A regional SCN that contracts simultaneously with Medicaid managed-care plans, Medicare Advantage plans, commercial group plans, and individual private-pay revenue does not. Demand aggregation is the single most powerful structural change available to any regional SCN, and it requires no federal or state legislative action.

Self-insured employers can include SCN access directly in their group health plan as a network benefit, the way they treat behavioral health or telemedicine coverage today. Health systems can integrate SCN referral into routine post-discharge transitions for the population they already serve. Regional health-planning bodies and community health improvement coalitions can negotiate population-level access to SCNs on behalf of multiple payers under existing community-benefit authority. Each of these paths produces multi-payer demand without requiring a new collective entity.

On the payer side, three concrete options sit under existing regulatory authority. First, Medicare Advantage plans can, by contract, route members directly through a regional SCN rather than build parallel internal networks. Second, commercial group plans can include SCN access as a contracted, in-network benefit, with behavioral health coverage as it is today. Third, state Medicaid agencies can write managed-care contract language requiring participating MCOs to satisfy their HRSN obligations through the regional SCN rather than through their own in-house networks (where MCOs have already built out HRSN infrastructure such as CHW programs and in-person navigation, the transition should preserve continuity of existing member supports). The managed-care contract language path is the most consequential in the near term because every state already revises managed-care contracts on a known cadence. The CCLCF multi-payer financing plan is the working prototype.

Strategic Priority 3: Make SCNs public utilities at the state level

The legal status of an SCN today is “vendor” or “grantee,” terms that imply contingent existence. The legal status the country granted to fire departments, public water systems, and rural electric cooperatives was that of an “essential public utility,” with statutory protections against politically motivated termination. The same status, applied to SCNs at the state level, provides the statutory durability that administrative pathways cannot. State legislatures should pursue state utility-like statutes that recognize regional SCNs as essential community infrastructure, with the protections that status confers, statutory funding floors, rate review, certificate-of-need-like protection against displacement, and an obligation to serve.

States that have created Accountable Communities for Health frameworks (California, Washington, Vermont, Minnesota) already have legal scaffolds that can be extended to SCN utility status with state legislative action. Continuity reserves at the state level (at least three months of HRSN service spending) should be paired with the utility-status framework to prevent an appropriation

lapse from suspending services. North Carolina is the leading indicator: the General Assembly should act while federal authority remains in force through December 2029.[102]

Statutory protection is necessary but not sufficient. The organizational form matters just as much: regional SCNs are most durable when built and managed by a local, community-connected nonprofit that already has the trust of the communities it serves. A nonprofit governance structure (a 501(c)(3) with a community-representative board, transparent finances, and an obligation to serve its geography) is best positioned to hold multi-payer financing on behalf of residents without being captured by any single payer, agency, or commercial vendor. Public-utility status, when paired with local nonprofit ownership and community board governance, produces the combination that is required: statutory durability, local accountability, and operational independence from the policy environment of any single payer.

Strategic Priority 4: Federate horizontally rather than wait for a federal program

A national social care network does not have to be built top-down. 211 did the opposite: approximately 200 independent local nonprofits federated under a single FCC dialing code, governed cooperatively, sharing standards but not a single corporate parent. A national federation of regional SCNs is the same model. The federation should maintain shared standards (Gravity Project data standards, FHIR HRSN profiles, community data governance principles, CBO rate floors, and workforce credentialing) while each regional SCN maintains its own governance, financing, and service mix. Federation is the answer to scale without centralization, and it is the most defensible posture in any future federal policy environment, because it continues to operate regardless of the direction federal policy takes.

The continuing role of federal and state authorities

Federal and state authorities are not the leaders in this theory of change; they are accommodators and partial financiers. Within that accommodating role, four levers do real work: protecting and extending current Section 1115 authority; building fiscal continuity at the state level; redirecting existing federal funding streams (1915(c), RHTP) toward durable integration infrastructure; and migrating the most consequential pathways into statute. Each is achievable under current authority; none requires a new federal program.

CMS should protect existing Section 1115 HRSN approvals through their current terms; adopt a ten-year savings horizon in OBBBA budget-neutrality review for HRSN-heavy waivers; publish the analytic standards used in those renewals within 60 days of each decision; deploy the FY2026 $50 million in new 1915(c) HCBS category implementation funding by Q2 2026; release the FY2027 $100 million in state grants by Q4 2026; and issue operational guidance on braiding Rural Health Transformation Program funds with Section 1115 and 1915(c) authority by Q3 2026.[103]

State Medicaid agencies should identify non-Medicaid financing sources for HRSN services in any 1115-authorized SCN before the next renewal cycle, set CBO and human-services-organization rate floors that cover indirect costs and infrastructure investment, and (in California and New York) treat the 2026–2027 renewal reviews as joint stress tests: addressing the methodological gaps identified in those reviews before subsequent renewals, rather than revisiting them at each one.[104]

State legislatures should establish continuity reserves equal to at least three months of HRSN service spending; such reserves typically require legislative appropriation.

Congress should pursue statutory authority for a residency-based community SCN with Medicaid contribution for enrolled residents and explicit pathways for non-Medicaid residents. Statutory durability is the answer to the reversibility demonstrated in 2025: administrative pathways were reversed in 2025; statutory ones outlast an administration.

