

## I. Introduction

Medicaid programs are increasingly considering how best to address the social factors, such as housing, healthy food, and economic security, that can affect health and medical expenditures. Often referred to as social determinants of health (SDOH), these factors drive as much as 80 percent of population health outcomes.<sup>1</sup> With Medicaid programs looking to contain costs and to pay for health outcomes—not simply the volume of health care services delivered—there is a growing focus on addressing these social factors in both Medicaid fee-for-service and managed care programs. While states historically have had some experience tackling such issues for specialized, high-need populations (e.g., disabled enrollees with mental illness or HIV/AIDS), they are now confronting whether, and how, Medicaid should address SDOH for a broader population of Medicaid enrollees in order to achieve better health outcomes.

In this issue brief, we explore the “next generation” practices that states are deploying to address social factors using Medicaid 1115 waivers and managed care contracts, as well as the specific steps states can take to implement these practices.<sup>2</sup> The issue brief is based on an in-depth review of the Medicaid managed care contracts in 17 states and Medicaid 1115 provisions in six states.<sup>3</sup> (For a detailed discussion of the methodology used to identify the states and review their policies, see Appendix A.) The next generation practices discussed in this analysis include:

- 1. Moving beyond screenings to systematic efforts to connect enrollees to social supports.** States are increasingly requiring plans to provide “closed-loop” referrals (i.e., to track what happens to someone referred to a social service provider); to maintain up-to-date information on community-based resources; and to integrate efforts to address SDOH into standard care management policies and practices.
- 2. Expanding the scope of SDOH interventions to more populations and social issues.** Some states are expanding SDOH interventions beyond high-need populations, such as those with disabilities or severe mental illness, to a broader array of children, families, and healthy adults. In some instances, they also are addressing harder-to-tackle social issues, such as social isolation and the impact of a history of incarceration on health expenditures and outcomes.
- 3. Building a stronger network of community-based organizations and collaboration with providers.** Recognizing that many community-based organizations operate on tight budgets and lack experience contracting with health care plans and providers, states are investing in community-based resources and fostering stronger working relationships between such organizations and health care plans/providers.
- 4. Creating opportunities for affordable housing.** Medicaid does not directly pay for housing, but states are increasingly identifying new ways to connect people to housing resources; providing housing-related services that can be covered via Medicaid; and encouraging their Medicaid managed care plans to participate in broader, cross-sector initiatives to address the affordability and safety of housing.
- 5. Aligning financial incentives to support SDOH interventions.** States are deploying a range of tools to strengthen the financial incentive for plans to address SDOH. These include the use of withhold payments linked to SDOH-sensitive outcomes and allowing plans to count investments in high-impact social services toward the numerator of their medical loss ratio (MLR).

**6. Systematic evaluation and greater use of SDOH data.** Since the evidence base for SDOH interventions is still evolving, particularly for lower cost populations, a number of states are carefully tracking and evaluating the effectiveness of particular SDOH interventions. They are doing so by testing interventions in pilots before going statewide and expanding the collection of SDOH data needed to evaluate population-level interventions.

## II. Emerging Trends in Efforts to Address Social Factors in Medicaid

States are expanding the scope and intensity of efforts to address social factors, reflecting their interest in paying for cost-effective improvements in health outcomes, rather than the volume of medical services provided.

