

Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations

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About the Association for Community Affiliated Plans

The Association for Community Affiliated Plans (ACAP) is a national trade association with represents not-for-profit Safety Net Health Plans. Collectively, ACAP plans serve more than twenty million enrollees, representing nearly half of all individuals enrolled in Medicaid managed care plans. For more information, visit www.communityplans.net.

About the Center for Health Care Strategies

CHCS is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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Executive Summary

The conditions in which we are born, live, learn, work, and play affect health in myriad ways—in some cases more than the medical care we receive. State Medicaid agencies have increasingly looked at ways to address these “social determinants of health” (SDOH) in an effort to provide more efficient care and improve health outcomes. They have begun to use a variety of approaches to support such work, thinking strategically about how best to align SDOH-related activities with other reforms, such as value-based purchasing, care transformation, and the development of larger partnerships focused on population health.

In this report, supported by the Association for Community Affiliated Plans (ACAP), the Center for Health Care Strategies (CHCS) examines Medicaid managed care contracts or requests for proposals (RFPs) in 40 states, in addition to 25 approved § 1115 demonstrations. CHCS compiled incentives and requirements relating to SDOH, identified common themes in the states’ approaches, and developed recommendations for federal policymakers, including the Centers for Medicare & Medicaid Services (CMS).

CHCS reviewed SDOH requirements and incentives through the following lenses:

- **Systems and Partnerships.** How is the state building the infrastructure and processes needed to address the interrelated health and social needs of low-income Americans? What types of SDOH-related activities are states requiring or incentivizing?
- **Authority and Funding.** Is the state using an existing flexibility in federal law, or requesting new, specific authority to provide traditionally non-covered services that address SDOH? How does the state finance SDOH-related work? How has the state ensured sustainability of this work beyond time-limited investments in delivery system reform?

Managed Care Contracts

In their contracts, states often require managed care organizations (MCOs) to screen for social needs and link members to needed community resources, but do not often establish specific expectations around the direct provision of services that address those needs. Nonetheless, states do have some flexibility under existing law, and CHCS’ review of managed care contracts suggests that states have, for the most part, not taken full advantage of this flexibility. CHCS found the following themes:

- **There is a growing focus on SDOH in state managed care contracts.** States most often encourage SDOH-related activities in care coordination and care management requirements, with some states beginning to integrate SDOH elements into quality assurance and performance improvement requirements.
- **Most states do not provide detail on how MCOs can use flexibilities under federal law to provide services that address SDOH.** Many state contracts restated federal authority allowing managed care plans to provide additional services, but did not provide additional clarification or detail on how this authority can be used for SDOH interventions.
- **Payment incentives linked to SDOH are not yet commonplace.** Some states have created specific financial incentives to address beneficiaries’ SDOH, but these activities are not common.

§ 1115 Demonstrations

CHCS reviewed key aspects of select § 1115 demonstrations relating to delivery system reform; healthy behavior incentives; and work or community engagement requirements. In reviewing these § 1115 demonstrations, CHCS identified a number of common themes:

- **There is a focus on enhancing care coordination and community partnerships to address SDOH.** Delivery system reform demonstrations often advance projects or programs that encourage screening for social needs, linkages to community resources that address SDOH, and partnerships with social service agencies and community-based organizations.
- **Payment incentives are increasingly deployed to address SDOH.** Some delivery system demonstrations discussed SDOH in the context of new or developing value-based payment (VBP) initiatives.
- **Healthy behavior incentives are not typically linked to SDOH.** Demonstrations that refer to healthy behavior incentives largely do not discuss the ways in which MCOs or the state can address the SDOH that influence health behaviors.
- **Two states allow health plans to help members meet eligibility requirements related to work and community engagement.** Demonstrations with work and community engagement requirements included standard requirements on connecting beneficiaries to community resources, but only two demonstrations allowed members to satisfy community engagement requirements through participation in an activity likely to be sponsored by a health plan.

Policy Recommendations

States have begun working on ways to address SDOH. However, additional guidance from CMS would support creativity and innovation at the state level and advance this work even further. Building on findings in its scan, CHCS developed several recommendations for federal policymakers to support continued development of SDOH-focused interventions:

1. **Make it easier for vulnerable populations to access needed health services and care coordination.** Effective SDOH strategies require health care organizations to engage beneficiaries over a sustained period of time. During its review and approval processes, CMS can suggest modifications to § 1115 demonstrations to help reduce eligibility churn and improve member engagement.
2. **Enhance agency collaboration at the federal level.** Targeted federal partnerships and cross-agency councils, such as the United States Interagency Council on Homelessness, can make collaboration on SDOH more commonplace.
3. **Provide additional guidance on addressing SDOH.** When CMS issues guidance to Medicaid agencies, states listen. States would benefit from guidance on ways to use *in lieu of* services and value-added services to provide upstream SDOH interventions; how to develop rates to address premium slide concerns; and how states can direct plans to use the quality assurance and performance improvement processes to test effective SDOH strategies.
4. **Approve § 1115 demonstrations that test strategies to address SDOH.** CMS can approve state § 1115 demonstrations that test the impact of targeted SDOH interventions in managed care.
5. **Support outcomes-based payment for SDOH interventions.** Pay-for-success models allow states and MCOs to pay only for “what works.” Building on precedent established by the Social Impact Partnerships to Pay for Results Act (SIPRA), CMS can identify ways in which the pay for success model can be adapted to Medicaid managed care and enable investments in SDOH.

CHAPTER 2

Introduction

SDOH disproportionately affect low-income individuals, many of whom are served by Medicaid.¹ Consequently, Medicaid health plans, providers, and state agencies increasingly recognize the importance of SDOH as key drivers to patients' health status and health care costs. Innovative Medicaid health plans are at the forefront of examining how they can leverage their considerable flexibility to help their members and providers address these factors. Plans can link to existing community resources and invest in new ones, like housing, that will better meet members' needs.

Within this context, state Medicaid agencies are using policy levers to drive the adoption of strategies that will address SDOH, improve outcomes, and lower costs. Two key levers used by Medicaid include: (1) demonstration projects under Social Security Act § 1115 ("§ 1115 demonstrations"); and (2) managed care contracts that deploy a variety of requirements and direct or indirect financial incentives to drive the uptake of SDOH interventions.

