Health-Related Social Needs:

Current Policy Landscape and Opportunities for Stakeholders

Overview

Health begins long before illness or injury strikes—in our homes, schools, neighborhoods, and places of work. The ability of individuals and families to lead healthy and productive lives is influenced by personal choices, as well as the experiences and the choices available to individuals, such as the conditions in the communities where we grow up and live. In fact, "an individual's ability to achieve good health is influenced by more than access to high-quality medical services; 80 percent of health outcomes are shaped by the social determinants of health – the conditions in which people are born, grow, work, live and age."[i]

For health care providers, screening is often the first step and can help in identifying these health-related social needs (HRSNs) to inform patients' treatment plans and make referrals to non-medical, community-based services and supports. Beyond screening and referrals, many providers are participating in programs to address HRSNs, including Accountable Health Communities and Food is Medicine programs. Providers are also investing in and connecting patients to community-based organizations (CBOs) which play a vital role in providing social supports to individuals and families.

Health-related social needs (HRSNs) are the immediate non-medical needs of an individual that contribute to health outcomes.[1] HRSNs are sometimes called upstream drivers or social determinants of health, and those terms are often used interchangeably. These needs can lead to lapses in coverage and access to care, higher downstream medical costs, and worse health outcomes, particularly for high-risk populations such as children, the elderly, and individuals in historically underserved communities. Evidence shows that addressing unmet HRSNs like homelessness, hunger, and exposure to violence can help reduce their harm to health.

A recent survey found that nearly two-thirds (63 percent) of primary care physicians screen their patients for at least one social need.[ii] A study found that in 2023, 88 percent of hospitals reported collecting HRSN data, with most using the data for internal purposes such as discharge planning (79 percent) and a portion collecting data routinely and in a structured format (58 percent) for coordination or exchange with other organizations, such as conducting referrals.[iii] While there are wide ranges in the prevalence of social needs screenings, it appears that screening prevalence overall is increasing.

Recent federal policy changes have created uncertainty among states, providers, public health organizations, and other providers of community-based services about coverage for HRSN screenings, referrals, and services. This issue brief explores the recent policy changes impacting HRSNs in Medicare and Medicaid and opportunities for states, providers, and other stakeholders to further these important screenings and services.

Medicaid

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 more likely to experience food and nutrition insecurity and other HRSNs. There are several policy approaches that offer states pathways to direct funding towards addressing HRSNs among Medicaid enrollees, such as Section 1115 waivers, In Lieu of Services (ILOS), state plan authorities, and section 1915 home and community-based services (HCBS).[1]

State Waivers

Many states have utilized 1115 waivers to address HRSNs, with CMS having approved 25 waivers with provisions related to HRSNs, including nutrition and housing services (see chart).[iv]

1115 waivers with specific HRSN provisions	
Infrastructure Funding or Delivery System Changes[2]	18 approved
Housing Supports	24 approved
Nutrition Supports	12 approved
Employment Supports	8 approved
Medical Respite	11 approved

Many of the current state 1115 waivers involve providing services to address upstream drivers of health, with some states including screenings and referrals as a part of identifying appropriate recipients and connecting them with services. For example, the Arkansas Health and Opportunity for Me (ARHOME) 1115 waiver established a Life360 HOMEs program which provides intensive care coordination and connection to services to different focus populations, including individuals with behavioral health needs who live in rural areas, individuals with high-risk pregnancies, and young adults at high risk for long-term poverty. The Life360 HOMEs program covers nutrition supports, case management, outreach and education for Life360 HOME beneficiaries. ARHOME expires at the end of 2026 and Arkansas' pending waiver request proposes to continue screening for and addressing HRSNs through success coaching and connections to community services.[v]

Additionally, NASDOH members Public Health Solutions and Healthy Alliance are designated Social Care Network (SCN) Lead Entities under New York's 1115 Waiver Amendment's SCN & HRSN Program. As SCNs, Public Health Solutions and Healthy Alliance build reliable networks of contracted organizations—including CBOs, local government units, FQHCs, health care systems, and more—to better enable HRSN screenings, using New York's Accountable Health Communities screening tool, for Medicaid Members and deliver social care services like housing, nutrition, transportation, and more. Contracted organizations of SCNs are reimbursed for screening Members under the Waiver.