*Table 1. Summary of Emerging Trends and Leading Edge Practices in Medicaid*

State Trends	Leading Edge Practices
Moving beyond screenings to systematic efforts to connect enrollees to social supports	<ul style="list-style-type: none"> <li>&gt; Requiring use of closed-loop referrals</li> <li>&gt; Requiring use of a standardized screening tool or standardized screening elements</li> <li>&gt; Requiring use of community health workers and expertise on local resources</li> <li>&gt; Stronger integration into primary care</li> </ul>
Expanding the scope of SDOH interventions to more populations and social issues	<ul style="list-style-type: none"> <li>&gt; Expanding interventions to children, families and healthy adults</li> <li>&gt; Addressing harder-to-tackle social issues</li> <li>&gt; Increasing focus on a recent history of incarceration as a key SDOH factor</li> </ul>
Building a stronger network of community-based organizations and collaboration with providers	<ul style="list-style-type: none"> <li>&gt; Using Medicaid 1115 waivers to strengthen community-based organizations</li> <li>&gt; Encouraging or requiring investments in communities</li> <li>&gt; Requiring contracts and data sharing with community-based organizations</li> </ul>
Creating opportunities for affordable housing	<ul style="list-style-type: none"> <li>&gt; Using waivers to provide additional housing-related services</li> <li>&gt; Requiring managed care organizations (MCOs) to work with state and local housing initiatives</li> <li>&gt; Requiring in-house expertise on housing</li> </ul>
Aligning financial incentives to support SDOH interventions	<ul style="list-style-type: none"> <li>&gt; Using value-based payments to incentivize cost-effective SDOH interventions</li> <li>&gt; Linking incentive or withhold payments to performance on SDOH-related metrics</li> </ul>
Systematic evaluation and greater use of SDOH data	<ul style="list-style-type: none"> <li>&gt; Developing an evidence-base through pilot projects</li> </ul>

The latest strategies to address social factors in Medicaid among leading edge states include the following.

**1. Moving beyond screenings to systematic efforts to connect enrollees to social supports.**

Nearly all states that operate managed care programs, 35 out of 39 states, now require or encourage MCOs to screen enrollees for social issues, and provide referrals to community services.<sup>4</sup> While almost all states now expect MCOs to play at least some role in addressing SDOH, it also is increasingly apparent that a simple “screen and refer” without follow up may prove ineffective for many people. An individual with significant social needs, combined with complex health needs, may not have the ability or resources to follow up on a referral. Even if they do, it is possible that the agency or organization to which they have been referred to cannot help as anticipated. Recognizing that screenings and referrals can become a “check-the-box” exercise, a number of states are establishing more robust MCO requirements to connect people to social supports.

- › **Requiring use of closed-loop referrals.** States such as North Carolina and Rhode Island are explicitly requiring MCOs to track and report on the outcome of referrals. In Rhode Island, MCOs must ensure that they identify and follow-up with members at high-risk of poor health outcomes due to significant health and social needs. North Carolina goes a step further, requiring in its draft Medicaid managed care contract that MCOs will establish closed-loop referrals, which is to say that plans are expected to track the outcome of referrals that are made, and provide additional help as needed. To ensure that referrals are based on current information, North Carolina plans to leverage a forthcoming statewide resource platform, administered by North Carolina’s Foundation for Health Leadership and Innovation, which will provide care managers with current information on community-based resources and assist them in determining the outcome of referrals.
- › **Requiring use of a standardized screening tool or standardized screening elements.** States such as New Hampshire, Virginia and Washington are specifically defining the social domains that need to be addressed in screenings and assessments. North Carolina has established a standardized screening tool for food, housing, transportation, and interpersonal violence issues that will be used by all MCOs. See Table 2 for additional examples.
- › **Requiring use of community health workers and expertise on local resources.** Several states are explicitly requiring that MCOs work with community health workers and/or contract with locally-based staff for purposes of care coordination, including efforts to address social factors. This reflects a belief that local staff are likely to have more on-the-ground knowledge of community resources and the members’ lived-experience, but also the ability to meet in-person with someone to address social needs. For example, New Mexico requires MCOs to make community health workers available to members for assistance in navigating the health care system; securing culturally appropriate health information; and obtaining information on community resources. Michigan broadens this requirement, and mandates that each MCO have at least one community health worker for every 15,000 Medicaid enrollees. See Table 2 for additional examples.
- › **Stronger primary care integration.** Through care management, primary care practices are embedding activities that address enrollees’ social needs and incorporating them into care delivery through multidisciplinary care management teams that coordinate and deliver care. North Carolina’s Advanced Medical Home (AMH) program requires, in its draft Medicaid managed care contract, MCOs/providers to give face-to-face assistance, wherever possible; to help enrollees secure health-related services; and connect to homelessness experts and medical-legal partnerships.