Don't wait for Washington, DC

What the country has been missing is not another federal program. What has been missing is the conviction that a residency-based social care network can be built now, by communities, with the financing layers already on the table, without waiting for federal or state policy to catch up. The CCLCF transition is a real-world test of that conviction. So is every regional collaborative that decides not to wait for the next CMS guidance, the next state Medicaid waiver, or the next congressional reauthorization. The recommendations above are intended for everyone willing to start building before that permission arrives.

IX. Conclusion

The United States does not need to wait for a new federal program, new legislation, or a new grant cycle to begin building a residency-based social care network. The legal and financing tools already exist: Medicaid options, hospital community benefit, employer benefit design, and philanthropic capital, to build something more durable than any one of them alone, a network as embedded in community life as a public library or a public health department, rather than a demonstration that expires with a waiver term or a budget cycle.

Pieces of this work are already underway in many states, in health systems large and small, and in thousands of community-based organizations carrying it on a shoestring. Almost none of it yet adds up to the durable, residency-based infrastructure this paper describes: as Figure 3 in Section V shows, and as the CCLCF case study in Section VII illustrates, only one initiative reviewed here is attempting to build it, and it is still in launch. The choice ahead is whether this work crystallizes into infrastructure (owned and governed at the community level, financed by sufficient independent sources to withstand the loss of any one, and horizontally federated with shared standards and local autonomy) or whether it remains a generation of reversible demonstrations.

In 2025, the consequences of the current model became clear. CMS revoked the federal HRSN Framework, OBBBA tightened Section 1115 budget neutrality and terminated the DSHP and DSIP match, and the OBBBA work requirements are set for January 2027. None of these changes ended integration efforts, but together they removed, within a single year, the federal support structure many states rely on to sustain the model. In North Carolina, federal authority extended through 2029, but this was insufficient to maintain HOP services. A single state-level appropriation lapse left the country's most extensively evaluated state Medicaid social care program in limbo as of July 1, 2025.

The lesson is not that the federal and state systems failed. The lesson is that infrastructure built primarily on those systems was always going to be reversible at the speed of a budget cycle or legislative whim. The country has made a different choice before. It made that choice for fire departments. For public schools. For public libraries. For public health departments. For 911. Each was deliberately removed from administrative discretion and market forces and given statutory protection as essential public infrastructure. None is gated by who pays.

Wellbeing is the right outcome, and the evidence that integrated social care improves it, even where it does not reliably reduce short-term costs, is substantial and growing. The individual financing tools needed to support durable infrastructure, Medicaid 1115 and 1915(c), where they hold, Medicare Advantage SSBCI, commercial multi-payer compacts, employer purchasing, philanthropy, and private pay for those who can contribute, already exist, even though no program today combines them at the scale and durability this paper proposes. What remains is the work of assembling them into that infrastructure, and the conviction that it can be done now.

Appendix A. Landscape Scan

This appendix incorporates the landscape scan prepared by Atrómitos, LLC, prior to the July 2025 enactment of OBBBA (P.L. 119-21) and the spring 2025 shifts in CMS guidance. Section IV of this paper updates the federal context. The networks below were evaluated against the standard of a social care network designed to serve every resident of a community, regardless of insurance status, income, or background. Each is structurally close enough to the standard to merit consideration, but each fails on at least one dimension (structure, eligibility, or breadth of funding and coverage). A central dimension in this scan is how far a model funds the service chain, from identifying and referring, through coordinating, to delivering the service, since each of those functions must be funded; several of the models below pay for the earlier functions but stop short of funding delivery, which is the step that turns a referral into a met need. Sources for each are cited in the footnotes attached to the network names in the original scan, which are retained on file.

Network / Model	Structure	Eligibility	Funding	Disqualifying Reason
Kaiser Permanente Thrive Local	Health-system-led closed-loop referral and community resource platform	KP members only	Hospital community benefit; KP operating budget	Membership-gated; serves only KP enrollees
Geisinger Fresh Food Farmacy	Health-system-led food-as-medicine program for patients with diabetes	Geisinger patients with uncontrolled diabetes	Hospital operating budget; philanthropy	System-gated; single condition; not a network
Highmark Health Social Care Network	Payer-led network connecting members to community services via Unite Us	Highmark plan members	Plan revenues; value-based contracts	Membership-gated; payer enrollees only
NC Healthy Opportunities Pilots	State Medicaid 1115 waiver; Network Lead Entities coordinate HRSN services	Medicaid enrollees with qualifying conditions	Federal/state Medicaid waiver (1115)	Medicaid-gated; time-limited; suspended 2025
NY Social Care Networks	State Medicaid 1115 waiver; regional social care networks	Medicaid enrollees	Federal/state Medicaid waiver (1115)	Medicaid-gated; time-limited