For this project, CHCS examined how, through managed care contracts and § 1115 demonstrations, states required or incentivized different entities—regional partnerships, hospitals, provider organizations, MCOs, and ACOs—to address SDOH. CHCS reviewed managed care contracts and approved § 1115 demonstrations, current as of November 2018, and catalogued the requirements and incentives. In doing so, CHCS used the following lenses:

- **Systems and Partnerships.** How is the state building the infrastructure and processes needed to address the interrelated health and social needs of low-income Americans? What types of SDOH-related activities are states requiring or incentivizing?
- **Authority and Funding.** Is the state using an existing flexibility in federal law, or requesting new, specific authority to provide traditionally non-covered services that address SDOH? How does the state

finance work related to SDOH? How has the state ensured sustainability of this work beyond time-limited investments in delivery system reform?

ACAP and CHCS intend for this report to accelerate and strengthen the numerous innovative efforts currently underway by health plans, states, provider organizations, and policymakers. While many reports and resources aim to help providers design work flows and tools for innovative SDOH approaches, this report addresses how states have implemented policies to incentivize this work and what federal policymakers can do to pave a path for this work—with an emphasis on managed care contracts and § 1115 demonstrations.

Methodology

CHCS reviewed managed care contracts in all 39 states with risk-based managed care programs, in addition to one state about to implement a managed care program in November 2019: North Carolina. In states with multiple managed care products, CHCS reviewed the most general model managed care contract that was publicly available or available through CHCS or ACAP contacts in the state. In some cases, such as for review of managed care documents in North Carolina and Washington, D.C., CHCS reviewed requests for proposal (RFP) relating to an operational date in the future. In states with separate behavioral health and physical health managed care programs, CHCS reviewed the physical health contract, which tends to be more comparable to fully-integrated managed care contracts. CHCS did not review dental managed care contracts, behavioral health organization contracts, or contracts that solely relate to managed long-term services and supports or dual eligible populations.

In addition, CHCS reviewed a subset of approved § 1115 demonstrations:

- **§ 1115 demonstrations related to delivery system reform.** CHCS used Kaiser Family Foundation’s waiver tracker² to identify this initial pool of demonstration projects, reviewing only those demonstrations in states with Medicaid managed care.
- **Additional § 1115 demonstrations that implemented a managed care model.** CHCS reviewed § 1115 demonstrations in Hawaii and Delaware because each implemented managed care models.
- **§ 1115 demonstrations that implemented incentives for healthy behavior.** Although health behaviors and SDOH are distinct concepts, CHCS reviewed these demonstrations because of the relationship between SDOH and health behaviors.
- **§ 1115 demonstrations that implemented community engagement and work requirements.** CHCS reviewed these demonstrations for specific references to health plan activities that would help members meet community engagement and work requirements.
- **The Demonstration Project for Case Management Services in Flint, Michigan.** CHCS reviewed this § 1115 demonstration because of its focus on lead poisoning.

For a full list of reviewed § 1115 demonstrations and managed care contracts, see [Appendix 1](#).

CHCS reviewed activities related to care coordination, partnerships, and traditionally non-covered services that address SDOH. During each review, CHCS searched for key terms, such as:

- Social needs;
- Social determinants of health;
- Community resources;
- Community and social supports;
- Housing;
- Homeless;
- Food;
- Population health;
- *In lieu of services*; and
- Value-added services.

Note, this is not an exhaustive review. CHCS relied solely on the examined documents and did not contact state officials to verify the information collected. Given the nature of the documents examined and the unique terminology in each state Medicaid program, CHCS may have inadvertently excluded some SDOH-related items.

Exclusions

CHCS chose to focus on activities outside the provision of established Medicaid-covered services. Therefore, CHCS excluded requirements related to Medicaid benefit categories that address SDOH, including:

- **Home- and Community-Based Services (HCBS).** This category includes HCBS programs and services that have been implemented—or largely could have been implemented—through a waiver under Social Security Act § 1915(c) or a state plan amendment under Social Security Act § 1915(i) or § 1915(k). These HCBS programs can target individuals with an institutional level of care or target a specific population, such as individuals experiencing homelessness, substance use disorder (SUD), or serious mental illness. HCBS programs may include services such as supportive housing services (absent room and board expenses), employment services, home modifications, and home-delivered meals.
- **Case Management Services.** Defined under Social Security Act § 1915(g)(2), this category of state plan services assists individuals in gaining access to needed medical, social, educational, and other services. To the extent that § 1115 demonstrations create specific case management programs with an SDOH focus, CHCS reviewed those programs.
- **Health Homes.** Health home services, authorized under Social Security Act § 1945, include referral to community and social support services, if relevant. States typically provide health home services through a state plan amendment.
- **Non-emergency medical transportation (NEMT).** Under 42 C.F.R. § 431.53, state Medicaid programs must provide NEMT services. To the extent that a demonstration project or managed care contract

discusses transportation outside of the established NEMT benefit, CHCS reviewed those provisions. CHCS did not track waivers of NEMT requirements.

States have implemented many important SDOH-related programs outside the activities and documents highlighted in this report. CHCS did not review the following initiatives, to the extent that they are not referenced in current managed care contracts and demonstrations. The scope of CHCS's review is not intended to downplay these important efforts:

- **Value-based payment (VBP) initiatives detailed outside of managed care contracts and demonstrations.** For example, Minnesota published requests for proposals for integrated health partnerships that discuss requirements and incentives relating to SDOH. CHCS did not review these types of RFPs as a part of this project.
- **State Innovation Model (SIM) initiatives.** For example, CHCS did not review accountable communities for health³ initiatives that were implemented through SIM and not referenced in § 1115 demonstrations or managed care contracts. CHCS did review SIM initiatives that were included in § 1115 demonstrations, such as Washington's accountable communities of health (ACHs).
- **Accountable Health Communities Model.** CMS is currently operating a five-year program providing support to community bridge organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their health-related social needs (i.e., housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs). This model may inform other state initiatives. For example, the model incorporates a health-related social needs tool.⁴
- **MCO incentives that do not specifically refer or relate to SDOH.** CHCS did not review incentive arrangements that may indirectly influence MCOs to invest in SDOH, such as incentive measures tied to health outcomes.
- **State organization changes related to SDOH.** For example, two states have started state offices dedicated to SDOH: the Office of Healthy Opportunities in Indiana and the Bureau of Social Determinants of Health in New York.

Overview:

State Activities Related to SDOH

Table 1 provides an inventory of SDOH-related activities and domains from the managed care contracts and § 1115 demonstrations reviewed under this project. This table summarizes the context in which requirements and incentives addressed SDOH and which SDOH domains were referenced in the documents.

