



Addressing Social Needs in the Medicaid Program

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National Alliance to Impact the Social Determinants of Health
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EXECUTIVE SUMMARY

Medicaid programs are the primary provider of health care benefits to tens of millions of Americans with limited incomes and resources, many of whom are vulnerable to adverse social determinants of health (SDOH) and as a result, are more likely to experience social needs in the Medicaid program. In the brief, NASDOH summarizes select federal authorities that allow states to address social needs in the Medicaid program. We call on states and managed care organizations (MCOs) to leverage the available flexibilities to address social needs and we make recommendations to the Centers for Medicare & Medicaid Services (CMS) about how they can support the states in their efforts.

ABOUT NASDOH: NASDOH is a non-partisan, multi-sector alliance of leading individuals and organizations working to build a common understanding of the importance of addressing SDOH as part of an overall approach to improving health outcomes. We recognize that addressing SDOH in a sustainable and successful way will take multisector partnerships that assess what individual communities need, find ways to deliver services, and seek sustainable financing. Please visit our website (<http://www.nasdoh.org/>) for more information.

IMPORTANCE OF ADDRESSING SOCIAL NEEDS IN THE MEDICAID PROGRAM

Medicaid programs are the primary provider of health care benefits to tens of millions of Americans with limited incomes and resources, many of whom are vulnerable to adverse social determinants of health (SDOH) and as a result, are more likely to experience housing instability, food and transportation insecurity, and other social risks. A 2019 survey of Medicaid beneficiaries indicated that around two-thirds of survey respondents reported one or more unmet social needs. The evidence demonstrates that these risks combined with having related non-medical health needs, or social needs, impact not just health outcomes, but also health care utilization, and costs.¹ As more and more Medicaid beneficiaries receive their benefits through managed care, both state Medicaid agencies and Medicaid managed care organizations (MCOs) are increasingly focused on impacting these social needs as part of a value-based care strategy.

Over the past decade, the federal government has made it clear that addressing social needs is within the purview of the Medicaid program and consistent with the program’s aims. The Medicaid program has a record of addressing non-medical needs, as seen through the provision of long-term services and supports and personal care services. CMS has also approved Section 1115 demonstration waivers for states to leverage their Medicaid programs to address a number of non-medical and social needs. Several state Medicaid programs and Medicaid MCOs are implementing practices and providing services to address those needs. However, more can be done to accelerate progress in states and ensure that federal flexibilities are utilized to meet the needs of millions of American enrolled in Medicaid and improve health.

In this brief, NASDOH summarizes select federal authorities that allow states to address social needs in the Medicaid program. We call on states and MCOs to leverage the available flexibilities to address the social needs specific to their beneficiaries and we make recommendations to the Centers for Medicare & Medicaid Services (CMS) to support the states in their efforts by enabling a broad array of tools and approaches which can be tailored to the needs of beneficiaries served in each state.

“State Medicaid and CHIP agencies are in a unique position to address SDOH for Medicaid and CHIP beneficiaries, due to the broad range of services and supports, including home and community-based services (HCBS), that can be covered within Medicaid and CHIP programs and the high number of Medicaid and CHIP beneficiaries who face challenges related to SDOH because of low income and other reasons.”

- State Health Official Letter,
Center for Medicaid & CHIP Services, January
2021

This brief focuses on how Medicaid authorities can be used or clarified to address social needs at the individual beneficiary-level, which aligns with the legal requirements that Medicaid services are provided on individual assessment of need.² Addressing these social needs will be of benefit to the individuals enrolled in Medicaid and can improve outcomes in the Medicaid program. However, social needs are driven by the underlying conditions in the environments where people are born, grow, live, work, and age, or the

¹ Thompson T, McQueen A, Croston M, Luke A, Caito N, Quinn K, Funaro J, Kreuter MW. Social Needs and Health-Related Outcomes Among Medicaid Beneficiaries. *Health Educ Behav.* 2019 Jun;46(3):436-444. doi: 10.1177/1090198118822724. Epub 2019 Jan 17. PMID: 30654655. Retrieved from <https://pubmed.ncbi.nlm.nih.gov/30654655/>

² 42 C.F.R. § 440.230(d); Centers for Medicare & Medicaid Services (CMS). (2021). Social Determinants of Health State Health Official Letter. Retrieved from: <https://www.medicare.gov/federal-policy-guidance/downloads/sho21001.pdf>

“social determinants of health.” Addressing SDOH requires larger systemic changes at both the state and federal level; NASDOH has discussed this and proposed recommendations in a [previous publication](#). In focusing this brief on addressing social needs in the Medicaid program, we recognize the importance of making rapid progress within existing authority, which we believe can be done concurrently to laying the groundwork for further progress in addressing more fundamental social determinants of health.