Network / Model	Structure	Eligibility	Funding	Disqualifying Reason
CalAIM Community Supports	State Medicaid 1115 waiver; managed care plans offer community supports	Medi-Cal managed care enrollees	Federal/state Medicaid waiver (1115)	Medicaid-gated; plan-level variation
WA Medicaid Transformation 2.0	State Medicaid 1115 waiver; ACH-led regional integration	Medicaid enrollees in participating regions	Federal/state Medicaid waiver (1115)	Medicaid-gated; regional; time-limited
CMS Accountable Health Communities (AHC)	CMS demonstration; screen, refer, and navigate for HRSNs	Medicare/Medicaid beneficiaries in selected sites	CMS demonstration grant	Population-specific; time-limited; ended
CMS Integrated Care for Kids (InCK)	CMS demonstration; pediatric integrated care models	Medicaid/CHIP children in selected states	CMS demonstration grant	Pediatric only; time-limited; Medicaid-gated
CMS Maternal Opioid Misuse (MOM)	CMS demonstration; integrated care for pregnant/postpartum women with OUD	Medicaid beneficiaries with OUD	CMS demonstration grant	Single condition; time-limited; Medicaid-gated
CMS Making Care Primary (MCP)	CMS demonstration; progressive primary care payment model with HRSN screening	Medicare FFS beneficiaries in participating practices	CMS embedded payment model	Medicare-gated; provider-specific
TEAM (Transforming Episode Accountability Model)	CMS demonstration; episode-based payment with social risk adjustment	Medicare FFS beneficiaries in selected episodes	CMS embedded payment model	Medicare-gated; episode-specific
AHEAD Model	CMS demonstration; state-level total cost of care with HRSN investment	Medicare/Medicaid beneficiaries in participating states	CMS multi-payer model; state agreements	Time-limited; requires state participation
211 Systems	Community referral and information infrastructure	Universal (anyone can call)	United Way; government contracts; grants	Referral only; does not fund coordination or delivery

Network / Model	Structure	Eligibility	Funding	Disqualifying Reason
Unite Us	Technology platform connecting health and social service providers	Varies by contract (typically plan/system members)	SaaS contracts with payers/systems; grants	Platform only; does not fund services
Findhelp (formerly Aunt Bertha)	Technology platform for social service search and referral	Universal search; closed-loop varies by contract	SaaS contracts; advertising; grants	Platform only; does not fund services
Pathways Community HUB	Care coordination model using community health workers and pathways	At-risk individuals identified by participating agencies	Medicaid; grants; pay-for-outcomes contracts	Agency-gated; not universal; funding fragile
ACL Community Care Hubs	Federal grant program supporting CBO coordination infrastructure	Older adults and people with disabilities	ACL/HHS grants	Population-specific; grant-dependent; time-limited
Vermont Blueprint for Health	State multi-payer primary care and community health team model	All Vermont residents in participating practices	Multi-payer (Medicaid, Medicare, commercial)	Practice-gated; not structured as centralized SCN
All-Payer ACO Model (Vermont/Maryland)	State multi-payer total cost of care model	All residents in participating state	Blended multi-payer contributions	Not structured as SCN; cost containment focus
Accountable Communities for Health	Place-based multi-sector collaboratives addressing SDOH	Residents of defined geographic area	Philanthropy; grants; braided public funding	Not structured as SCN; no sustained service funding

Appendix B. Methodology, Figure Data Notes, and Cross-Program HRSN Financing Detail

Methodology

This paper draws on three sources of evidence. The first is a structured landscape scan of U.S. integration models, included as Appendix A and updated in Section IV to reflect federal-context developments in 2025 and 2026. The second is a cross-program financing analysis using publicly available rate schedules, 1115 budget-neutrality documents, evaluation reports, and analyses by KFF, Manatt Health, the Center for Health Care Strategies, the Milbank Memorial Fund, and the Duke-Margolis Institute for Health Policy. The third is Atrómitos, LLC's direct experience in social care integration, including a decade of engagement with Community Care of the Lower Cape Fear, Inc., including supporting its implementation as the Network Lead Entity for the southeastern region (Region 5) of North Carolina's Healthy Opportunities Pilots, post-suspension sustainability planning, and the design of its new Social Care Network. The CCLCF case study presented in Section VII draws on public sources, CCLCF's 2026 planning report and associated publicly available materials, and the documentation CCLCF has authorized for inclusion; proprietary CCLCF financial data is not reproduced. The author's disclosure is set out in footnote 94.

Source recency standard

Sources cited in this paper are dated April 2021 or later, with one narrow exception. Foundational primary sources, including federal statutes, CMS State Medicaid Director letters, CMCS Informational Bulletins, and federal regulations, are cited regardless of age if they remain in force or have not been superseded; each such citation is identified in the footnote with its currency status. Where a foundational synthesis older than five years would otherwise have been cited, the reference is replaced with a 2021 or later secondary source that reports the same finding. The sources of record include the National Academies of Sciences, Engineering, and Medicine 2019 report on integrating social care into health care; the County Health Rankings model, as developed in Hood et al. (American Journal of Preventive Medicine, 2016); and the Permanent Supportive Housing evidence synthesis published by NASEM in 2018. This paper retains direct citations to NASEM 2018 and IRS § 501(r) (2014) as foundational primary sources that remain in force.

Figure data and sources

Each figure in the paper is constructed from publicly available data and Atrómitos analysis as follows. Some figures aggregate or interpret published data rather than reproducing it directly; the notes below identify what is published, what is derived, and what is illustrative.

FIGURE 1. WHAT ACTUALLY DETERMINES HEALTH

Shares are from the County Health Rankings & Roadmaps weighting model (UWPHI/RWJF), which assigns 20% to clinical care, 40% to social and economic factors, 30% to health behaviors, and 10% to the physical environment. Figure 1 combines social and economic factors with the physical environment into a single "social, economic, and environmental factors" bar (50%), shows health behaviors at 30% and clinical care at 20%, and includes a bracket indicating that non-clinical drivers account for roughly 80% of population health. The methodology is documented in Hood et al., "County Health Rankings: Relationships Between Determinant Factors and Health Outcomes," American Journal of Preventive Medicine 50(2):129–135 (2016), which is retained as a foundational citation per the source recency standard above, and in subsequent annual County Health Rankings & Roadmaps reports (UWPHI/RWJF). Shares are approximate; the literature reports modest variation across populations and studies.