In March 2025, CMS rescinded two guidances and the HRSN Framework that had outlined how states could use Medicaid and CHIP to address HRSNs. The framework had detailed allowable interventions like housing transition services, caregiver respite, home modifications, nutrition counseling, medically tailored meals, and nutrition prescriptions. In rescinding the guidances, CMS stated it will now review state applications for HRSN services on a case-by-case basis without reference to the prior documents.

[1] For more information on these authorities, see: Health Related Social Needs | Medicaid.

[2] Includes "infrastructure investments to support implementation and delivery of the new services and/or to make other delivery system changes. Waivers approved under the Biden HRSN framework specify approved infrastructure funding may be used for technology, development of business or operational practices, workforce development, and outreach, education, and stakeholder convening." For more information see: Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State | KFF.

Rescinding the guidances does not preclude the possibility of approving innovative waivers that address HRSNs, particularly upstream drivers such as food and nutrition. Further, while several existing 1115 waivers were approved under the HRSN Framework that was rescinded March 2025, the recission did not impact waivers that were previously approved. Five states currently have waivers pending that include HRSN provisions.[vi]

While 1115 waivers have become a prominent mechanism among states to advance efforts to screen for and address HRSNs, states and other stakeholders can also consider other authorities and mechanisms that may not previously have received as much attention. These could include ILOS and managed care contracts. The Kaiser Family Foundation's Survey of Medicaid Officials indicated that by 2021, almost half of state Medicaid agencies had established requirements for social needs screening in state Medicaid managed care contracts.[vii]

State proposals that are aligned with Administration priorities to address upstream drivers such as access to healthy food and nutrition could be of particular interest to CMS. Additionally, states and stakeholders should consider ILOS managed care contracts, and other authorities to advance HRSN screening and services.

Rural Health Transformation Fund

In response to the anticipated impact of Medicaid policies included in H.R. 1, the One Big Beautiful Bill Act, Congress established the $50 billion Rural Health Transformation Fund (RHTF) which can be used to support activities to address HRSNs in rural areas. The application instructions from CMS required states to describe SDOH in rural communities, including income levels, employment sectors, unemployment rates, education attainment, and availability of public transportation.[viii] In response, **many states included proposals to address HRSNs within their RHTF applications which are currently pending with CMS**:

- In Indiana's application, the state cited a recent health survey of Indiana residents which found that transportation barriers were the most frequently cited concern, with nearly 56 percent of rural residents identifying the cost of gasoline and financial expense of travel as barriers to care.[ix] CMS also suggested community health worker programs as opportunities to improve health outcomes for rural patients.[x]
- Alaska's application recognized a need for "nutrition programs addressing food insecurity and teaching healthy eating habits" and proposed to use funding to support community wellness centers to create dedicated spaces for physical activity and nutrition education.[xi]
- Georgia proposed increasing access to nutrition services for children with autism spectrum disorder (ASD) and dietician/nutritionist support for women between ages 19-44 who meet certain clinical requirements.[xii]
- Additionally, many applications include subgrant programs or call for partnerships with community-based organizations.

Focusing efforts to address HRSNs on specific populations can provide a meaningful path toward improving health outcomes among populations that face additional barriers to health.

The Rural Health Transformation Fund awards, which will be made by December 31, 2025, will provide an opportunity for states and stakeholders to implement their proposals to address HRSNs in rural communities that currently face additional barriers in accessing health care.