SDOH-Related Activities:

Reviewers categorized requirements and incentives relating to SDOH according to the following categories:

- **Additional Services:** Examples include provisions relating to value-added services and *in lieu of* services, as well as similar types of flexible services created through § 1115 demonstrations.
- **Partnerships with Community-Based Organizations (CBOs) and Social Service Agencies.** In this table, CHCS noted when contracts and demonstrations created partnerships with CBOs and social service agencies.
- **Value-Based Payment (VBP) Initiatives.** While many states include requirements around VBP, CHCS notes in this table when VBP initiatives expressly relate to SDOH.
- **Care Coordination and Management.** In this table, CHCS notes whether a state's managed care contract includes a care coordination and management provision relating to SDOH. This category includes activities related to screening for social needs and connecting members to community resources.
- **Work/Community Engagement Requirements.** In this table, CHCS notes whether the state has an approved community engagement requirement. CHCS provides footnotes for those demonstrations that include qualifying activities that can be provided by a health plan.

- **Delivery System Reform.** In this table, CHCS notes whether the state has a delivery system reform demonstration. Footnotes indicate a specific delivery system reform partnership, project, or incentive that relates to SDOH, usually with a focus on care coordination and management.
- **Healthy Behavior Incentives.** In this table, we note whether the state has a healthy behavior incentive program implemented through a § 1115 demonstration or a managed care contract.
- **MCO Payment Incentive.** This category relates to incentive arrangements, withhold arrangements, and penalties that directly relate to SDOH.
- **Quality Assessment & Performance Improvement (QAPI).** In this table, we note whether the contract or demonstration requires activities relating to SDOH in the context of QAPI requirements.

SDOH-Related Topics:

In this table, CHCS notes particular SDOH domain areas of interest in the state.

- **Employment;**
- **Education;**
- **Food;**
- **Housing;**
- **Transportation; and**
- **Violence/Abuse.**

Because state contracts often discussed SDOH-related concepts such as wellness, disparities, and community health workers, CHCS also notes states with a focus on these SDOH-related concepts.

- **Community Health Workers (CHWs);**
- **Disparities;**
- **Justice-Involved Population; and**
- **Wellness.**

Table 1

| State Activities Related to SDOH | | | | | | | | | | | | | | |
|----------------------------------|--|-----------------|--|------|---------------------------------|-----------------|----------------------------------|---|--------------------------------------|-------------------------------|-----------------------|--|--|------------|
| | SDOH-Related Activities | | | | | | | | | | SDOH-Related Topics | | | |
| | Additional Services | | Partnerships with CBOs & Social Service Agencies | | Value-Based Payment Initiatives | | Care Coordination and Management | Work / Community Engagement Requirement | Delivery System Reform Demonstration | Healthy Behavior Incentives | MCO Payment Incentive | Quality Assessment & Performance Improvement | SDOH Domains or SDOH-Related Concepts | |
| | MCO | 1115 | MCO | 1115 | MCO | 1115 | | | | | | | | |
| AR | State does not have risk-based managed care, but uses Medicaid funds for Qualified Health Plan premiums. | | | | | | | X ⁵ | | | | | | Employment |
| AZ | | | | | X ⁶ | X ⁷ | X ⁸ | | X ⁹ | X ¹⁰ | | | Education, Housing, Justice-Involved Populations, Wellness, Violence/Abuse | |
| CA | | | | X | | X ¹¹ | X ¹² | | X ¹³ | | | X ¹⁴ | CHWs, Disparities, Food, Housing, Wellness | |
| CO | | | X ¹⁵ | | | | X ¹⁶ | | | X ¹⁷ | | | Wellness | |
| DC | X ¹⁸ | | | | | | X ¹⁹ | | | | | X ²⁰ | Disparities, Wellness | |
| DE | X ²¹ | | | | | | X ²² | | | | | | Housing, Wellness | |
| FL | X ²³ | X ²⁴ | | | | | X ²⁵ | | X | X ²⁶ | | | Food, Wellness | |
| GA | | | | | | | | | | | | | | |
| HI | | | | | | | X ²⁷ | | | | | X ²⁸ | Housing | |
| IA | X ²⁹ | | X ³⁰ ³¹ | | X ³² | | X ³³ | | | X ³⁴ ³⁵ | | | Wellness, Education | |

State Activities Related to SDOH

| State Activities Related to SDOH | | | | | | | | | | | | | |
|----------------------------------|-------------------------|-----------------|--|-----------------|---------------------------------|-----------------|----------------------------------|---|--------------------------------------|-----------------------------|-----------------------|--|--|
| | SDOH-Related Activities | | | | | | | | | | | SDOH-Related Topics | |
| | Additional Services | | Partnerships with CBOs & Social Service Agencies | | Value-Based Payment Initiatives | | Care Coordination and Management | Work / Community Engagement Requirement | Delivery System Reform Demonstration | Healthy Behavior Incentives | MCO Payment Incentive | Quality Assessment & Performance Improvement | SDOH Domains or SDOH-Related Concepts |
| | MCO | 1115 | MCO | 1115 | MCO | 1115 | | | | | | | |
| IL | | | X ³⁶ | | | | X ³⁷ | | | | | X ³⁸ | |
| IN | X ³⁹ | | | | | | X ⁴⁰ | X ⁴¹ | | X ⁴² | | | Employment |
| KS | X ⁴³ | | X ⁴⁴ | | | | X ⁴⁵ | | X | | | X ⁴⁶ | CHWs, Food, Education, Employment, Housing, Transportation, Violence/Abuse |
| KY | | | | | | | | X | | X ^{47 48} | | | Wellness |
| LA | X ⁴⁹ | | X ⁵⁰ | | | | X ⁵¹ | | | | | | Housing |
| MA | X ⁵² | X ⁵³ | X ⁵⁴ | X ⁵⁵ | | X ⁵⁶ | X ⁵⁷ | | X ⁵⁸ | X ⁵⁹ | | | Housing, Education, Violence/Abuse |
| MD | X ⁶⁰ | | X ⁶¹ | | | | X ⁶² | | | | | | Housing |
| MI | | | X ^{63 64} | | | | X ⁶⁵ | | | X ⁶⁶ | | X ⁶⁷ | CHWs, Disparities, Employment, Food, Transportation |
| MN | X ⁶⁸ | | X ⁶⁹ | | | | X ⁷⁰ | | | | | | CHWs, Disparities |
| MO | | | X ⁷¹ | | | | | | | X ⁷² | | | |
| MS | X ⁷³ | | | | | | X ⁷⁴ | | | | | | |