*Table 2: Additional leading edge strategies moving beyond screenings to systematic efforts to connect enrollees to social supports*

Strategy	State Example
Requiring use of a standardized screening tool or standardized screening elements	<ul style="list-style-type: none"> <li>› <b>Wisconsin</b> requires that plans use a health needs assessment that evaluates whether people face socioeconomic barriers to care, including whether they have housing stability, reliable transportation and/or nutrition and food resources.</li> <li>› <b>Virginia</b> requires screening for social, economic and housing needs. MCOs must establish referral mechanisms to link members with providers not covered through Medicaid, and when making referrals, to establish relationships with key state partners and community-based partners.</li> <li>› <b>New Hampshire</b> ensures that members receive social supports by providing in-person assistance to complete forms and submit applications.</li> </ul>
Requiring use of community health workers and expertise on local resources	<ul style="list-style-type: none"> <li>› <b>Rhode Island</b> requires that care management staff be located within the state, reflecting that it is “key for their ability to work closely with local resources and communities, including face-to-face meetings where appropriate.”</li> <li>› <b>Illinois</b> requires that plans employ at least one full-time community liaison to develop and maintain relationships with community resources, state agencies, and community entities that traditionally provide services to Medicaid enrollees.</li> </ul>

## 2. Expanding the scope of social determinants of health interventions to more populations and social issues

In the past, state efforts to tackle SDOH have been primarily focused on enrollees with complex health conditions. That’s changing.

- › **Expanding interventions to children, families and healthy adults.** A number of states now are requiring MCOs to consider the social and economic factors that affect health outcomes for all enrollees, not just those identified as having special needs. For example, Michigan MCOs are required to contract with local community-based organizations to address the socioeconomic, environmental, and policy factors that can impact health outcomes and costs for all enrollees, including children and healthy low-income adults.
- › **Addressing harder-to-tackle social issues.** Some states now are looking to address SDOH issues beyond socioeconomic factors, such as loneliness and social isolation, both of which are well-established in the clinical literature as contributors to poor population health outcomes and higher health care costs.<sup>5</sup> Virginia requires its MCOs to address “social cohesion” (for example, relationships with family and friends) when assessing an enrollee’s SDOH needs and Rhode Island requires its MCOs to ensure that their Integrated Health Homes for individuals with mental health issues address social isolation and withdrawal to increase “client opportunities for leading a normal, socially integrated life.” Other states are looking to provide trauma-informed care and address, or ameliorate, the impact of adverse childhood experiences (ACEs). To support these efforts, New Hampshire requires care managers to have competencies in trauma-informed care and related community resources.
- › **Increasing focus on a recent history of incarceration as a key SDOH factor.** Individuals leaving jail or prison are at relatively high risk for a range of serious health conditions, including: diabetes; heart disease and hospitalization; or death from overdose.<sup>6</sup> Additionally, formerly incarcerated individuals often struggle with securing housing, finding a job and connecting with family and friends due to their criminal records. A number of states are now explicitly including incarceration as a factor that can adversely affect health outcomes and increase health care costs. For example, Arizona alerts MCOs to when they have a member being released from jail or prison and requires them to conduct outreach, even prior to release, to help establish community-based care options.

### 3. Building a stronger network of community-based organizations and collaboration with providers

Increasingly, state Medicaid agencies are recognizing that addressing social factors via Medicaid requires stronger coordination with, and support for, community-based social service organizations. In particular, many community-based organizations have little or no experience working directly with health care providers and plans, and have historically been funded through grants, rather than billing for services. They may need new information technology (IT) and billing systems, as well as technical assistance with contracting and claim submissions before they can work effectively in partnership with the health care system. Moreover, if they are expected to scale up their resources to provide services to more people or to expand their scope of services, they may need infrastructure investments. States are using Medicaid managed care contracts and Medicaid 1115 waivers to strengthen community-based organizations and their capacity to engage with MCOs and health care providers.