Medicare

In 2025, CMS also proposed and finalized several changes to how HRSN screenings and referrals are incentivized and reimbursed. These changes generally de-emphasized reimbursing for the process and time involved in screening. However, since completion of social risk screening was previously included as a quality measure for inpatient hospitals and other health care facilities, many providers have already invested resources in developing processes and capabilities to screen for and address HRSNs.

Medicare Payment Rules

In recent months, CMS finalized several changes that reduce the emphasis on social determinants of health across Medicare quality reporting programs and payment policies. Within multiple quality reporting programs, such as the Inpatient Hospital Quality Reporting Program and the Merit-based Incentive Payment System, CMS removed quality measures related to SDOH screening, which measured the percentage of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

With the removal of SDOH screening quality measures, incentives for screening and addressing for HRSNs may be more limited in Fee for Service Medicare, but stakeholders can look to Medicare Advantage for more opportunities to support seniors address HRSNs.

In the Physician Fee Schedule, CMS initially proposed eliminating the HCPCS code[3] for SDOH Risk Assessment (G0136), which reimburses clinicians in outpatient settings for conducting a validated assessment of a patient's social needs. However, stakeholder feedback led to the code's retention. Moving forward, the code will have a revised focus on utilization of a standardized, evidence-based assessment for physical activity and nutrition.

With the removal of SDOH screening quality measures[4] across Medicare quality reporting programs, incentives for screening and addressing for HRSNs may be more limited in Fee for Service Medicare, but stakeholders can look to Medicare Advantage (MA) for more opportunities to address HRSNs among seniors.

Medicare Advantage Supplemental Benefits

Within MA, special supplemental benefits for the chronically ill (SSBCI)[5] can be used to address upstream drivers. By offering a wider variety of supplemental benefits, MA plans have provided seniors with grocery assistance, non-medical transportation, home modifications, pest control, and in-home support services to help enrollees with activities such as dressing, eating, and housework. In 2024, the most common SSBCI offerings were food and produce, general supports for living, transportation for non-medical needs, pest control, and meals delivered at home or in a congregate setting.[xiii] Additional SSBCI

[3] Healthcare Common Procedure Coding System (HCPCS) is a set of codes for common medical procedures, services, and supplies in order to facilitate billing and reimbursement. For more information, see: Healthcare Common Procedure Coding System (HCPCS) | CMS.

[4] "Quality measures are tools that help [CMS] measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care." For more information, see: Quality Measures | CMS.

[5] SSBCIs are supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees in Medicare Advantage. For more information, see: DEPARTMENT OF HEALTH & HUMAN SERVICES.

offerings include indoor air quality equipment and services, home modifications, and complementary therapies offered alongside traditional medical treatment.[xiv]

MA supplemental benefits are critical to supporting the health outcomes of seniors and provide a model for how health care and social services can work together to support the health and wellbeing of all Americans. Currently, many of these benefits are limited to people with specific chronic conditions which excludes seniors without chronic conditions interested in services and supports to *prevent* chronic conditions. Allowing MA plans to provide high-quality supplemental benefits to additional MA enrollees could increase the number of seniors that receive support in addressing their HRSNs. In November 2025, CMS included a Request for Information (RFI) on how to improve and modernize Medicare Advantage in the 2027 Medicare Advantage and Part D Proposed Rule. This RFI includes a request for feedback on wellness and nutrition policies through a time-limited Centers for Medicare & Medicaid Innovation (CMMI) model or potential program-wide regulatory changes. Comments in response to the RFI are due by January 26, 2026.[xv]

CMS Innovation Center Models that Address HRSNs

CMMI tests new payment models for Medicare and Medicaid, seeking to increase value and reduce health care costs. **The mission of CMMI is in strong alignment with the goals of screening for and addressing HRSNs—to support value-based care that improves health outcomes.** CMMI has been a leader in addressing HRSNs, beginning with the Accountable Health Communities Model, in which multiple NASDOH members participated, as well as the MA Value-Based Insurance Design Model and dozens of other models that address HRSNs and SDOH.[xvi] The current CMS Innovation Center strategy emphasizes promoting evidence-based prevention, empowering people to achieve their health goals, and driving choice and competition.[xvii]