FIGURE 2. KEY FEDERAL AND STATE POLICY ACTIONS, 2024–2027

Each event on the timeline is a documented federal or state policy action with a published date. CMS approval of the NC HOP 1115 renewal (December 10, 2024) is documented in CMS, "North Carolina Medicaid Reform Demonstration." The March 4, 2025, HRSN Framework rescission and the April 10, 2025, DSHP/DSIP termination are documented in the corresponding CMCS Informational Bulletin and in a CMS letter to states. The July 1, 2025, NC HOP service suspension is documented in NCDHHS, "Healthy Opportunities Pilots Update" (June 2, 2025), and in contemporaneous coverage in North Carolina Health News and WHQR. OBBBA, enacted on July 4, 2025 (P.L. 119-21), is statutory. The December 8, 2025, CMS work-requirements CIB and the December 29, 2025, CMS announcement of RHTP state awards are documented in CMS releases. The June 1, 2026, CMS Interim Final Rule with Comment Period implementing the Medicaid work requirement (CMS-2454-IFC) is documented at https://www.federalregister.gov/documents/2026/06/03/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals.

Governor Stein's April 21, 2026, budget recommendations are documented in NC Office of State Budget and Management materials and in the Office of the Governor press release. The December 31, 2026, CalAIM renewal date and the March 31, 2027, NYHER renewal date are the end dates for the Special Terms and Conditions for the respective demonstrations. The January 1, 2027, work-requirements implementation deadline is from the December 8, 2025, CMS CIB. No data is illustrative; each event is publicly documented.

FIGURE 3. A TYPOLOGY OF U.S. INTEGRATION MODELS, BY REACH AND HOW FAR THEY FUND THE SERVICE CHAIN

Figure 3 presents the Atrómitos analysis of the integration model landscape, organized along two structural axes: population eligibility (gated to open access) and how far the model funds the service chain. That chain has four functions, identifying, referring, coordinating, and delivering the HRSN service, and the paper argues that each must be paid for. On the vertical axis, models that fund only the earlier functions (screening, referral, navigation, or care coordination) and stop before delivery fall below the line, because funding a care-coordination team or a referral pathway is necessary but not sufficient: it does not, by itself, pay for the food, housing, or transportation the resident needs. Delivery is the link most often missing, which is why it marks the dividing line, but the paper's standard is the complete funded chain, not delivery alone. Figure 3 plots the full landscape scan of Appendix A, updated for the federal-context developments described in Section IV, and each model is discussed in Section V and Appendix A. The upper-left quadrant (gated eligibility; funds the chain through delivery) includes the Medicaid Section 1115 in-lieu-of-services programs (NC HOP, NY SCN, CalAIM Community Supports, MassHealth Flexible Services, Oregon CCOs, Washington MTP 2.0 and Foundational Community Supports, Arizona H2O, and the NJ, NM, and HI programs), each of which pays community-based organizations to deliver the HRSN service to eligible populations, together with plan- and system-led payers that fund delivery within a membership or system boundary (Highmark Health Social Care Network, ACL Community Care Hubs, Geisinger Fresh Food Farmacy, health-system-led networks such as Intermountain, CommonSpirit, and RWJBarnabas, and the national health-plan SDOH programs of UnitedHealthcare, Humana, Elevance, Centene, and Aetna, which combine navigation with partial delivery), and Tribal Public Health Authorities and IHS partners, which deliver services within tribal and IHS service areas under distinct authority. The lower-left quadrant (gated eligibility; funds only part of the chain, not delivery) includes the CMMI demonstrations, which fund the earlier functions but not delivery: AHC paid for screening and navigation, InCK paid for model design and integration infrastructure, MOM pays

for care coordination and clinical services with social-service costs absorbed by other Medicaid authorities, MCP added social-risk payment adjustments without paying for housing or food, and EOM and TEAM require or required screening and referral without paying for the referred service, and the historical State Innovation Models Round 2 funded state-level system transformation rather than delivery. It also includes the multi-payer alignment models, which fund coordination but not delivery: the Vermont Blueprint for Health, the closest multi-payer precedent on reach, funds Community Health Teams that provide care coordination and navigation rather than CBO-delivered HRSN services, and the Vermont All-Payer ACO Model and the AHEAD Model apply global-budget and equity overlays without reimbursing delivery. Kaiser Thrive Local, the CMS hospital IQR and OQR SDOH screening mandates, the Pathways Community HUB Model, and the Camden Coalition likewise fund screening, referral, navigation, or coordination without paying for delivery; PCHI pays Care Coordination Agencies for completed pathways, which funds coordination but not delivery of the service. The lower-right quadrant (open access; funds only part of the chain, not delivery) includes the open referral and information systems (211 and the 211 San Diego CIE, the Chicago Regionwide CIE, the free public tier of Findhelp), the referral and payment platforms (NCCARE360 and Unite Us, Unite Us Social Care Payments, and the paid Findhelp platform tier), which are enabling infrastructure and do not themselves fund delivery, the open-access clinical and charitable providers (free clinics and faith-based networks), which deliver clinical care but do not fund HRSN social-service delivery, and the place-based Accountable Communities for Health in California, Washington, Minnesota, and Vermont, which coordinate rather than centrally deliver. The upper-right quadrant (open access; funds the chain through delivery) is the missing layer the paper argues for: no current U.S. model funds the full chain through delivery for every resident, regardless of coverage. A dashed marker identifies Community Care of the Lower Cape Fear (CCLCF), formerly a Network Lead under NC HOP, as the first model entering this space, with a separate, universal, residency-based SCN now launching in New Hanover County.