- › **Using Medicaid 1115 waivers to strengthen community-based organizations.** Medicaid generally cannot provide funding to community-based organizations to prepare for contracting with health care plans. Some states, such as New York, North Carolina, Rhode Island and Washington, however, have secured Medicaid 1115 waivers that explicitly require some level of contracting with and/or investment in community-based organizations that provide social services. Rhode Island has used a Medicaid 1115 waiver to establish “Accountable Entities” or “AEs,” which are social service provider organizations charged with improving management of complex conditions, and better addressing social needs. Using Medicaid dollars, Rhode Island Medicaid provides fiscal incentives to AEs based on their performance, and they, in turn, are required to allocate 10 percent of these funds to community-based organizations with whom they work to provide behavioral health care, substance abuse treatment, or SDOH interventions. More recently, North Carolina secured waiver authority to expend up to \$650 million in Medicaid funds (federal and state) to create pilot projects aimed at addressing SDOH. Up to \$100 million of this amount can be used in the early years of the waiver for capacity building of regional entities charged with establishing and strengthening a network of social service providers.
- › **Encouraging or requiring investments in communities.** Although not yet common, some states, such as Arizona, require their Medicaid managed care plans to make investments in the community under certain conditions. The dollars can be used to strengthen the capacity of community-based organizations to provide social services or otherwise address the non-medical factors that drive health outcomes. Specifically, Arizona requires its MCOs to reinvest 6 percent of any profits back into their community, giving them broad discretion to identify appropriate investments. Originally this provision applied only to the state’s behavioral health organizations, but, in 2018, Arizona extended it to all MCOs. North Carolina’s draft Medicaid managed care contract encourages MCOs to make voluntary investments in community-based resources to address social factors. If they do so, they can count these contributions in the numerator of their medical loss ratio (MLR).<sup>7</sup>
- › **Requiring contracts and data sharing with community-based organizations.** Some states, such as Massachusetts and Michigan, are pushing MCOs to contract and better integrate with community-based organizations. Massachusetts and Michigan require MCOs to establish affiliations with community-based organizations. States are also investing in and pursuing technology solutions for greater integration with community-based organizations. Some states, such as Louisiana, Minnesota and Arizona, have developed policies and procedures that encourage the use of health information exchange (HIE) technologies that allow for standardized information sharing across systems. Washington is also investing in a “Clinical Data Repository” that will allow for any authorized HIPAA entity, for example a housing provider, to share information on shared patients. These efforts allow for better coordination of interventions among MCOs, providers, and the community-based service entities to support patient SDOH needs.

#### 4. Creating opportunities for affordable housing

A significant body of research indicates that stable housing can reduce health expenditures, particularly for homeless enrollees with complex health conditions who cycle through hospitals, jails and being housing insecure. Housing remains one of the most difficult SDOH issues for states to address. Not only is housing a costly service, but many areas of the country face an acute shortage of affordable housing options. Moreover, Medicaid rules do not allow states to use Medicaid dollars to pay for housing. In light of this history, states increasingly are deploying creative strategies to tackle the issue, even if they are not directly covering rent or other housing expenses.