| State Activities Related to SDOH | | | | | | | | | | | | | |
|----------------------------------|-------------------------|------------------|--|------------------|---------------------------------|------------------|----------------------------------|---|--------------------------------------|-----------------------------|-----------------------|--|---|
| | SDOH-Related Activities | | | | | | | | | | | | SDOH-Related Topics |
| | Additional Services | | Partnerships with CBOs & Social Service Agencies | | Value-Based Payment Initiatives | | Care Coordination and Management | Work / Community Engagement Requirement | Delivery System Reform Demonstration | Healthy Behavior Incentives | MCO Payment Incentive | Quality Assessment & Performance Improvement | SDOH Domains or SDOH-Related Concepts |
| | MCO | 1115 | MCO | 1115 | MCO | 1115 | | | | | | | |
| NC | X ⁷⁵ | X ⁷⁶ | X ⁷⁷ | X ⁷⁸ | X ⁷⁹ | X ⁸⁰ | X ⁸¹ | | X ⁸² | X ⁸³ | X ⁸⁴ | X ⁸⁵ | Housing, Food, Transportation, Violence/Abuse |
| ND | X ⁸⁶ | | | | | | | | | | | | |
| NE | X ⁸⁷ | | X ⁸⁸ | | | | X ⁸⁹ | | | | | | Food |
| NV | | | | | | | | | | | | | |
| NH | | | X ⁹⁰ | X ⁹¹ | | | X ⁹² | X | X ⁹³ | | | | CHWs, Justice-Involved Populations, Wellness |
| NJ | X ⁹⁴ | | X ⁹⁵ | | | | X ⁹⁶ | | X | | | | |
| NM | | | | | X ⁹⁷ | | X ⁹⁸ | | X | X ⁹⁹ | X ¹⁰⁰ | | CHWs, Housing, Wellness |
| NY | X ¹⁰¹ | | X ¹⁰² | X ¹⁰³ | | X ¹⁰⁴ | X ¹⁰⁵ | | X ¹⁰⁶ | | | | CHWs, Disparities, Education, Food, Housing, Wellness |
| OH | | | | | | | X ¹⁰⁷ | | | | | X ¹⁰⁸ | Disparities, Wellness |
| OR | X ¹⁰⁹ | X ¹¹⁰ | X ¹¹¹ | X ¹¹² | | X ¹¹³ | X ¹¹⁴ | | X ¹¹⁵ | | | X ¹¹⁶ | CHWs, Disparities, Food, Wellness |
| PA | X ¹¹⁷ | | X ¹¹⁸ | | | | X ¹¹⁹ | | | | | X ¹²⁰ | Housing, Wellness |

State Activities Related to SDOH

| State Activities Related to SDOH | | | | | | | | | | | | | |
|----------------------------------|-------------------------|------------------|--|------------------|---------------------------------|------------------|----------------------------------|---|--------------------------------------|-----------------------------|-----------------------|--|--|
| | SDOH-Related Activities | | | | | | | | | | | SDOH-Related Topics | |
| | Additional Services | | Partnerships with CBOs & Social Service Agencies | | Value-Based Payment Initiatives | | Care Coordination and Management | Work / Community Engagement Requirement | Delivery System Reform Demonstration | Healthy Behavior Incentives | MCO Payment Incentive | Quality Assessment & Performance Improvement | SDOH Domains or SDOH-Related Concepts |
| | MCO | 1115 | MCO | 1115 | MCO | 1115 | | | | | | | |
| RI | X ¹²¹ | X ¹²² | | X ¹²³ | X ¹²⁴ | X ¹²⁵ | X ¹²⁶ | | X ¹²⁷ | X ¹²⁸ | | | CHWs, Housing, Food, Violence/ Abuse, Wellness |
| SC | X ¹²⁹ | | | | | | X ¹³⁰ | | | | | X ¹³¹ | Wellness |
| TN | X ¹³² | | X ¹³³ | | | | X ¹³⁴ | | X | X ¹³⁵ | | X ¹³⁶ | Housing, Food, Employment, Wellness |
| TX | X ¹³⁷ | | X ¹³⁸ | | | X ¹³⁹ | X ¹⁴⁰ | | X ¹⁴¹ | | | | CHWs, Housing, Food, Wellness |
| UT | | | X ¹⁴² | | | | X ¹⁴³ | | | | | | |
| VA | | | X ¹⁴⁴ | | | | X ¹⁴⁵ | | | X ¹⁴⁶ | | | Housing, Violence/ Abuse |
| WA | | | X ¹⁴⁷ | X ¹⁴⁸ | | | X ¹⁴⁹ | | X ¹⁵⁰ | | | | CHWs, Justice-Involved Populations, Housing, Education, Employment, Wellness |
| WI | X ¹⁵¹ | | X ¹⁵² | | | | X ¹⁵³ | X | | X ¹⁵⁴ | | | Employment, Violence/Abuse, Wellness |
| WV | X ¹⁵⁵ | | | | | | X ¹⁵⁶ | | | | | X ¹⁵⁷ | Employment, Wellness |

Managed Care Contracts: Findings

Thirty-nine, and soon to be 40, states provide services to Medicaid beneficiaries through risk-based managed care plans. The parameters of those arrangements are defined by federal rules, recently updated in 2016.¹⁵⁸ Building upon flexibilities in these federal rules, states have increasingly directed or incentivized MCOs to address their beneficiaries' SDOH. Managed care contracts necessarily incorporate federal rules and require MCOs to perform care coordination activities that address SDOH, such as coordination with community and social support providers. States, however, can go beyond the language in the regulations to require MCOs to address SDOH—either generally or to focus on certain issues that they have identified as particularly relevant.

CHCS' scan sought to identify those provisions specifically related to beneficiaries' SDOH, and how states have used contract terms to create incentives or establish requirements for MCOs to address them. This inventory includes discrete contract terms such as: requiring screening for SDOH-related needs; linking members to providers of non-medical, SDOH-related services; requiring cooperation with other state and federal initiatives that address beneficiaries' SDOH; and authorizing reimbursement for elements of the health care workforce that are focused on SDOH.