FIGURE 4. HOW ELIGIBILITY GATING NARROWS WHO RECEIVES INTEGRATION

Figure 4 presents Atrómitos' analysis. The total U.S. resident figure (~340M) is from the 2024 Census Bureau resident population estimate. The insured-population layer (~313M) reflects the 2024 KFF/U.S. Census uninsured rate of approximately 8 percent (≈92% of U.S. residents insured at any point in the year). The Medicaid enrollment layer (~79M) reflects the December 2024 CMS Medicaid and CHIP enrollment of approximately 78.8 million (Medicaid plus CHIP), per CMS

enrollment data. The continuous-enrollment layer (~60M) reflects the post-PHE unwinding, continuously enrolled Medicaid population, and projected OBBBA work-requirements churn, based on KFF Medicaid Enrollment and Unwinding Tracker analyses and Congressional Budget Office post-OBBBA enrollment-loss estimates (the Congressional Budget Office projects roughly 5.3 million Medicaid enrollment losses from the work requirements by 2034, within a total coverage loss of about 10 million people under the law). The 1115 HRSN-waiver-region layer (~14M) reflects Medicaid managed-care enrollees within HRSN-approved 1115 pilot regions across approximately a dozen states (NCDHHS HOP enrollment data plus published 1115 STC managed-care figures from NY DOH, DHCS, WA HCA, MassHealth, OHA, and AHCCCS). The condition-and-risk-gate layer (~5M) reflects the subset meeting both qualifying-condition and social-risk criteria, derived from NCDHHS HOP eligibility documentation (New Hanover County narrowed from approximately 47,000 Medicaid enrollees to approximately 4,200 served residents over three years); because the county figure spans both the condition-and-risk gate and the reach gate together, it is more directly comparable to the combined ~14M-to-~1.7M narrowing shown across those two national layers than to this single gate in isolation, though the two remain broadly consistent in order of magnitude. The reached-and-served layer (~1.7M) reflects the most recent published operational service-delivery counts across NC HOP, NY SCN, CalAIM Community Supports, WA MTP 2.0 HRSN, MA Flexible Services, and OR CCO HRSN, aggregating to roughly 1.5–2 million enrolled service recipients as of late 2024 and early 2025. Estimates are approximate and vary by waiver design and state. The figure illustrates the structural pattern; precise national totals require state-by-state aggregation that this paper does not undertake.

FIGURE 5. HRSN SERVICE FINANCING ACROSS PROGRAMS AND PAYER TYPE

Figure 5 places each program in approximate per-member-per-month (PMPM) equivalents derived from published rate schedules and program documentation, with the explicit caveat that the underlying programs use different units (per-service rates, per-case rates, fixed-pool budgets, plan-discretionary supplementals, per-employee benefits) and that no clean cross-program PMPM band exists in the public record. The per-program ranges shown are Atrómitos derivations from the following published sources: NC HOP ($71–$501 PMPM): NCDHHS Healthy Opportunities Pilots Fee Schedule (effective July 1, 2024). The range reflects PMPM-rate services only: Transportation PMPM Add-On ($71.30), Violence Intervention Services ($168.94), IPV Case Management ($221.96), Housing Navigation Support and Sustaining Services ($433.62 as of July 2024; $400.26 in the October 2021 schedule), and Holistic High-Intensity Enhanced

Case Management ($501.41). Housing Navigation ($400–$434 PMPM) is directly comparable to CalAIM Housing Navigation ($324–$449 PMPM).

Separately, the NCDHHS and Cecil G. Sheps Center evaluation (2026) reported approximately $164 PMPM in net Medicaid medical-cost savings across 31,597 enrollees from March 2022 to November 2024; this figure is a savings estimate, not a service cost, and is shown as a reference annotation in the figure. NY SCN ($12–$70 PMPM): NY 1115 STCs and SCN Lead Entity contracts (2024–2025), Level 1 Navigation at $17.50 per fifteen-minute increment with a $70 per-event cap. Range reflects 1–4 billable interactions per member per month. MassHealth Flexible Services ($20–$80 PMPM): MassHealth Flexible Services Protocol on Medicaid.gov and ACO contracts on Mass.gov (per-member spending caps; current cycle April 2023–December 2027). Range is an Atrómitos PMPM derivation from published program caps. CalAIM Community Supports ($324–$449 PMPM): California DHCS CalAIM Community Supports rate guidance (2023–2025), Housing Navigation services. WA MTP 2.0 HRSN ($25–$110 PMPM): WA Health Care Authority MTP 2.0 HRSN documentation ($1.5 billion services + $270 million infrastructure). Range is an Atrómitos PMPM derivation; actual per-member cost varies by service mix and region. MA SSBCI ($10–$75 PMPM): Medicare Advantage Special Supplemental Benefits for the Chronically Ill. Range is derived from MedPAC's October 2024 presentation to Congress ("Supplemental Benefits in Medicare Advantage"), which reports annualized combined benefit limits of approximately $452 per year (~$38 PMPM) for conventional MA plans and $1,798 per year (~$150 PMPM) for Special Needs Plans in 2024. MedPAC explicitly notes that actual PMPM utilization data are unavailable at the enrollee level, as Medicare does not collect reliable spending data by benefit type. The range shown reflects Atrómitos' estimate of actual utilization (sub-cap) across conventional and SNP plan types; it is not a published spending figure. SSBCI is included because the paper proposes it as a Medicare Advantage revenue source for a universal SCN (see Section VII and Figure 6). No clean cross-program PMPM band exists in the public record. A universal SCN's per-resident cost should be derived program by program for any specific region.