- › **Using waivers to provide additional housing-related services.** States have the authority under state plan amendments (SPAs) and home and community-based services (HCBS) waivers to provide some housing-related services, such as assistance filling out housing applications or, in some instances, helping people who might otherwise be institutionalized find and remain in housing.<sup>8</sup> A handful of states have secured Medicaid 1115 waivers that allow them to cover additional services to help enrollees find stable housing. Most recently, North Carolina secured a Medicaid 1115 waiver that authorizes the state to use Medicaid funds to provide an array of housing-related services to selected enrollees with a demonstrated social need and certain health conditions. These services include, for example: assistance maintaining relationships with a landlord; one-time coverage of moving costs and utility set-up; remediation of mold and pests (if this is a cost-effective strategy for maintaining housing); and short-term housing of up to six months after a hospitalization. Similarly, Maryland, Hawaii and Washington have used Medicaid 1115 waivers to cover some of these housing-related services, though their waivers do not extend as far as North Carolina's, which is being closely watched around the country.<sup>9</sup>
- › **Requiring MCOs to work with state and local housing initiatives.** Some states are requiring MCOs to participate in state and local initiatives to improve affordable housing options. Rhode Island requires MCOs to support its housing stabilization program for homeless people by working actively with the Rhode Island Housing Authority, the Rhode Island Office of Housing and Community Development and the Corporation for Supportive Housing. Similarly, Massachusetts has launched a "housing first" model for homeless individuals with serious mental illness and a history of frequent behavioral health hospitalizations, known as the "Social Innovation Financing for Chronic Homelessness Program," or "SIF Program." The MCOs in Massachusetts are expected to support the SIF Program and enter into good faith negotiations with its providers to pay for housing services on behalf of their eligible homeless members.
- › **Requiring in-house expertise on housing.** States such as New Mexico, New Hampshire and North Carolina require their MCOs to have at least one in-house staff expert on housing options in the state. In New Mexico, the full-time supportive housing specialist is dedicated to working with members to assess housing needs and identify appropriate resources in order to help them attain and maintain housing. New Hampshire and North Carolina similarly require that MCOs have a housing specialist on staff.

#### 5. Aligning financial incentives to support social determinants of health interventions

The question of how to finance SDOH interventions not covered by Medicaid underpins all of the trends discussed in this analysis. In the context of managed care, it might seem that MCOs have a "natural" incentive to finance social interventions if they do, in fact, lower medical costs. In practice, however, plans must contend with the reality that an enrollee may switch to another plan or move to another source of coverage before an SDOH investment pays off. In light of this issue, states are exploring ways to ensure that health plans have the right financial incentive to invest in cost-effective SDOH interventions.

- › **Using value-based payments to incentivize cost-effective SDOH interventions.** Many states with Medicaid managed care, 28 out of 39 according to a 2018 Manatt Health survey, require MCOs to ensure a portion of their provider payments are distributed as value-based payments.<sup>10</sup> Value-based payments can take

many forms, but at a high level, they link provider reimbursements to outcomes and the ability of a provider to contain costs (rather than only to volume of services provided as under the fee-for-service system). Value-based payments are a vehicle for incentivizing SDOH interventions (when cost-effective) because they reimburse providers for improving outcomes and reducing costs; regardless of whether the providers do so by offering medical care, or by addressing social, and economic factors that drive health outcomes and expenditures. Some states, such as New York, specifically require their MCOs to articulate in their value-based payment strategy how they will incorporate addressing SDOH; SDOH interventions must be done in partnership with a community-based organization, and MCOs must provide start-up funding to the provider or community-based organization for the SDOH intervention.<sup>11</sup>

- › **Linking incentive or withhold payments to performance on SDOH-related metrics.** One of the more powerful tools available to states to advance their priorities is the use of performance incentive or withhold payments linked to MCO performance on specific outcomes. It is still rare to see states linking incentive and withhold payments directly to SDOH interventions, but many of the metrics to which they are linked are highly sensitive to such interventions. For example, a number of states, including Arizona, Michigan and Virginia, link withhold and/or incentive payments to reductions in avoidable readmissions after a hospitalization, an outcome that can be impacted by ensuring that someone has a safe place to live, access to food, and is not socially isolated after a hospitalization.

## 6. Systematic evaluation of social determinants of health interventions and use of data

Since sustained efforts to encourage cost-effective SDOH interventions are relatively new, states are keenly interested in evaluating and assessing the impact of their efforts. A number of states are establishing specific evaluation requirements and reporting of data, reflecting a strong commitment to ensuring that Medicaid's role in addressing SDOH remains cost-effective and efficient. Some of the strategies in Medicaid managed care contracts and 1115 waivers include evaluating pilot projects and expanding data reporting on SDOH measures.