SOCIAL NEEDS: The immediate non-medical needs of an individual. Efforts to address social needs provide invaluable assistance to individuals – for example, providing food, housing, and transportation to a person or their family – but not the underlying economic or social conditions that lead to social needs.³

SOCIAL DETERMINANTS OF HEALTH: The conditions in the environments where people are born, grow, live, work, and age that affect health outcomes and risks; and the broader systems that shape those conditions, including social, political, and economic programs, and policies.⁴ Efforts to address SDOH prioritize the underlying social and economic conditions in which people live, rather than the immediate needs of any one individual.⁵

SELECT AUTHORITIES ALLOWING SOCIAL NEEDS TO BE ADDRESSED IN MEDICAID AND EXAMPLES FROM THE FIELD

States have broad flexibility to design Medicaid programs that meet each state’s needs and policy goals. Through several authorities, CMS permits states to design benefits, delivery approaches and financing strategies to address social needs in the Medicaid program. In January of 2021, CMS released a letter to State Officials outlining the key authorities and consolidating guidance to states on how these authorities can be used to address social needs, including:

- Medicaid managed care rule provisions, which encourage or require Medicaid managed care organizations (MCOs) to address social needs;
- Section 1915 Home and Community-Based Services (HCBS) waivers, which can be used to address non-medical needs of individuals to facilitate their opportunity to live and work in the community if they would otherwise need institutional care; and,
- Section 1115 Demonstration waivers, which provide states flexibility to address or incorporate social needs interventions into their Medicaid programs.⁶

Additionally, there are existing and emerging alternative payment and innovation models, which seek to assess the impact of addressing non-medical needs, such as care coordination, screening services, referral services, community navigation services, and more, on health care costs and utilization.

³ Castrucci, B., & Auerbach, J. (2019). Meeting individual social needs falls short of addressing social determinants of health. Health Affairs Blog, 10.

⁴ World Health Organization. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. World Health Organization.

⁵ Castrucci, B., & Auerbach, J. (2019). Meeting individual social needs falls short of addressing social determinants of health. Health Affairs Blog, 10.

⁶ Centers for Medicare & Medicaid Services (CMS). (2021). Social Determinants of Health State Health Official Letter. Retrieved from: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>

In the appendix, we summarize these authorities, which are being leveraged in the field, in greater detail.

CALL TO ACTION

Despite expanded flexibilities and allowances to address social needs in Medicaid and some uptake across states, the proliferation of efforts remains uneven. For example, a recent review of SDOH Initiatives in managed care contracts and 1115 waiver demonstrations found that more than 20 states incorporate social need in care management requirements for MCOs but 10 or fewer states are using ‘leading edge practices’ as allowed by Medicaid managed care regulation to encourage MCOs to address social needs. Only 16 states are pursuing 1115 waivers to test innovative SDOH models through pilot programs and delivery system.⁷

It is essential that more state-based efforts are deployed given their potential impact on health outcomes. NASDOH calls on state Medicaid agencies and Medicaid MCOs to continue to prioritize and take up the afforded allowances to address social needs services in Medicaid and offers the following recommendations.

MEDICAL LOSS RATIO (MLR): Insurance companies spend premium dollars on clinical services, quality improvement activities, administrative costs, and profits. The medical loss ratio (MLR) is the proportion of premium revenues spent on clinical services and quality improvement. The ACA set Federal standards on the MLR numerator, or the percentage of premiums which must be spent on medical and quality improvement activities; a Medicaid MLR was adopted in 2016.

“IN-LIEU- OF” SERVICES: “In-lieu-of” services are medically appropriate and cost-effective services MCOs may cover as an alternative to state plan services or settings. “In-lieu-of” services are covered by Medicaid and can be included in capitation rates and incurred claim toward to numerator of the MLR.

VALUE-ADDED SERVICES: Extra benefits offered to Medicare beneficiaries by MCOs beyond the required Medicaid-covered services. Value-added services can be medical or non-medical and may include routine dental, vision, podiatry, and health and wellness services. Value-added services are not covered by Medicaid nor are they included in the capitation rate, but they can count as incurred claim toward to numerator of the MLR if they improve health.

State Medicaid Agencies

1. *Integrate clear and specific expectations to address social needs into state Medicaid Managed Care Contracts.*

As noted, there are several mechanisms within the Medicaid managed care authorities that can be used to incentivize MCOs to cover services to address social needs.⁸ More states should take up

⁷ Dutton, M., Newman, D., Ferguson, M., Mann, C. (2020). In Pursuit of Whole Person Health: A Review of Social Determinants of Health (SDOH) Initiatives in Medicaid Managed Care Contracts and 1115 Waivers, Select Highlights from Manatt’s National Survey. Manatt Health. Retrieved from: <https://www.manatt.com/insights/press-releases/2020/sdoh-integration-and-innovation-a-manatt-health-re>

⁸ NORC Medicaid Managed Care Learning Hub. (2020). Key Findings from the Medicaid MCO Learning Hub Group Discussion Series and Roundtable – Focus on Social Determinants of Health. Retrieved from:

these flexibilities and incorporate expectations and incentives for Medicaid MCOs to address social needs into their managed care contracts directly. This would demonstrate that states prioritize social needs services and facilitate sustainable action. For example, states should include “in-lieu-of” services and value-added services that address social needs directly in contracts with Medicaid MCOs and be specific about how social needs services are accounted for separate from medical encounters. State and federal regulations and guidance should permit inclusion in MLR of both care coordination and coordination with states and community organizations on services and programs that support the needs of health plan members. Such activities should be able to be categorized as “covered medical expenses.”