FIGURE 6. PROPOSED FINANCING ARCHITECTURE FOR A UNIVERSAL RESIDENCY-BASED SOCIAL CARE NETWORK

Figure 6 presents Atrómitos' proposed financing architecture for a universal residency-based SCN that reaches every resident of a service area regardless of insurance status. The figure is a design schematic, not a published program budget. The eight revenue sources and their proposed shares are: Federal Medicaid (35%), Hospital Community Benefit (18%), Private Pay on a Sliding

Scale (5%), and Federal Grants (4%). These shares reflect Atrómitos' design analysis of the financing mix required to reach non-Medicaid residents while maintaining structural insulation from single-payer dependency; the actual mix will vary by market, demographics, and policy environment, and should be derived program by program for any specific region. Vermont Blueprint for Health is the only U.S. model with documented multi-payer HRSN-adjacent financing at a statewide scale (see Section V and Appendix A). Blueprint's PCMH support payments are contributed by commercial insurers (approximately $3.00 PMPM) and Medicaid (approximately $4.65 PMPM), as reported in the Vermont Legislature Act 51 Report on Payments to Patient-Centered Medical Homes (Vermont Department of Health). Vermont Blueprint is a primary care and Community Health Team model, not a CBO-structured SCN, and its financing structure is cited here as evidence that multi-payer contributions to HRSN-adjacent services are achievable in practice. No SCN program currently publishes a diversified multi-payer financing breakdown at the scale this figure proposes.

A NOTE ON ECONOMIC MULTIPLIERS VERSUS RETURN ON INVESTMENT

A multiplier and a return on investment are distinct concepts: a multiplier measures the gross economic activity generated per dollar of input, while a return on investment compares a net benefit (such as Medicaid medical cost savings) to the program's cost. Combining the multiplier with the per-member savings figure into a single composite ROI would conflate the two and overstate the program's case; this paper presents both figures separately.

Endnotes

[1] Elevance Health Public Policy Institute, “Employer-Sponsored Insurance and Health-Related Social Needs” (2023–2024); AARP and National Alliance for Caregiving, “Caregiving in the U.S. 2025”; HHS ASPE, “Supporting Families and Caregivers of Adults with Behavioral Health Disorders” (December 2024); Falconi et al., “Health-Related Social Needs and Whole Person Health,” PMC10728312 (2023).

[2] P.L. 119-21 (July 4, 2025), Medicaid community engagement and Section 1115 budget neutrality provisions. Throughout this paper, P.L. 119-21 is cited as “OBBBA” (2025 Budget Reconciliation Act). The short title “One Big Beautiful Bill Act” was removed during Senate consideration; P.L. 119-21 has no official short title. Its formal long title is “An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14.” CMS, CMCS Informational Bulletin, “Section 71119 of the ‘Working Families Tax Cut’ Legislation, Public Law 119-21: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals” (December 8, 2025); CMS, “Community Engagement” State Implementation Resource Page (medicaid.gov, 2025–2026); KFF, “Health Provisions in the 2025 Federal Budget Reconciliation Law” (2025); Center for Children and Families, Georgetown University, “CMS Guidance on Medicaid Work Requirements Leaves States Hanging” (December 2025).

[3] CMS, CMCS Informational Bulletin, March 4, 2025 (rescinding HRSN Framework guidance); CMS letter to states on Designated State Health Programs and Designated State Investment Programs, April 10, 2025; CMS, “CMS Refocuses on its Core Mission and Preserving the State-Federal Medicaid Partnership” (press release, 2025).

[4] CMS, “North Carolina Medicaid Reform Demonstration” (December 10, 2024; effective through December 9, 2029); NCDHHS, “Healthy Opportunities Pilots Update” (June 2, 2025); North Carolina Health News, “Healthy Opportunities Pilot Told to Prepare for Program to Shutter” (June 3, 2025); Milbank Memorial Fund, “The Future of North Carolina’s Healthy Opportunities Pilots” (2025); NC Office of State Budget and Management, “Governor Stein’s FY 2026–27 Budget Recommendations” (April 21, 2026).

[5] Commonwealth Fund, “Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System” (2024).

[6] Dwyer-Lindgren et al., “Ten Americas: a systematic analysis of life expectancy disparities in the USA,” The Lancet 404(10469):2299–2313 (2024) (life-expectancy gap of 12.6 years in 2000 widening to 20.4 years in 2021); Dwyer-Lindgren et al., “Life expectancy by county, race, and ethnicity in the USA, 2000–19: a systematic analysis of health disparities,” The Lancet 400(10345):25–38 (2022); Institute for Health Metrics and Evaluation, “US Health Map” (continuously updated through 2024).