- › **Developing an evidence-base through pilot projects.** High-quality data and research are required to determine high-value SDOH initiatives that states can employ. The first step is to require greater and more systematic gathering of data on SDOH needs. In Michigan, the state requires plans to participate in initiatives to develop a core set of SDOH data that providers must provide to the plan (along with other data). The plans, and in turn Michigan's Medicaid agency, are expected to use the data to assess the extent to which enrollees have disparate levels of social needs; the effectiveness of various interventions; and the related data on utilization of medical services. By systematically tracking and analyzing SDOH data, states will be better prepared to evaluate the magnitude of social and economic issues confronting enrollees; assess how they affect health and utilization of medical care; and explore the extent to which interventions are proving effective in improving outcomes and reducing costs. Through its 1115 waiver, North Carolina has secured approval for pilots that will systematically test, on a population level, the extent to which evidence-based interventions in each of four key domains, including housing, food, transportation, and interpersonal safety, have been successful in improving health outcomes and lowering health care costs in selected regions of the state. North Carolina will consider incorporating findings from the pilots' evaluation into the Medicaid program through various means, such as changes to State Plan benefits or payment models, including value-based payments. Over time, these services are expected to become a standard part of the care provided by plans if they prove effective.

### III. State Implementation Strategies

States can implement the emerging practices discussed in this analysis through a variety of tools and strategies, outlined below. The specific strategies and tools a state will need will depend on the scope and nature of its SDOH initiatives, as well as its approach to Medicaid managed care; local and community resources; existing infrastructure; and more.

- › **Background research and analysis.** To support their SDOH work, most states begin with a review of the existing evidence base on the effectiveness of various SDOH interventions across Medicaid populations, particularly any programs or interventions already in play within the state. States also may want to review any existing data from other state agencies or local universities on the magnitude of unmet social and economic needs among Medicaid beneficiaries. For example, some state Medicaid agencies have leveraged work done by their public health partners or local researchers to inform their SDOH work, including: maps of the housing distribution and shortages; people living with food insecurity; unemployment; and poverty rates. Ideally, if feasible, a state would crosswalk any available data on unmet social and economic needs with Medicaid data on claims and utilization to establish a baseline from which to evaluate future initiatives.
- › **Convene stakeholders and build partnerships with social service organizations.** Any effort to address SDOH requires a new, or expanded, level of cooperation and coordination among Medicaid managed care plans, providers, state social service agencies, community-based organizations, consumers, and advocates who can offer insight into the primary SDOH issues affecting beneficiaries. To that end, states may want to consider setting up a process for working with stakeholders, or, alternatively, leveraging existing avenues for people to provide input into programs that address SDOH, including Medicaid program initiatives. Stakeholder convening could be initially focused on developing shared priority outcomes related to SDOH initiatives. A number of the SDOH practices described in this analysis also require extended coordination and partnership between health and social service stakeholders, potentially creating a role for an ongoing system for consultation and collaboration.
- › **Work with managed care plans to gather information on existing SDOH practices.** Increasing numbers of Medicaid managed care plans have experience working on SDOH and, in some instances, may already have in-house products or contracts with organizations such as local social service agencies; care management entities experienced on SDOH issues; or with national vendors that build databases on community resources. For example, some plans have developed in-house databases on the local social service organization that could help their beneficiaries, while others contract with external companies (for example, Aunt Bertha or Healthify) to provide such information, ideally with a feedback loop on the outcome of the referral. By consulting with plans through a request for information (RFI) or a more informal process, states can gain a better sense of what plans already can offer and where they could be encouraged to take further action.
- › **Revise Medicaid managed care contracts.** States' Medicaid managed care contracts will be their primary tool for implementing many of the practices described in this paper. Nearly all states are expected to renew, re-procure, or extend their Medicaid managed care contracts over the next year, creating an opening to integrate SDOH strategies.<sup>12</sup> In reviewing their contracts through an SDOH lens, states likely will want to assess whether to make modifications in key sections, including:
  - › **Care management requirements** as they relate to screening for and connecting people to social and economic supports;
  - › **Quality provisions and reporting requirements**, including any discussion of SDOH-related metrics, requirements that plans develop performance improvement plans aimed at SDOH, or SDOH-specific reporting requirements;
  - › **Provider network requirements**, including requiring use of community health workers and other non-traditional providers to assist beneficiaries with SDOH issues;