States are encouraged to evolve their contracts and work with MCOs to scale a diversity of social needs focused practices – for example, moving beyond requirements to screen or coordinate social needs and towards less commonly used but allowed requirements addressing data sharing and reporting, financing and incentives that incorporate social need services, and investing in communities.⁹ States should be mindful to balance needed flexibility to Medicaid MCOs to support innovation and meet the needs of members, while also providing clear and detailed guidance and requirements to MCOs on addressing social needs.¹⁰

In January 2021, the CMS state health official guidance letter consolidated approved guidance, and other resources exist to support states in implementing these flexibilities.^{11,12,13,14}

2. Apply for Section 1115 waiver demonstrations to test and pay for social needs interventions.

States are afforded flexibilities, not available under other authorities, through 1115 waivers to test new strategies to deliver Medicaid. States should leverage 1115 waiver demonstrations to test pilot programs, delivery system reforms, and enhanced benefit packages to provide social needs services that align with the state’s needs. Because states are expected to evaluate demonstrations,

https://www.norc.org/PDFs/Medicaid%20Managed%20Care%20Organization%20Learning%20Hub/MCOLearningHub_KeyFindings_SDOHGroupRoundtableDiscussion_Formatted.pdf

⁹ Dutton, M., Newman, D., Ferguson, M., Mann, C. (2020). In Pursuit of Whole Person Health: A Review of Social Determinants of Health (SDOH) Initiatives in Medicaid Managed Care Contracts and 1115 Waivers, Select Highlights from Manatt’s National Survey. Manatt Health. Retrieved from:

<https://www.manatt.com/insights/press-releases/2020/sdoh-integration-and-innovation-a-manatt-health-re>

¹⁰ NORC Medicaid Managed Care Learning Hub. (2020). Key Findings from the Medicaid MCO Learning Hub Group Discussion Series and Roundtable – Focus on Social Determinants of Health. Retrieved from:

https://www.norc.org/PDFs/Medicaid%20Managed%20Care%20Organization%20Learning%20Hub/MCOLearningHub_KeyFindings_SDOHGroupRoundtableDiscussion_Formatted.pdf

¹¹ Kartika, T. (2018). How States Address Social Determinants of Health in their Medicaid Contracts and Contract Guidance Documents. National Academy for State Health Policy (NASHP). Retrieved from: <https://www.nashp.org/how-states-address-social-determinants-of-health-in-their-medicaid-contracts-and-contract-guidance-documents/>

¹² Centers for Medicare & Medicaid Services (CMS). (2021). Social Determinants of Health State Health Official Letter. Retrieved from: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>

¹³ Crumley, D., Spencer, A., Ralls, M., and Howe, G. (2021). Building a Medicaid Strategy to Address Health-Related Social Needs. Center for Health Care Strategies. Retrieved from: https://www.chcs.org/media/Tool-Building-a-Medicaid-Strategy-to-Address-HRSNs_042921v3.pdf

¹⁴ McGinnis, T., Crumley, D., and Chang, D. (2018). Implementing Social Determinants of Health Interventions in Medicaid Managed Care: How to Leverage Existing Authorities and Shift to Value Based Purchasing. AcademyHealth. Retrieved from:

https://academyhealth.org/sites/default/files/implementing_sdoh_medicaid_managed_care_may2018.pdf

waivers that incorporate social needs services will add to emerging evidence demonstrating which social needs interventions are effective and their impact.

In 2018, CMS approved an 1115 waiver submitted by North Carolina that transitions the state from a fee-for-service model to a capitated managed care program. It also approved the Healthy Opportunities Pilot program, in which all health plans are required to screen for enrollees’ non-medical needs, using standardized questions, and when unmet needs are identified, connect beneficiaries to community resources. In qualifying circumstances, Medicaid funds can be used to pay for case management and support services. The state has developed a state-wide referral management system – NCCARE360.¹⁵ CMS authorized \$650 million over 5 years in Medicaid funding for this first of its kind program and it will be widely watched by stakeholders eager to learn from it.

3. *Build a statewide network of resources using open, non-proprietary, interoperable standards for referrals.*

There is an opportunity for more states to support or build integrated networks that facilitate coordination and promote coordinated service delivery across multiple proprietary systems using open standards like HL7® FHIR® APIs. NASDOH has [previously written](#) about how fragmented communication, data sharing and coordination efforts between health care and social services inhibit efforts to address social needs. States should take advantage of existing funding sources to develop state-wide infrastructure that would improve social needs service provision in the Medicaid program. Until 2021 states received 100% federal matching funds to adopt, implement, and upgrade electronic health record (EHR) technology, now states receive 90% federal matching for administrative expenses related to the program. States can and should seek to leverage this funding to support technology needs and innovation to address social needs.¹⁶

States should also continue to monitor and leverage other federal funding opportunities. Examples include:

- In March 2021, Congress passed the American Rescue Plan Act ([H.R 1319](#)) which provides substantial funding to states. One potential use for this funding is to develop information technology infrastructure which could improve referral and coordination systems across states. The funding includes, for example, \$80 million for the Office of the National Coordinator for Health Information Technology (ONC) to invest in training public health professionals and modernizing the public health data infrastructure, and \$500 million to the Centers for Disease Control and Prevention (CDC) to modernize public health data.
- In FY 2021, ONC issued a notice of funding opportunity for Leading Edge Acceleration Projects (LEAP) in Health Information Technology (Health IT) Grants to fund projects that

¹⁵ Kaiser Family Foundation. (2019). A First Look at North Carolina’s Section 1115 Medicaid Waiver’s Healthy Opportunities Pilots. Available at: <https://www.kff.org/report-section/a-first-look-at-north-carolinas-section-1115-medicaid-waivers-healthy-opportunities-pilots-issue-brief/>