Through its review of managed care contracts and RFPs, CHCS noted several broad themes:

- **Variation in State Approaches.** States' approaches to addressing members' SDOH varied in how much attention was paid to SDOH, as well as how narrowly or broadly the contract defined SDOH.
- **Coordination with Other Initiatives.** Fifteen states engaging in other health care reform efforts cited that work in their MCO contracts and included requirements for MCOs to align with those other initiatives to address their members' SDOH.
- **Care Coordination Terms.** Thirty-five states built upon care coordination requirements in federal rule. These contract sections direct MCOs to screen for members' social needs and permit MCOs to engage in coordination with providers of non-medical, SDOH-related services.
- **Quality Assessment and Performance Improvement (QAPI).** Thirteen states also used their required QAPI terms to focus MCO efforts on members' SDOH, which not only allow the MCOs flexibility to design interventions to address them, but also support an evidence base for future SDOH-focused work.
- **Member Engagement, Health Equity, and Other Approaches.** States have also required MCOs to consider SDOH in a variety of other contexts, including improving member engagement, addressing health equity, and providing their services in a culturally competent manner.
- **Additional Services.** Many contracts restated federal authority for *in lieu of* services and value-added services, but did not provide additional clarification or detail on how these services could be used to address SDOH.
- **Contract Provisions Related to Payment.** States are beginning to require plans to address SDOH through VBP initiatives and include SDOH-related measures in MCO incentive and withhold arrangements, but these activities are not common.
- **Community Investment.** Two states require or incent plans to invest in local communities with a percentage of their profits or revenues.

This section contains several tables, including examples of a state's use of authority to grant flexibility to MCOs to address members' SDOH. The examples show the range of ways that states address those requirements in their contracts. Some are notable because they represent an innovative approach to addressing members' SDOH, or focus on a particular question that is not widely highlighted in contracting. The tables are not comprehensive of all relevant approaches—rather, they reflect the variety of contracting approaches that states have taken, and present the range of contracting levers that states have used to focus on SDOH.

Systems and Partnerships

In this section, CHCS explores how states have directed MCOs to develop systems, processes, and partnerships that address SDOH. Specifically, CHCS examines the ways in which states have built upon existing requirements in federal law to define: (1) how MCOs should partner with outside organizations that address SDOH; (2) how services should be coordinated across disciplines; (3) what obligations MCOs have to screen for social needs and address SDOH; and (4) how this work should factor into quality improvement activities.

State approaches vary.

There is substantial variation among states' MCO contracts with respect to addressing beneficiaries' SDOH. **Kansas**, for example, states that “[t]he goal [of its 2019-2023 reprocurement is] to help Kansans achieve healthier, more independent lives by providing services and supports for Social Determinants of Health and Independence.”¹⁵⁹ Kansas Medicaid includes the theme throughout the RFP, in sections devoted to the various funding authorities, required care coordination terms, and the creation of a “community service coordinator,” who acts as a hub for connecting members to needed SDOH service providers. On the other hand, **Georgia's** model Medicaid managed care contract includes language that MCOs “place strong emphasis” on some services related to SDOH, but does not specify steps that contractors must take with their providers and members.¹⁶⁰ This is not to say that such work is not happening—only that Georgia does not address it through MCO contracting.

States typically discuss SDOH in select areas of the contract and rarely develop a comprehensive SDOH strategy. One notable exception is **North Carolina**. Its recent RFP directs SDOH activities in many of the categories discussed in this section: care coordination and management requirements; quality

and performance improvement; value-based payment; medical loss ratio (MLR) calculations; and additional services. In addition, the state creates three specific tools for MCOs to use: (1) the *North Carolina Resource Platform*, a comprehensive database and referral platform with a “closed loop referral” capacity; (2) the North Carolina “Hot Spot” Map,¹⁶¹ which uses geographic information system technology to map resource needs and other indicators across the state; and (3) standardized screening questions for “health-related resource needs,” with targeted questions on food, housing and utilities, transportation, and interpersonal safety.¹⁶²

States also vary in the specificity used to describe SDOH activities in their MCO contracts. Some states take broad approaches requiring MCOs to address SDOH as a whole, or to work with state services established to address them without specifying particular SDOH. Others specify areas that they would like addressed by MCOs. **New Mexico's** MCO contract contains extensive terms requiring MCOs to maintain a “full-time Supportive Housing Specialist” to provide training to the MCOs' care coordination teams. **Minnesota's** contract requires MCOs to coordinate with the state Department of Health to support the Minnesota Community Measurement (MNCM) initiative, and requires MCOs to retain race and ethnicity data and provide the data to the state to further MNCM's goals.

States also differ in terms of target populations and SDOH priorities, and may require MCOs to consider the social needs of only specific high-cost, high-need populations. States have used MCO contracting terms to direct their MCOs' efforts toward issues of housing, food insecurity, involvement with the criminal justice system, racial disparities in health care, and employment, alongside more broadly defined SDOH initiatives. Table 2 includes several MCO contract terms that relate to specific SDOH domains.

Table 2

| Examples of Medicaid Managed Care Activities Related to SDOH | |
|--|--|
| Employment | |
| KS ¹⁶³ | Encourages MCOs to consider supports to bridge independence, such as job counseling. |
| WV ¹⁶⁴ | Requires the MCO to assist members with workforce opportunities and identify behavioral health or medical needs preventing employment, and use care management staff to address barriers to employment. |
| Housing | |
| MD ¹⁶⁵ | Requires the MCO to identify homeless individuals and link them with services. |
| MA ¹⁶⁶ | Requires the MCO to provide services to homeless individuals through the Community Support Program for Chronically Homeless Individuals and interface with the Social Innovation Financing for Chronic Homelessness Program, a Housing First model. |
| NM ¹⁶⁷ | Requires the MCO to employ a full-time Supportive Housing Specialist to provide training and technical assistance to care coordinators. |
| RI ¹⁶⁸ | Requires the MCO to connect members with housing supports and develop strategies to identify resources to support members experiencing homelessness. |
| Food Security | |
| FL ¹⁶⁹ | Requires MCOs to offer the “Healthy Start” services. Through “Mom Care” and “Healthy Start Coordinated System of Care” programs, MCOs provide connections to community resources, including resources related to nutrition, e.g., assistance with benefits under the Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC) and nutritional counseling. |
| NE ¹⁷⁰ | Requires the MCO to ensure coordination between its providers and the WIC program. |

Contracts can encourage coordination with other state efforts.