- » **Value-based payment language**, including encouraging to requiring states to use value-based payments strategies that allow providers to address SDOH;
  - » **Incentive and withhold procedures** that provide a fiscal incentive to plans to address SDOH-sensitive metrics;
  - » **MLR requirements**, which offer a platform for describing how the state intends to treat a plan's value-added services or other quality initiatives related to SDOH; and
  - » **Training requirements** for providers on SDOH-specific material, such as a requirement that care managers be trained on SDOH issues, or that the plan directly offer training on trauma-informed care or socioeconomic issues affecting Medicaid beneficiaries.
- › **Review rates and supplemental Medicaid managed care materials.** States that add significant requirements for plans to address SDOH will want to ensure that their rate setting process takes into account related costs when appropriate. Some of the practices described above—such as value-added services and performance improvement plans related to SDOH—will not have any impact on rates, but others will. Additionally, states typically have a number of supplemental materials outside of their actual Medicaid managed care contract that amplify their requirements and expectations. These include clinical guidelines, value-based payment roadmaps, and the state's Medicaid managed care quality strategy, each of which can be reviewed and updated to reflect a state's SDOH agenda.
  - › **Modify or seek an 1115 waiver.** Some of the practices outlined above, such as using Medicaid dollars for some health-related services that do not fit into a Medicaid benefit category, may require a Medicaid 1115 waiver. To the extent a state is including a focus on SDOH into an existing or newly-proposed Medicaid 1115 waiver, the key often is to secure CMS approval to use Medicaid matching funds for activities that are not otherwise matchable. This typically will come up during discussions with CMS regarding the budget neutrality of a waiver and when a CMS agreement that coverage of health-related services could reduce other Medicaid expenditures and improve health outcomes.
  - › **Review and address implications for data strategy.** States pursuing significant SDOH initiatives likely will want to consider the implications for their Medicaid data strategy. These might compel changes to the state's claims system; the care coordination software used by Medicaid managed plans in the state; investment in data capacity and data sharing with community-based organizations; and data gathered for evaluation and monitoring purposes.

## IV. Conclusion

States are entering a new phase of work related to SDOH: moving beyond simply referring people to social supports and looking to ensure that people receive the services they need; as well as, engaging Medicaid managed care companies more fully as partners in addressing social factors. Increasingly, SDOH interventions will be more closely integrated into the delivery of care. As these interventions expand, it will be important to measure their impact, and recognize (and determine how to address in payment strategies) that some of the benefits of addressing social factors may have a long-term impact and may also benefit programs and entities outside of Medicaid.

## V. Appendices

### Appendix A: Methodology

Manatt performed a literature review to determine the current state of SDOH provisions in both managed care contracts and 1115 demonstration waivers. Through this review, Manatt identified 17 states with SDOH provisions in their risk-based managed care programs and identified seven key questions to examine within each of their contracts. State Medicaid managed care contracts reviewed include: Arizona; Colorado; Illinois; Louisiana; Massachusetts; Michigan; Minnesota; Nevada; New Mexico; New Hampshire; New York; North Carolina; Rhode Island; Tennessee; Virginia; Washington; and Wisconsin. Manatt reviewed general model managed care contracts that were publicly available and, in some cases, examined requests for proposals (RFP) relating to contracts that will be in place in the near future. In cases where a model contract was not available, the single most general contract was reviewed. Manatt reviewed physical health or physical and behavioral health integrated contracts. The list of questions below was used to develop a corresponding list of over 50-search terms that guided Manatt's review and subsequent development of key themes. After cataloguing the SDOH provisions, Manatt cross-referenced these with existing materials and created summaries for each key question. In situations where model contracts identified auxiliary materials (such as separate quality measures or guidelines), Manatt did not choose to further review materials, instead choosing to focus solely on the contracts themselves. Manatt reviewed state 1115 demonstration waivers more broadly, including waivers of: Hawaii; Maryland; New York; North Carolina; Rhode Island; and Washington.