¹⁶ Centers for Medicare & Medicaid Services (CMS). (2021). Social Determinants of Health State Health Official Letter. Retrieved from: <https://www.medicare.gov/federal-policy-guidance/downloads/sho21001.pdf>

address the development, use, and/or advancement of well-designed, interoperable health IT for social need referral management.¹⁷

- The Administration for Community Living (ACL) launched a Social Care Referrals Challenge competition in March of 2020. The challenge seeks to reward the development and optimization of interoperable and scalable technology solutions that connect health care and community-based organizations to provide social services for older adults and people with disabilities.¹⁸
- A future potential funding source is the [Leveraging Integrated Networks in Communities \(LINC\) to Address Social Needs Act \(S. 509\)](#), which was recently introduced in the Senate. The bill would authorize HHS to award grants to States to establish new or enhance existing community integration network infrastructure. States should be looking to leverage opportunities like these to support state-wide resources which would facilitate social need coordination and care.

Some regions and a few states are making key commitments to build integrated networks to share data and coordinate social need services; as referenced earlier, North Carolina worked with NASDOH member Unite Us to develop a statewide platform to connect providers, insurers, and community-based organizations across the state to connect people with the services they need, and allow for collaboration, outcome tracking and system improvement.¹⁹

4. *Train community health workers to bolster a crucial workforce pipeline to identify and address social needs.*

CMS has made it clear that states can require MCOs to include community health workers (CHWs) in care teams as a part of strategies to address social needs; CMS notes that CHWs promote patient-centered care and provide needed linkages between beneficiaries and services.²⁰ Published evidence further supports this – a recent study demonstrated that the use of CHWs is an effective strategy to address unmet needs and that they generate a positive return on investment.²¹

As more states require MCOs to use CHWs, it is crucial there is an adequate supply of community health workers who are adequately trained to identify and address social needs. States should offer or support existing training programs to ensure that CHWs can be deployed to meet Medicaid program goals, and to ensure they are well equipped to meet social needs effectively. The

¹⁷ Office of the National Coordinator. (2021). Leading Edge Acceleration Projects (LEAP) in Health Information Technology (Health IT) Notice of Funding Opportunity (NOFO) Retrieved from: <https://www.healthit.gov/topic/onc-funding-opportunities/leading-edge-acceleration-projects-leap-health-information>

¹⁸ Administration for Community Living. (2020). Challenge: Innovative Technology Solutions for Social Care Referrals. Available at: <https://acl.gov/socialcarereferrals>

¹⁹ Unite Us. (2018). NCCARE360 Selected to Build a New Tool for a Healthier North Carolina – The NC Resource Platform. Retrieved from: <https://uniteus.com/nccare360-selected-to-build-a-new-tool-for-a-healthier-north-carolina-the-nc-resource-platform/>

²⁰ Centers for Medicare & Medicaid Services (CMS). (2021). Social Determinants of Health State Health Official Letter. Retrieved from: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>

²¹ Kangovi, S., Mitra, N., Grande, D., Long, J. A., & Asch, D. A. (2020). Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment: A return on investment analysis of a randomized controlled trial of a standardized community health worker program that addresses unmet social needs for disadvantaged individuals. *Health Affairs*, 39(2), 207-213.

American Rescue Plan Act of 2021 provides funding for CHWs, and states should use that funding to recruit and train CHWs, while Medicaid funding can be used to sustain CHW programs over time.²²

Medicaid Managed Care Organizations

1. *Create mechanisms for consumer and community engagement to inform social need strategies and address social needs.*

MCOs should regularly engage their members, in accordance with relevant requirements, to ensure that members' experiences, needs, and preferences are informing the provision of services. Similarly, MCOs should engage with members, key community representatives, and other community advocates to ensure that social need interventions and delivery mechanisms are meeting the non-medical social health needs of members and their families, and supporting community needs and community-based organizations. Engagement should be meaningful, such that consumer and CBO stakeholders are able to collaborate with MCO leaders on policies, decision-making, and service provision.

Further, MCOs should be developing relationships and partnership with community-based organizations that provide these social services. MCOs should be exploring how they can support the capacity of CBOs to partner and provide social services needed by their members.

2. *Share best practices with other MCOs and State Medicaid Officials.*

Forward-leaning MCOs have invested in and are implementing initiatives to address social needs. We encourage these organizations to share their learnings and to help identify best practices to other MCOs or community-based organizations to accelerate efforts to address social needs. For example, MCOs can join learning hubs, like the NORC MCO learning Hub, which was funded by the Robert Wood Johnson Foundation.²³ Learning Hubs, like NORC's, can provide information and key opportunities for MCO leadership, consumer groups, state Medicaid leaders, and other stakeholders to convene and share ideas and strategies. Statewide and national trade associations and affinity groups also offer opportunities for both structured and less formal information sharing.