[7] County Health Rankings & Roadmaps, 2024 Annual Report (UWPHI/RWJF, 2024).
[8] HHS, Healthy People 2030, wellbeing objectives.
[9] KFF, “Medicaid Enrollment and Unwinding Tracker” (2024 and subsequent updates); KFF, “Medicaid Enrollment Churn and Implications for Continuous Coverage Policies” (2023, updated 2024–2025).
[10] See note 9.
[11] See note 3.
[12] See note 4.
[13] U.S. Department of Agriculture, Economic Research Service, “Household Food Security in the United States in 2023” (ERR-337, September 2024); U.S. Department of Housing and Urban Development, “The 2024 Annual Homelessness Assessment Report (AHAR) to Congress” (2024); HHS ASPE, “Supporting Families and Caregivers of Adults with Behavioral Health Disorders” (December 2024). Town M, Eke P, Zhao G, et al. “Racial and Ethnic Differences in Social Determinants of Health and Health-Related Social Needs Among Adults – Behavioral Risk Factor Surveillance System, United States, 2022.” MMWR Morb Mortal Wkly Rep 2024;73:204–208. https://doi.org/10.15585/mmwr.mm7309a3 (housing insecurity, defined as inability to pay mortgage, rent, or utility bills in the prior year, was 9.6% among non-Hispanic White adults and 17.6% among non-Hispanic Black adults; adjusted prevalence across all racial and ethnic groups ranged from 8.5% among non-Hispanic Asian adults to 19.6% among non-Hispanic Native Hawaiian or other Pacific Islander adults).
[14] Kaiser Family Foundation, “A Look at Recent Medicaid Guidance to Address Social Determinants of Health and Health-Related Social Needs” (2023, updated); Health Resources and Services Administration, Uniform Data System (UDS) Reports on community health center HRSN screening and unmet need (2022–2024); Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey HRSN Supplements (2021–2024).
[15] U.S. Department of Agriculture, Economic Research Service, household food security trend reports (2020–2024); U.S. Department of Housing and Urban Development, Annual Homelessness Assessment Reports (2022, 2023, 2024); KFF and Center on Budget and Policy Priorities, post-PHE coverage and housing affordability analyses (2024–2025).

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[19] NCDHHS and Cecil G. Sheps Center for Health Services Research, “Healthy Opportunities Pilots Lead to Healthier Outcomes and Reduce North Carolina Medicaid Costs” (June 2, 2026) (medical-cost savings of approximately $164 per member per month across 31,597 enrollees, March 2022–November 2024; savings grew over time from approximately $85 per member per month at the two-year milestone); Duke-Margolis Institute for Health Policy, “North Carolina’s Healthy Opportunities Pilots: Impacts and Budgetary Considerations” (2025).
[20] Some health-related social needs interventions are warranted on equity and dignity grounds independent of demonstrated cost savings; this is a normative claim, distinct from the cost-effectiveness evidence discussed at notes 17–20. See SIREN/UCSF and Commonwealth Fund, “Guide to Evidence for Health-Related Social Needs Interventions: 2022 Update,” on the limits of a strictly return-on-investment case.
[**21]** SIREN/UCSF, evidence and equity analyses of health-related social needs interventions (2022–2024); see SIREN/UCSF and Commonwealth Fund, “Guide to Evidence for Health-Related Social Needs Interventions: 2022 Update,” on heterogeneity of intervention effects across populations and delivery settings.
[22] Carroll et al., “The CARE Principles for Indigenous Data Governance,” Data Science Journal 19:43 (2020); First Nations Information Governance Centre publications (2022–2024).

[23] Harvard Human Flourishing Program, Global Flourishing Study initial cohort findings (2024 and 2025); VanderWeele, "On the promotion of human flourishing," Proceedings of the National Academy of Sciences (2017); Lomas, Pawelski, and VanderWeele, "A flexible map of flourishing," International Journal of Wellbeing (2023); CDC, Behavioral Risk Factor Surveillance System optional modules on life satisfaction and emotional support (multi-state, intermittent participation since 2005).
[24] CMS, Hospital Inpatient Quality Reporting Program FY2024 final rule (addition of three SDOH screening measures effective for the FY2024 reporting period); CMS, Hospital Outpatient Quality Reporting Program (continuously updated); The Joint Commission, R3 Report Issue 36, "New Requirements to Reduce Health Care Disparities" (June 22, 2022; standards effective January 1, 2023); CMS Quality Payment Program MIPS measure set (continuously updated).
[25] The precise count varies across published trackers depending on whether full HRSN demonstrations, broader 1115 approvals with HRSN components, and narrower housing-only authorities are counted together.
[26] CMS, Medicaid Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F, April 22, 2024; published in the Federal Register May 10, 2024); 42 CFR § 438.3(e)(2) (In Lieu of Services and Settings provisions); KFF, Medicaid Managed Care Final Rule analyses (2024).
[27] 42 U.S.C. § 1396n(c) and (i); CMS, "Home and Community-Based Services" guidance (2022–2024); foundational primary statutory source, see Appendix B.
[28] CMS, Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F, April 4, 2024), Special Supplemental Benefits for the Chronically Ill provisions; 42 CFR § 422.102 (supplemental benefits); CMS Innovation Center, ACO REACH (with Health Equity Benchmark Adjustment; model concludes December 31, 2026) and Shared Savings Program (the MSSP Health Equity Benchmark Adjustment was renamed the Population Adjustment in the CY2026 Medicare Physician Fee Schedule final rule and refined for PY2026; the LEAD Model succeeds ACO REACH in 2027).
[29] IRS, Rev. Rul. 69-545 (the § 501(c)(3) community-benefit standard) and Form 990, Schedule H (community-benefit reporting); IRS, "Charitable Hospitals: General Requirements for Tax-Exemption Under § 501(c)(3)"; see also IRS Final Regulations under § 501(r) (2014), the separate ACA requirements governing community health needs assessments, financial-assistance policy, charge limits, and billing (foundational primary source still in force, see Appendix B); KFF, "Hospital Community Benefit" (2022–2024).
[30] See note 2. Statutory cite OBBBA, P.L. 119-21 (July 4, 2025); CMS implementation guidance, December 8, 2025, CMCS Informational Bulletin.
[31] OBBBA, P.L. 119-21 (July 4, 2025), Section 71118 (Section 1115 budget neutrality) provisions; ASTHO, "One Big Beautiful Bill Law Summary" (2025).