Key questions and search terms included:

- › **SDOH Definition:** Does the contract directly reference social determinants of health or related needs?
  - › **Search terms:** Social determinants of health; social determinants; unmet resource needs; unmet needs; social needs; SDOH; psychosocial; social service; and social support.
- › **Screening:** Does the contract specify the screening of social, unmet, or informal needs? Does the contract screen for specific areas within those, such as housing, food insecurity, etc.?
  - › **Search terms:** Screen; social needs screen; and screening for unmet resource needs.
- › **Data Development, Collection, and Evaluation:** Does the contract seek data development, collection, or evaluation for the purpose of determining social determinants of health needs? Does the contract use data to coordinate between providers, community-based organizations, and other key stakeholders to impact specific social determinants of health?
  - › **Search terms:** Data; analytics; data integration; resource platform; closed-loop referral; Health Information Exchange (HIE); linkage; high-utilizer; and resource map.
- › **Data Development, Collection, and Evaluation:** Does the contract seek data development, collection, or evaluation for the purpose of determining social determinants of health needs? Does the contract use data to coordinate between providers, community-based organizations, and other key stakeholders to impact specific social determinants of health?
  - › **Search terms:** Data; analytics; data integration; resource platform; closed-loop referral; Health Information Exchange (HIE); linkage; high-utilizer; and resource map.
- › **Quality Metrics, Strategy, or Screening; Items related to withholds:** Are the quality metrics (or quality strategy) aimed at addressing social determinants of health needs? Does the contract requirement Performance Improvement Projects that address these needs? Do the needs reference high-utilizers of emergency departments?
  - › **Search terms:** Quality; withhold; value-based payment or purchasing; VBP; pilot; performance improvement; Performance Improvement Project (PIP); Alternative Payment Methodology (APM); navigator; and risk-sharing.

- › **Partnerships with Community Health Workers, CBOs, etc.:** Does the contract direct coordination with community resources and providers? Does the contract specify staffing supports for community health resources that may facilitate care management and coordination (e.g., warm transfer or handoff)?
  - › **Search terms:** Care coordination; care coordinator; community health workers; community resources; community; warm handoff; warm transfer; social worker; community-based organization (CBO); and community supports.
- › **Care Management Services:** Does the contract require care management services (e.g., care needs screening, health risk screening, care coordination, case management, etc.) aimed at addressing social determinants of health, unmet, or social service needs?
  - › **Search terms:** Care management; care plan; care screening; case management; Patient-Centered Medical Home; Primary Care Case Management; and Health Home.
- › **SDOH Interventions and Initiatives; Reporting Requirements:** Does the contract specify additional areas of investment related to social determinants of health, such as housing, food insecurity, adverse childhood experiences (ACEs), education, trauma-informed care, home visiting, child care, literacy, or employment?
  - › **Search terms:** Housing, Food Insecurity; Integration; adverse childhood experiences (ACEs); education; trauma-informed; trauma; employment; child care; home visiting; literacy; in lieu of services; and value-added services.

## Appendix B: Managed Care Contracts and 1115 Waivers

### Managed Care Contracts:

- [Arizona Health Care Cost Containment System \(AHCCCS\)](#). *Arizona Complete Care Contract Amendment*. 2018.
- [Colorado Department of Health Care Policy and Financing](#). *Health First Colorado Rocky Mountain Health Maintenance Organization, Inc. Contract*. 2018.
- [State of Illinois Department of Healthcare and Family Services](#). *Managed Care Organization Contract*. 2018.
- [Louisiana Department of Health](#). *Amendment to Agreement between State of Louisiana, Louisiana Department of Health, Medical Vendor Administration Bureau of Health Services Financing and Aetna Better Health, Inc.* 2018.
- [Massachusetts Executive Office of Health and Human Services](#). *MassHealth Managed Care Organization (MCO) Program RFP Attachment A Model Contract*. 2018.
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Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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#### ABOUT MANATT HEALTH

This highlight was prepared by Jocelyn Guyer, Patricia Boozang, and Bardia Nabet. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future. For more information, visit <https://www.manatt.com/Health>.

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