3. *Contribute to the evidence base demonstrating the value of addressing social needs.*

The evidence base demonstrating the benefit to health outcomes and health care costs is still growing. We encourage MCOs, which are at the forefront of providing services to address social needs, to robustly evaluate initiatives addressing social needs so it can contribute to the body of evidence demonstrating which interventions are successful and under what circumstances. Large MCOs may also consider how they can leverage data they have and invest in key data systems and

²² The White House Briefing Room. (2021). Fact Sheet: Biden-Harris Administration to Invest \$7 Billion from American Rescue Plan to Hire and Train Public Health Workers in Response to COVID-19; <https://www.whitehouse.gov/briefing-room/statements-releases/2021/05/13/fact-sheet-biden-harris-administration-to-invest-7-billion-from-american-rescue-plan-to-hire-and-train-public-health-workers-in-response-to-covid-19/>

²³ NORC at the University of Chicago. (n.d.). Medicaid Managed Care Organization Learning Hub. Retrieved from: <https://www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx>

evaluations to help build the evidence base. Additionally, when results are studied, publishing the findings, and presenting at conferences can boost awareness and serve to inform other MCOs about new program options.

RECOMMENDATIONS: FEDERAL ACTIONS TO SUPPORT STATE EFFORTS

While the federal government has already taken many important steps, further action could reduce remaining barriers and accelerate the uptake of the options described earlier in more states. NASDOH outlines recommendations below to the new administration to provide greater clarity and support state efforts to address social needs in Medicaid. The following requests reflect input from NASDOH members, conversations with members of states and other experts, and aligns with calls from others.^{24,25}

1. *Creating a robust, sustained Medicaid learning collaborative so states can learn from each other and work with CMS.*

States continue to seek guidance from CMS on how they can use program authorities and waivers to address social needs. While these are complex issues making it difficult to issue guidance, CMS should facilitate information sharing across states by establishing a CMS-led learning collaborative.

A learning collaborative would provide states the opportunity to learn from each other’s successes and create an environment where CMS could offer more detailed technical support to states to incorporate social needs into their programs. For example, CMS could collaborate with states, provide more specific guidance, and provide resources, which address:

a. *MCO contract templates and social needs interventions acceptable for waiver inclusion – to accelerate efforts to address social needs.*

We call on more state Medicaid agencies to use the existing authorities to address social needs in Medicaid managed care contracting and through 1115 waiver. However, CMS could provide additional technical resources which would help overcome barriers to uptake in the states.

While some states have been successful at incorporating requirements for MCOs to address social needs or applying for waivers, there is a lag in implementing the authorities granted in the 2016 Medicaid Managed Care Regulation changes, which sought to improve investment. A 2021 survey of Medicaid Managed Care Contracts and 1115 waivers found that some initiatives are more common – e.g., more than 20 states have contracts which include screening or assessing for social needs and coordinating services – but fewer states

²⁴ NORC Medicaid Managed Care Learning Hub. (2020). Key Findings from the Medicaid MCO Learning Hub Group Discussion Series and Roundtable – Focus on Social Determinants of Health. Retrieved from: https://www.norc.org/PDFs/Medicaid%20Managed%20Care%20Organization%20Learning%20Hub/MCOLearningHubKeyFindings_SDOHGroupRoundtableDiscussion_Formatted.pdf

²⁵ AHIP. (2019). Social Determinants of Health and Medicaid: Policy Recommendations to Achieve Greater Impact on Reducing Disparities & Advancing Health Equity. Retrieved from: https://www.ahip.org/wp-content/uploads/AHIP_IB-SDOH_Medicaid.pdf

are leveraging payment incentives or quality improvement requirements to address social needs, and work with community-based organizations and providers.²⁶

Developing both impactful managed care contracts and successful Medicaid waivers is resource intensive for states. Confusion about which SDOH interventions are impactful, how to structure contracts, and in the case of waivers, which interventions CMS will approve disincentivizes states to pursue the existing flexibilities. CMS could provide states with approved template contract language, and previously approved social needs interventions for inclusion in waivers to increase state uptake. Further, CMS could more readily share findings from previous waiver evaluations which demonstrate successful social needs interventions. This would facilitate shared learning between states and ensure that effective interventions are utilized.

b. Provide Medicaid MCOs greater clarity on allowable services addressing social needs and their classification.

Confusion still exists on the classification of non-traditional services, and potentially on what services are quality improvement activities, as opposed to value added services or “in-lieu-of” services. Lack of clarity limits inclusion in Medicaid managed care contracts and plan confidence or willingness to provide non-medical services designed to address social needs, as well as subjects plans to potential penalties for failing to reach the minimum MLR threshold.²⁷

In its recent State Health Official Letter, CMS stated that MCOs can voluntarily cover “in-lieu-of” and value-added services addressing social needs but did not include specific examples of what can be covered. For example, it said that MCOs may choose to provide “supportive housing services” for certain beneficiaries as value-added services, but it is not clear what it considers to be “supportive housing services” and therefore, what can be included in the numerator of the MLR and what should be counted as an administrative service. Similarly, the letter clarifies that states could allow plans to provide medically tailored meals as an “in-lieu-of” service in specific circumstances but does not clarify if that includes, for example, the cost of meal delivery or contracting with a meal delivery service provider, making it difficult to determine what can be included in the MLR and should be accounted for in the capitated rate.

In a learning collaborative environment, CMS could work with states to address questions about specific services, and how they may be classified (*e.g.*, as “in-lieu-of” or value-added services). This would assure states and MCOs they can take advantage of the flexibilities intended in current law, and spur innovation. For now, many MCOs are investing in social

²⁶ Dutton, M., Newman, D., Ferguson, M., Mann, C. (2020). In Pursuit of Whole Person Health: A Review of Social Determinants of Health (SDOH) Initiatives in Medicaid Managed Care Contracts and 1115 Waivers, Select Highlights from Manatt’s National Survey. Manatt Health. Retrieved from: <https://www.manatt.com/insights/press-releases/2020/sdoh-integration-and-innovation-a-manatt-health-re>

²⁷ 42 C.F.R. § 438.8

needs services using reserves or other funds because of lack of clarity.²⁸ This could impact their long-term sustainability and scalability, and as a result, the conclusions about the benefit of social need interventions.

c. Support states' capacity to develop and utilize flexibilities and allowances by providing educational training opportunities and professional development for staff.