Because of the many broader health care reform efforts taking place at the state level (e.g., value-based payment initiatives, State Innovation Models awards, Accountable Communities for Health, Accountable Care Organization models, etc.), alignment of various initiatives is a key theme among policymakers and other stakeholders in the health care sector. These initiatives frequently focus on addressing beneficiaries’ SDOH, and states have attempted to link these initiatives through their MCO contracting. This formal alignment: (1) empowers the MCOs and other initiatives to bolster each other’s impact on beneficiaries’ health; (2) allows the MCOs to support or coordinate with the delivery of SDOH-related activities that are funded by non-Medicaid funds; and (3) further safeguards against duplication of services.

Iowa, for example, developed a robust SIM program, aimed in part at addressing Medicaid beneficiaries’ SDOH through the establishment of Community and Clinical Care regions to address beneficiaries’ social needs, and the development of a standard health risk assessment that incorporates SDOH. Iowa’s managed care contract requires MCOs to “obtain agency approval of an approach to support” Iowa’s SIM project. Similarly, Michigan’s contracts require MCOs to “participate in [SIM] initiatives,” including coordinating with Community Health Innovation Regions, a collaborative model designed to drive population health improvements that the state developed under SIM. See examples of additional state partnerships in Table 3.

Table 3

| Examples of Partnerships for Delivery System Reform | |
|---|--|
| CO ¹⁷¹ | Requires the MCO to establish and sustain relationships with “Health Neighborhoods” in its region, including establishing referral processes, promoting utilization, and identifying and addressing access barriers. Additionally, the MCO must demonstrate an understanding of health disparities and inequities in its region and work with members, providers, and stakeholders to address these disparities and promote the health of local communities and populations. |
| MI ¹⁷² | Requires the MCO to participate in State Innovation Model initiatives, including Community Health Innovation Regions. |
| NC ¹⁷³ | Requires the MCO to authorize enrollment into the Opportunities for Health Pilot Program and coordinate with the Lead Pilot Entity on tracking pilot services. |

Thirty-five states discuss SDOH or SDOH-related activities in the context of care coordination and management requirements.

CHCS found that most SDOH-related activities were in the care coordination and management sections of state managed care contracts. Most SDOH-related activities can be categorized as either screening or linkages (see state examples in Tables 4 and 5).

1. **Screening.** Under federal rules, an MCO must make a best effort to conduct an initial screening of each member’s needs—within 90 days of the effective date of enrollment for all new members. If the initial attempt to contact the enrollee is unsuccessful, the MCO must make other attempts to complete the screening.¹⁷⁴

When individuals have been identified as having long-term services and supports or special health care needs, the MCO must “comprehensively assess” and develop care plans for those members—a process that often involves an analysis

of social needs. **Iowa**, for example, requires that MCOs use a screening tool that “assess[es] the member’s physical, social, functional, and psychological status” that will “determine the need for . . . any other . . . community services” required by the member.¹⁷⁵ **Massachusetts** requires its MCOs to develop care plans for their members that specifically address identified needs, including housing, employment status, food security, and risk of abuse.¹⁷⁶

Care coordination and management processes often rely on risk stratification of members, based on screening information, among other data. For example, **Ohio** requires the MCO to consider SDOH and safety risk factors when developing its risk stratification level framework for the purpose of targeting interventions and allocating resources based on member needs. Similarly, **Michigan** requires MCOs to maintain a multi-year plan to incorporate SDOH into data analytic processes that support population health management.¹⁷⁷

Table 4

| Examples of MCO Social Needs Screening Requirements | |
|---|--|
| KS ¹⁷⁸ | Requires the MCO to provide a plan to assess the health and needs of members, and provides an example of a screening tool. |
| MO ¹⁷⁹ | Requires the MCO to screen for legal issues and assistance in planning for alternative living arrangements for individuals subject to abuse or abandonment for certain populations, such as pregnant women, children with elevated lead levels, and individuals with certain chronic conditions. |
| NC ¹⁸⁰ | Requires the MCO to use standardized screening questions developed by the state to identify members with unmet health-related resource needs. |
| OR ¹⁸¹ | Requires the MCO to use assessments to understand the member population and ensure that services are provided in a culturally and linguistically appropriate manner to increase member engagement and positive health outcomes. |

2. **Linkages and Coordination.** Under federal rules, MCOs must also coordinate their services with those provided by community and social support agencies.¹⁸² Building upon this concept, states often require MCOs to refer and link members to community resources, and require MCOs to develop

certain tools to support this function. For example, **Nebraska’s** MCO contract requires that MCOs deploy a “tool accessible to their care management staff” that manages information on community resources that can help address their members’ SDOH needs.¹⁸³

Table 5

| Linkages, Referrals, and Coordination with Social Service Providers | |
|---|--|
| DE ¹⁸⁴ | Requires the MCO to identify members who may benefit from wellness programs, covered by the MCO or available through community organizations, and to provide appointment assistance and linkages with these services. |
| IA ¹⁸⁵ | Requires the MCO to coordinate with state agencies and community-based organizations to support community-based efforts. Examples of partnerships include the Department of Education, Juvenile Justice Services, and community-based agencies. |
| KS ¹⁸⁶ | Requires the MCO to have a Community Service Coordinator available to members who will act as the single point of contact for the member and will ensure linkage and referral to community resources and non-Medicaid supports. |
| MA ¹⁸⁷ | Requires the MCO to contract with the state's Housing First program, a Social Innovation Financing program. |
| NH ¹⁸⁸ | Requires the MCO to develop relationships that actively link members with other state, local, and community programs that may provide or assist with related health and social services to members, including but not limited to justice systems, schools, family organizations, youth organizations, consumer organizations, faith-based organizations, and the court system. |
| NJ ¹⁸⁹ | Requires the MCO to establish a Community/Health Education Advisory Committee to solicit representatives from community agencies that do not offer covered services, but are important to the health and well-being of members. |
| TX ¹⁹⁰ | Requires the MCO to have a systematic process for working with community organizations and connecting members with services that will support health and well-being. Also requires the MCO to provide member advocates to assist members in accessing community resources. |
| VA ¹⁹¹ | Requires the MCO to work with other state agencies and community organizations to address population health concerns. |
| WA ¹⁹² | Requires the MCO to coordinate with and enroll members in social service programs available through other state agencies such as the Department of Health, Department of Corrections, and Department of Vocational Rehabilitation. |

States use QAPI terms to address SDOH.

States have also included contract language focusing on SDOH in the context of QAPI requirements. Federal rules¹⁹³ require that states include instructions in their MCO contracts to “establish and implement an ongoing comprehensive quality assessment and performance improvement program.” The federal regulations further require that the QAPI section of an MCO contract include a section on performance improvement projects, which must be designed to “achieve significant improvement . . . in health outcomes and enrollee satisfaction,” and must be structured in a way to facilitate evaluation.