[32] OBBBA, P.L. 119-21, 1915(c) HCBS expansion provisions (FY2026 $50M for CMS implementation and oversight; FY2027 $100M for state grants; services beginning July 1, 2028); KFF analysis (2025).
[33] OBBBA, P.L. 119-21 (July 4, 2025), Section 71401 (Rural Health Transformation Program); CMS, "CMS Launches Landmark $50 Billion Rural Health Transformation Program" (press release, 2025); CMS, "CMS announces state distribution of $50 billion in rural health funds" (December 29, 2025); NCDHHS, "North Carolina Awarded $213 Million for Rural Health Transformation Program" (December 29, 2025); Office of the NC Governor, NC ROOTS announcement (December 2025).
[34] See note 33.
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[83] See note 22 (SIREN/UCSF, equity considerations) on differential reach and connection across populations.
[84] See note 49 (suspension of the North Carolina Healthy Opportunities Pilots effective July 1, 2025, while federal authority continues through December 9, 2029).
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[93] Author's cross-program comparison of per-member-per-month equivalents, derived from published rate schedules and program documentation (California DHCS Community Supports pricing guidance; New York State Social Care Networks rate schedules; Massachusetts Flexible Services Program documentation; Vermont Blueprint for Health); see Appendix B, Figure 5, for program-by-program detail.
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[96] On philanthropy as both launch capital and a permanent gap-filler: Episcopal Health Foundation HRSN/SCN grantmaking (continuously updated).
[97] On philanthropy as launch capital for community-anchored social care, see note 93; CCLCF's transition is anchored by the New Hanover Community Endowment planning grant (2025–2026) and is documented in the Section VII case study that follows.
[98] Author disclosure: Atrómitos, LLC has supported Community Care of the Lower Cape Fear, Inc. on multiple initiatives over the past decade, including its implementation as a Network Lead Entity for the North Carolina Healthy Opportunities Pilots, post-waiver sustainability planning for HOP, and strategic communications and policy support for its new Social Care Network. The case study presented here draws on public sources and on documentation CCLCF has authorized for inclusion. Proprietary CCLCF data is not included in this paper.
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[103.] See note 33 (OBBBA Section 71401 Rural Health Transformation Program); on braiding RHTP funds with Section 1115 and 1915(c) authority, CMS RHTP implementation guidance (2025–2026).
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About the Author

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Michealle Gady, JD, is the Founder, President, and Chief Executive Officer of Atrómitos, LLC, a boutique consulting firm specializing in health and human services policy, fund development, and organizational strategy. Before founding Atrómitos, she served as a Senior Health Policy Analyst at Families USA; as Health Counsel to Congressman Lloyd Doggett on the House Ways and Means Committee during the development and enactment of the Affordable Care Act; and as Deputy Policy Director at the Medicare Rights Center. She holds a JD with a Health Law Certificate from Quinnipiac University School of Law and a BS in Rehabilitation Services from Springfield College.

Drawing on more than twenty-five years of experience in health law and policy, her work focuses on Medicaid program design, nonprofit capacity building, and the alignment of clinical care with social services to advance whole-person health. Recent engagements relevant to this paper include strategic communications and policy support for Community Care of the Lower Cape Fear's Social Care Network initiative in North Carolina, as well as Medicaid consulting and engagement with community-based organizations nationally.

About Atrómitos, LLC

Health and human service providers achieve greater impact when they work together. Cross-functional teams within organizations also achieve better results when they collaborate. We break down silos and build connections to create a cooperative environment where obstacles are overcome and goals are met.

Atrómitos, LLC is a boutique consulting firm founded in 2016 in North Carolina and relocated to Washington State in 2022. The firm operates as a fully virtual practice, with team members and clients across the United States and internationally. Atrómitos provides comprehensive, accessible senior-level expertise to develop bold, tailored solutions for each client's unique needs.

Practice Areas

Public Policy Research and Analysis. We transform complex legislation and regulations into concise guidance that organizations can use to influence and respond to public policies affecting their work.

Fund Development and Grant Management. We maximize revenue potential and ensure streamlined, compliant administration of fund development programs throughout the full grant lifecycle, including strategy, application, and post-award management.

Organizational Strategy and Operations. We clarify strategic direction through data-driven analysis and then strengthen organizational capacity to achieve ambitious goals and deliver meaningful results.

Social Care Network practice

Atrómitos' Social Care Network practice supports state agencies, health systems, payers, philanthropic funders, and community-based organizations throughout the SCN lifecycle, from design and launch to growth. Engagements include strategic communications and policy support, operating-model design, blended financing strategy, governance and network development, evaluation and impact analysis, and post-policy transition planning.

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