In the most recently available Annual Survey of State Medicaid Directors (2019), the median tenure of Medicaid Directors was 21 months. In order for states to take advantage of the flexibilities to address social needs, and the tools we call for above, CMS should consider how they can provide or support the development of training modules and educational resources for state Medicaid staff to help them understand what's allowable, when and how it should be deployed, and what resources are available to them to address social needs. Educational training opportunities, virtual learning modules, and other such professional development opportunities are important to grow the capacity of the state program staff to use the tools made available to address social needs.

2. Allow social needs interventions to be counted as covered medical expenses and encourage states to incorporate these activities into the MLR.

Many social needs interventions are seeking to improve health outcomes and reduce costs, and many states are requiring MCOs to invest in them. However, addressing social needs often requires plans to make upfront investments and sustained funding to maintain these services. In addition, if plans make investments and they succeed in improving outcomes and reducing avoidable utilization, plans are subject to reduced payments, which can limit the sustainability of social needs services over time. CMS should allow the costs of care coordination and coordination with states and community organizations on services and programs that support the needs of health plan members to be categorized as "covered medical expenses," and permit inclusion in MLR of both. These allowances should be made clear to states and CMS should encourage states to address them when contracting with MCOs. This would ensure effective social needs services are sustainable and scalable, and meet beneficiary needs.

3. Test more Medicaid innovation models which address social needs services in Medicaid and CHIP.

CMS has authority to test new and innovative payment and service delivery models through the Center for Medicare and Medicaid Innovation (CMMI). CMS has proposed or is currently testing model(s) or demonstrations which allow for, or include, benefits to address health-related social needs or "non-primarily health related," benefits like meals, transportation for non-medical needs, and others.²⁹ To date, many of the CMMI models are being tested in the Medicare program. CMS should prioritize testing innovation models in the Medicaid program and incorporate efforts to address social needs and SDOH.

²⁸ NORC Medicaid Managed Care Learning Hub. (2020). Key Findings from the Medicaid MCO Learning Hub Group Discussion Series and Roundtable – Focus on Social Determinants of Health. Retrieved from: https://www.norc.org/PDFs/Medicaid%20Managed%20Care%20Organization%20Learning%20Hub/MCOLearningHub_KeyFindings_SDOHGroupRoundtableDiscussion_Formatted.pdf

²⁹ CMS. "Innovation Models." Available at: <https://innovation.cms.gov/innovation-models#views=models>

“Models to date have been largely Medicare-oriented, and voluntary models have primarily drawn only those health care providers and organizations with resources and capital to apply and participate, resulting in limited attention to Medicaid and safety net providers. From here on, the Innovation Center will embed equity in every aspect of its models by seeking to include more providers serving low- and modest-income, racially diverse, and/or rural populations; the Innovation Center will aim to ensure everyone has access to providers at the leading edge of transformation.”

– CMS and CMMI Leaders,
2021 Health Affairs Blog, “Innovation at the Centers for Medicare and Medicaid Services: A Vision for the Next 10 Years

In a recent editorial, CMS and CMMI leaders reflected on how the innovation center is and can drive meaningful change to make the health system better. In this piece, they recognized the disadvantages of the over-weighted focus on Medicare models and committed to embedding equity in its models moving forward.³⁰ We call on CMS to include approaches to meeting non-medical health related needs, or social needs, and, as we touched both at the beginning of this piece and at the end, considering how federal health care dollars can be used to address social determinants of health as well.

4. *Coordinate across agencies to optimize program waivers and flexibilities.*

In 2020, NASDOH [released](#) our issue brief highlighting the importance of the broad range of public programs that address social needs but noted that they are often inflexible and operate in relative isolation. We explained that the COVID-19 Public Health Emergency demonstrated program flexibilities could be used, and coordinated, to ensure effective and efficient approaches to address social needs and asserted that these would improve health during non-pandemic times too. In that commentary, NASDOH called on the federal government to focus on program integration, and pathways to coordinate parallel waiver authorities across federal programs to allow states or other implementing organizations to optimize social needs interventions. CMS should explore how Medicaid waivers can be coordinated with other agency and department flexibilities to deliver social needs services without compromising the intent or allowances of each program.

Similarly, in its Medicaid policy recommendations earlier this year, America's Health Insurance Plans (AHIP) called for the explicit creation of pathways allowing state Medicaid agencies to coordinate with and request inter-disciplinary waivers to provide social need services with other state agencies.³¹ We agree with AHIP’s recommendations and underscore the need for appropriate guardrails to ensure that the fundamental goals of those programs are maintained.