Thirteen states have used their QAPI requirements to encourage MCOs to address members’ SDOH. **Washington, D.C.**’s RFP contains a section requiring MCOs to identify disparities in health outcomes between subpopulations of their members and develop a plan with measurement and evaluation components as part of their QAPI programs.¹⁹⁴ **Michigan** leaves more flexibility for its contracted MCOs, but its contract points to the state’s Population Health Management efforts in requiring that MCOs consider the goals of those activities when designing their QAPI plans.

Table 6 includes several examples of innovative state approaches to quality improvement and describes briefly how these states incorporated members’ SDOH into their contracting.

Some states require MCOs to consider SDOH in health equity and member engagement strategies.

States have also chosen to engage MCOs in addressing members’ SDOH through a variety of other means. Table 7 includes examples of how states have used member engagement and cultural competency terms to require MCOs to focus on members’ SDOH.

Table 6

| State SDOH-Related Quality Assessment and Performance Improvement Measurement Requirements | |
|---|--|
| CA¹⁹⁵ | Requires the MCO to include proposed interventions that address health disparities in its quality improvement plans. |
| DC¹⁹⁶ | Requires the MCO to identify health disparities and SDOH across subpopulations and to develop a plan and timeline to remediate these disparities through targeted interventions in the MCO's QAPI program. Also requires a performance measurement and evaluation component to accompany this plan of action. |
| MI¹⁹⁷ | Requires the QAPI plan to (1) analyze data, including SDOH, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to enrollees; and (2) develop system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of emergency services. |
| NC¹⁹⁸ | Requires a QAPI plan to include the following elements: <ul style="list-style-type: none"> – Mechanisms to assess and address health disparities, including findings from the disparity report that MCOs are required to develop; and – The MCO's contributions to health-related resources must be in alignment with improvement in particular health outcomes outlined in the quality strategy. |
| OH¹⁹⁹ | Requires a quality indicator that is used when the MCO conducts outreach, educates the member, or makes referrals/coordination with physical, behavioral, or social services. Also requires the MCO to develop a strategy that tracks performance indicators for population health, including those related to certain populations (such as women of reproductive age). |
| OR²⁰⁰ | Requires the MCO to commit to addressing population health issues within a specific geographic area and utilizing Certified Traditional Health Workers and Traditional Health Workers. |

Table 7

| Health Equity and Member Engagement Provisions in Managed Care Contracts | |
|---|---|
| Member Engagement | |
| AZ²⁰¹ | Requires the MCO to engage members through web-based applications that can assist members with self-management of health care needs and social determinants of health. |
| Cultural Competency | |
| MN²⁰² | Requires the MCO to utilize race and ethnicity data provided by the state in developing population-informed programming. |
| Disparities | |
| OR²⁰³ | Requires the MCO to carry out health improvement strategies to eliminate health disparities and improve the health and well-being of all members. Also requires the MCO to collect social determinants of health-related data and partner with diverse community organizations to use these data to address the causes of health disparities. |

Authority and Funding

There are numerous categories of authority under which MCOs may address their members' SDOH, each referencing different parts of the federal regulations and specifying different parameters under which they may be used. In this section, CHCS provides an overview of funding-related items: (1) additional services; (2) special contract provisions related to payment; and (3) community reinvestment requirements and incentives.

Medicaid is a state and federal partnership. States define the services their programs will cover, subject to limitations in federal statute, and publish descriptions of those services in a "state plan." Typically, these services are medical services, but can include non-medical services in select benefit categories, such as HCBS.

States that contract with MCOs pay a capitation rate based on services in the state plan. Under its contract with a state, an MCO must take on care coordination duties and ensure that members have access to timely care via an adequate network of providers. Because MCOs receive a per-member-per-month rate, they can provide services that are not defined in the state plan.

However, plans often cite "premium slide" as a barrier to investing in SDOH. Premium slide refers to the dual forces that may reduce future MCO capitation rates. These downward forces arise from the following issues: (1) SDOH interventions may actually reduce medical expenditures that are included in the capitation rate; and (2) services that are not included in the state plan (or provided as an *in lieu of service*) are excluded from the calculation of the capitation rate. In turn, the MCO's rates may be lowered in future years, penalizing the plan for investing in SDOH.

Additional Services

Generally, an MCO's capitation rate is based on services in the Medicaid state plan.²⁰⁴ But, new federal rules explicitly allow the MCO to provide additional services. These services have different rate setting implications. However, both categories of services may be included in the numerator of the MCO's medical loss ratio (MLR).²⁰⁵ The MLR measures how much an MCO spends on claims, quality activities, and fraud prevention activities, as a percentage of premium revenue.²⁰⁶ Under federal rule, rates must be developed in such a way that the MCO would reasonably achieve a MLR standard of at least 85 percent for the rate year.²⁰⁷ A state's minimum MLR must be 85 percent or higher.²⁰⁸

In Lieu of Services and Settings. MCOs may provide *in lieu of services*, which are alternative services or settings that the state determines to be a medically appropriate and cost-effective substitute for the covered service or setting under the state plan.²⁰⁹ Because *in lieu of services* are substitutes for covered services or settings, they are often medical in nature. The approved *in lieu of services* are authorized and identified in the MCO contract, and may be offered to enrollees at the option of the MCO. The costs of *in lieu of services* may be included in the numerator of the MCO's medical loss ratio and are also taken into account when developing the capitation rate paid to the MCO, unless otherwise noted in rule (e.g., restrictions on "institutions for mental disease" services).

Value-added Services. In addition to services under the state plan, MCOs may also provide "any services that the [MCO] voluntarily agrees to provide,"²¹⁰ commonly referred to as "value-added services." CMS has explicitly noted that value-added services may not always be medical in nature.²¹¹ For example, in an informational bulletin, CMS provided the following examples of value-added services that could reduce the risk of contracting Zika, including: mosquito repellents and "non-medical measures to deter mosquitoes, such as inspections to determine likely mosquito-breeding locations, aerosol insecticides (dispensed to the air or environmental surfaces), protective clothing, window screens, and other environmental modifications to combat the spread of the Zika virus."²¹² Other examples of value-added services include safe sleeping spaces for infants, such as a portable crib, and repairs and cleaning services to reduce asthma triggers in the home. Costs of value-added services are included in the numerator of the MCO's MLR calculation under either "incurred claims"²¹³ or "activities that improve health care quality,"²¹⁴ but a critical difference between value-added services and *in lieu of services* is that the costs of value-added services are *not* considered when developing MCO capitation rates.