Ambulatory Specialty Model

As part of the Calendar Year 2026 Physician Fee Schedule, CMS created the Ambulatory Specialty Model (ASM),[xviii] which aims to improve prevention and upstream management of chronic disease to reduce avoidable hospitalizations and unnecessary procedures. The model focuses on specialists who commonly treat people in Original Medicare for heart failure or lower back pain in an outpatient setting across selected regions. The model includes Improvement Activity 1: "Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs Screening." This improvement activity requires annual attestation by ASM participants on activities related to enhancing connections to and relationships with primary care providers to ensure patients have received HRSN screenings. The five-year model will begin January 1, 2027.

Programs and demonstrations emphasizing value-based care continue to offer opportunities for addressing upstream drivers in order to improve health outcomes. Participation in voluntary models can expand the reach of these activities, and potential future mandatory models provide the potential for cementing the role of screening and addressing HRSNs in value-based care.

Cell and Gene Therapy (CGT) Access Model

Additionally, the new CGT Access Model aims to improve the lives of people living with rare and severe diseases by increasing access to potentially transformative treatments. This voluntary model for states and manufacturers is testing whether a CMS-led approach to developing and administering outcomes-based agreements (OBAs) for CGT increases Medicaid beneficiaries' access to treatments, improves health outcomes, and reduces health care costs and burden to state Medicaid programs. The initial focus of the model is on individuals with sickle cell disease (SCD), and participating states were announced in July of 2025.

As part of the model, states receive implementation funding to support required and optional model activities that involve staff/contractor time and infrastructure costs. Applicants were able to request implementation funding for several optional activities that would increase equitable access to gene therapy or promote comprehensive care, including for health-related social needs. States can also use these funds to partner with CBOs with a focus on providing services to individuals with SCD for providing services to address HRSNs.[xix]

CMMI continues to provide an opportunity for researching and gathering evidence on screening for and addressing HRSNs as a part of value-based care. Participation in voluntary CMMI models that involve screening for and addressing HRSNs provides an opportunity for stakeholders to receive reimbursement for these activities, while generating data and resources to support other entities. For example, NASDOH member Camden Coalition participated in the AHC model, which developed the PRAPARE screening tool and data showing the model reduced inpatient visits, emergency department visits, and reduced total health care expenditures.[xx]

Conclusion

Efforts to screen for and address HRSNs and SDOH remain possible and prevalent, including in Medicaid, the Rural Health Transformation Fund, Medicare Advantage, and CMMI. Appropriately addressing individuals' social determinants of health will require collaborative and innovative approaches across the private and public sectors.

The National Alliance to Impact the Social Determinants of Health (NASDOH) is committed to supporting the widespread adoption of effective policies and programs to address these upstream drivers of health, as well as health-related social needs (HRSNs). To accomplish this, NASDOH:

- supports flexibilities and waivers that allow states to provide non-medical services, building on existing medical services and supports, that improve health outcomes of Americans enrolled in Medicaid.
- supports expanding the availability of evidence-based supplemental benefits, including by creating a regulatory pathway for CMS to use gathered evidence to determine whether and how a benefit can be provided as a primarily health related benefit; implementing models to target high-value benefits; and establishing a best-practices repository for food, nutrition, and other SSBCIs with related research and operational guidance.
- has encouraged CMS to develop a new value-based care payment model that focuses on addressing the health and wellness of rural populations including through addressing non-medical drivers of health. NASDOH also encourages CMMI to adopt models that expand on existing evidence and learnings to build evidence for interventions impacting upstream drivers that could be more broadly adopted by payers and providers.

NASDOH's advocacy is intended to support the ability of stakeholders in addressing the upstream drivers of health. By working together, we can achieve meaningful improvements in the health and well-being of all Americans.

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