5. *Allow Medicaid dollars to be pooled to fund social need services.*

As we noted earlier in this paper, NASDOH has [previously written](#) on the benefits of pooling federal funds with other public, private, and philanthropic sources to ensure that a broad array of sectors jointly fund and share in the benefits of SDOH investment. Medicaid MCOs and providers should

³⁰ Brooks-LaSure, C., Fowler, E., Seshamani, M., and Tsai, D. (2021). “Innovation At The Centers For Medicare And Medicaid Services: A Vision For The Next 10 Years,” Health Affairs Blog, August 12, 2021. DOI: 10.1377/hblog20210812.211558

³¹ AHIP. (2019). Social Determinants of Health and Medicaid: Policy Recommendations to Achieve Greater Impact on Reducing Disparities & Advancing Health Equity. Retrieved from: https://www.ahip.org/wp-content/uploads/AHIP_IB-SDOH_Medicaid.pdf

have flexibility to pool funds from Medicaid with other social service agencies to provide social services and supports to their plan beneficiaries. In addition to ensuring that beneficiaries' needs are met and improving health outcomes, coordinating, and pooling funds could reduce administrative costs and duplication of services across programs.³²

CMS can also examine options for using this model for coordination of more fundamental federal approaches to mitigating social needs and social determinants that accrue to the benefit of Medicaid beneficiaries but are not directly tied to individual beneficiaries – for example, permitting Medicaid dollars to be co-used with other funding streams to support the infrastructures needed to manage the pooling of funds.³³

CONCLUSION

Medicaid covers more than 90 million Americans in 2021, many of whom will be at disproportionate risk of poor health outcomes because of addressable social needs.³⁴ States, MCOs and the federal government have demonstrated a willingness to address beneficiary needs, but more can be done to accelerate these efforts and improve health outcomes. We encourage federal policymakers, states, and MCOs to implement our recommendations, and to continue working collaboratively towards innovative and sustainable solutions.

³² NORC Medicaid Managed Care Learning Hub. (2020). Key Findings from the Medicaid MCO Learning Hub Group Discussion Series and Roundtable – Focus on Social Determinants of Health. Retrieved from: https://www.norc.org/PDFs/Medicaid%20Managed%20Care%20Organization%20Learning%20Hub/MCOLearningHub_KeyFindings_SDOHGroupRoundtableDiscussion_Formatted.pdf

³³ Hughes, D. L., & Mann, C. (2020). Financing The Infrastructure of Accountable Communities for Health Is Key To Long-Term Sustainability: A legal and policy review to identify potential funding streams specifically for Accountable Communities For Health infrastructure activities. *Health Affairs*, 39(4), 670-678.

³⁴ Congressional Budget Office. (2021). Medicaid. Available at: <https://www.cbo.gov/system/files/2021-07/51301-2021-07-medicaid.pdf>

APPENDIX. SUMMARY OF SELECT AUTHORITIES TO ADDRESS SOCIAL NEEDS IN MEDICAID

Medicaid Managed Care Rules

In 2016, CMS updated its Medicaid managed care rules with the intent of modernizing Medicaid MCO operations and improving mechanisms for oversight and accountability. CMS outlined explicit goals for the rule; included among those goals was supporting state efforts at integrating care, including efforts to address social needs.³⁵ Provisions in the rule which allow states to encourage or require MCOs to address social needs included:

- Codifying earlier guidance to states requiring MCOs that provide long-term services and supports (LTSS) to cover home and community-based services (HCBS), which improve or maintain an individual’s ability to live in the community.³⁶
- Empowering states to require participation in value-based purchasing models for provider reimbursement. This change was intended to give states more control over how plans pay providers and permitting them to require MCOs to include incentives to address social needs.³⁷
- Allowing states to directly incentivize MCOs to invest in meeting non-medical health-related needs; for example, quality withholds, or incentives tied to population health performance metrics. The rule limited the amount plans may be reimbursed for these arrangements, indicating that plans cannot contract with incentive arrangements above 105 percent of the approved capitation payments.³⁸
- Clarifying and improving the ability of MCOs to cover non-traditional services by both (1) explicitly allowing for coverage of “in lieu-of” services in capitation rate setting and inclusion in the numerator of the, then newly established, Medical Loss Ratio (MLR) and (2) allowing for coverage of “value-added services,” which counted toward the MLR numerator.³⁹
- Requiring MCOS to strengthen care coordination for community, social support, and clinical care. The rule requires that MCOs follow State set procedures on care and coordination, which must (1) ensure an ongoing appropriate source of care, (2) coordinate services between settings of care, with services from other plans, with FFS, and with community and social support providers, (3) provide for an MCO to make a best effort to conduct an initial screening for enrollee needs within 90 days of enrollment, (4) share results of the screening with the State, (5) ensure providers maintain appropriate health records, and (6) ensure enrollee privacy.⁴⁰

³⁵ Medicaid and Children’s Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Final Rule. 81 Fed. Reg. 27498. (2016, May 6).

³⁶ 42 C.F.R. § 438.2; Machledt, D. (2017, Nov). Addressing Social Determinants of Health Through Medicaid Managed Care. The Commonwealth Fund. Retrieved from: <https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/addressing-social-determinants-health-through-medicaid-managed>

³⁷ 42 C.F.R. § 438.6(c); Machledt, D. (2017, Nov). Addressing Social Determinants of Health Through Medicaid Managed Care. The Commonwealth Fund. Retrieved from: <https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/addressing-social-determinants-health-through-medicaid-managed>

³⁸ 42 C.F.R. § 438.6(b); Machledt, D. *supra*.

³⁹ 42 C.F.R. § 438.208(b); Machledt, D. *supra*.

⁴⁰ 42 C.F.R. § 438.3(e); Machledt, D. *supra*.

Section 1915 Home and Community-Based Services Waivers

States can use several Section 1915 waiver authorities to address non-medical needs.

- 1915(c) waivers provide long term services and supports (LTSS) in home and community-based settings to individuals to provide the opportunity to live and work in the community if they would otherwise need institutional care. States can use this authority to waive certain Medicaid requirements for beneficiaries to provide targeted services to specific populations (*e.g.*, by diagnosis or age). Section 1915(c) waivers can be used to address social needs including housing and tenancy supports, habilitation services – like those that support individuals in attaining or maintaining employment – non-medical transportation, and home-delivered meals. States can also propose additional services designed to address social and economic factors.
- 1915(i) waivers allow states to provide home and community-based services (HCBS) to individuals that reside in the community and who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target certain group criteria). Under the waiver, states can cover services that include those necessary to live in the community.
- 1915(j) waivers allow for self-directed personal assistance services (PAS), including personal care and other services like HCBS to individuals eligible for state plan personal care services. Services include, at the state's option, items that increase the individual's independence or substitute for human assistance (*i.e.*, a microwave oven, grab bars, or an accessibility ramp) to the extent that expenditures would otherwise be made for the human assistance.
- 1915(k) Community First Choice (CFC) waivers provide certain individuals the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. The services include several required and optional services, like services and supports to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks, through hands-on assistance, supervision, and/or cueing.

The Kaiser Family Foundation reported 265 Section 1915(c) HCBS waivers and 11 Section 1915(i) HCBS waivers in 2018.⁴¹

The American Rescue Plan Act, signed into law in March 2021, provided states with a temporary ten percentage point increase to the Federal Medical Assistance Percentage (FMAP) for Medicaid HCBS.⁴² The increased FMAP for Medicaid HCBS can be used for activities such as increased access to HCBS, work force recruitment and training, support for caregivers, one-time community transitions costs, transition coordination between facilities, and other activities.⁴³

⁴¹ Kaiser Family Foundation. (2018). Total Number of Medicaid Section 1915(c) Home and Community-Based Services Waivers. Retrieved from: <https://www.kff.org/health-reform/state-indicator/total-number-of-medicaid-section-1915c-home-and-community-based-services-waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁴² Centers for Medicare and Medicaid Services. (2021). CMS Issues Guidance on American Rescue Plan Funding for Medicaid Home and Community Based Services. Available at: <https://www.cms.gov/newsroom/press-releases/cms-issues-guidance-american-rescue-plan-funding-medicaid-home-and-community-based-services>

⁴³ Centers for Medicare & Medicaid Services (CMS). (2021). Social Determinants of Health State Health Official Letter. Retrieved from: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>

Section 1115 Demonstration Waivers

States can leverage Section 1115 Medicaid demonstration waiver flexibility to address or incorporate social needs interventions. Section 1115 of the Social Security Act allows the Secretary of Health and Human Services (HHS) to waive certain federal Medicaid requirements and allow a state to pursue demonstration projects that “are likely to promote the objectives of the Medicaid program,” instead; this can include social need focused services and supports and testing alternative payment methods which are designed to address SDOH.⁴⁴

CMS provides information on approved and pending Section 1115 Medicaid waivers; there were 58 approved 1115 waivers across 36 states and the District of Columbia and 38 pending waiver applications across 29 states as of August 2021.⁴⁵ These approved and pending waivers address financing changes, eligibility and enrollment restrictions, work requirements, benefit restrictions, copays, health behaviors, behavioral health, delivery system reform, Managed Long Term Services and Supports (MLTSS), and other targeted eligibility changes.⁴⁶

Alternative Payment and Innovation Models

There are several existing and emerging models aimed at testing the impact of addressing non-medical needs, such as care coordination, screening services, referral services, community navigation services, and more, on health care costs and utilization. For example, with 28 participants, The Centers for Medicare and Medicaid Innovation (CMMI) is testing the Accountable Health Communities Model, which aims to address a critical gap between clinical care and community services in the delivery of health care services. The model promotes clinical-community collaboration through screening, referral, community navigation services and alignment/coordination across community-based and health care organizations.⁴⁷

⁴⁴ 42 U.S.C. § 1315.

⁴⁵ Center for Medicaid Services. (2021). State Waivers List, Retrieved from: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?f%5B0%5D=state_waiver_status_facet%3A1591&f%5B1%5D=waiver_authority_facet%3A1566&search_api_fulltext=&items_per_page=10#content#content

⁴⁶ Kaiser Family Foundation. (2019). Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. Retrieved from: <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>

⁴⁷ Center for Medicare and Medicaid Innovation (CMMI) (2021); <https://innovation.cms.gov/innovation-models/ahcm>

ABOUT US

The National Alliance to impact the Social Determinants of Health (NASDOH) is a group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement and economic vitality of families and communities. The Alliance brings together health care, public health and social services expertise, local community experience, community-convening competence, business and financial insight, technology innovation, data and analytics competencies, and policy and advocacy acumen to assess and address current regulatory frameworks, funding environments and opportunities, and practical challenges to implementing and sustaining social determinants of health efforts.

We seek to make a material improvement in the health of individuals and communities and, through multi-sector partnerships within the national system of health, to advance holistic, value-based, person-centered health care that can successfully impact the social determinants of health. To learn more, visit us at NASDOH.org.

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