Table 8

| Examples of <i>In Lieu Of</i> and Value-Added Services | |
|--|---|
| DC ²¹⁵ | Permits the MCO to provide <i>in lieu of</i> services that are a medically appropriate and cost-effective substitute for a covered service. |
| NC ²¹⁶ | Encourages the MCO to voluntarily contribute to health-related resources targeted toward high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the regions and communities it serves. The MCO that voluntarily contributes to health-related resources may count the contributions toward the numerator of its MLR. Encourages the use of <i>in lieu of</i> services to finance services that improve health through connecting members with resources, social services, and other supports upon receipt of state approval. |
| OR ²¹⁷ | Requires the MCO to include health-related services to target member wellness and improve population health goals. |
| TX ²¹⁸ | Value-added services can be added or removed only by written amendment of the contract. Value-added services may be actual health care services, benefits, or positive incentives that the state determines will promote healthy lifestyles and improved health outcomes among members. Value-added services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by the Texas Health and Human Services Commission. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be value-added services. MCOs can also provide “case-by-case” services, additional benefits that are outside the scope of services to individual members on a case-by-case basis. The MCO does not have to receive state approval for case-by-case services and does not have to provide such services to all MCO members. |

Many contracts restated federal authority for in lieu of services and value-added services, but did not provide additional clarification or detail.

Twenty-four MCO contracts contained some reference to additional services, frequently just restating the language from the regulations themselves. However, the contracts very rarely specify how these services should be reported in the MLR. Table 8 includes contract sections that provide examples of terms regarding the flexibility to provide these additional services.

Payment-Related SDOH Activities

MCO contracts may also have SDOH provisions related to payment. The provisions may be at the MCO-level, as with MCO incentive and withhold arrangements, or at the provider level, as with VBP models.

Many states tie MCO incentives to performance on quality measures or require MCOs to implement VBP arrangements with its providers. These activities may push providers and MCOs to address SDOH in an effort to provide more quality and efficient care, but do not directly require MCOs to develop an SDOH strategy. In its review, CHCS examined requirements and incentives that specifically referenced SDOH (see Table 9 for examples of state MCO contract provisions related to payment).

Five states require plans to address SDOH through VBP Initiatives.

States may require MCOs to consider SDOH in the context of their VBP initiatives. States generally may not direct MCO expenditures within contracts. However, the state may direct the MCO to implement a certain VBP model, meet VBP benchmarks, or participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.²¹⁹

Two states include SDOH-related measures in MCO payment arrangements.

States also have the option to implement incentive arrangements²²⁰ in their contracts that directly encourage work related to SDOH. Under 42 C.F.R. § 438.6(b), states can use incentive and withhold arrangements to encourage the MCO to meet certain

targets in its contract. In addition to the two states with specific references in its contracts, one state, **North Carolina**, introduces future MCO payment incentives relating to SDOH in its § 1115 demonstration.

Table 9

| State MCO Contract Provisions Related to Payment | |
|--|---|
| Value-Based Payment | |
| AZ ²²¹ | Implements the targeted investments incentive program, which can target justice-involved populations. |
| NM ²²² | Establishes a Care Coordination Delegation program where care coordination is delegated, or partially delegated, to a specific provider as part of a VBP arrangement. Under one option, the MCO can share care coordination functions related to coordinating referrals and linking members to community services. |
| RI ²²³ | Requires the MCO to work toward incorporating value-based purchasing initiatives that integrate medical care with social determinants of health and related social services. |
| MCO Incentive Arrangements, Withhold Arrangements, and Penalties | |
| MI ²²⁴ | Ties bonuses under the state’s Pay for Performance program to the submission of plans and reports relating to a proposed population health intervention focused on SDOH, noting the state’s specific interest in housing. Performance bonuses are tied to a withhold arrangement, under which 1% of capitation payments are withheld. Also includes related SDOH-related focus bonus programs on low birth weight and emergency department use. |
| NM ²²⁵ | Incorporates a community health worker (CHW) delivery system improvement performance target: 3% of the MCO’s total enrollment to be served by CHWs, Community Health Representatives, and Certified Peer Support Workers. This metric is assigned 20 points out of 100. If targets are not met, the state can impose performance penalties of 1.5% of the capitation rate. |

Two states require or encourage plans to invest in local communities with a percentage of their profits or revenues.

Two states push MCOs to invest in local communities. For example, **Arizona** requires its new Complete Care plans to contribute six percent of their annual profits to community reinvestment and submit an annual Community Reinvestment Report. In a less prescriptive approach, **North Carolina** requires an MLR of 88 percent, higher than the required 85 percent MLR. If the MLR is less than the minimum MLR threshold, the

plan can either remit a rebate back to the state or “contribute to health-related resources targeted toward high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the regions and communities it serves.” A plan that voluntarily contributes at least 0.1 percent of its annual capitation revenue in a region to health-related resources may be awarded a preference in auto-assignment to promote enrollment in each region in which the plan contributes.²²⁶

CHAPTER 5

§ 1115 Demonstrations: Findings

CHCS reviewed three types of § 1115 demonstrations: (1) delivery system reform demonstrations, many of which—but not all—are considered delivery system reform incentive payment (DSRIP) demonstrations; (2) § 1115 demonstrations with healthy behavior incentives; and (3) § 1115 demonstrations that included a work or community engagement requirement. CHCS found the following:

1. Seven delivery system reform demonstrations build multi-disciplinary partnerships that include community-based organizations or social service agencies.
2. Ten delivery system reform demonstrations advance projects or programs that encourage screening for social needs and linkages to community resources that address SDOH.
3. Two § 1115 demonstrations specifically fund Medicaid ACOs' capacity to address SDOH.
4. Three § 1115 demonstrations created new types of services related to SDOH and linked those services to VBP initiatives.
5. Two DSRIP demonstrations referred to SDOH in the context of the state's overall approach to sustain delivery system reform investments through managed care and VBP.
6. Demonstrations that refer to healthy behavior incentives largely do not discuss the ways in which MCOs or the state can address the SDOH that influence health behaviors.
7. Demonstrations with work and community engagement requirements included standard requirements on connecting beneficiaries to community resources.

Delivery System Reform

CHCS reviewed all approved § 1115 demonstrations relating to delivery system reform and inventoried projects that specifically address SDOH. Delivery system reform demonstrations establish projects and

partnerships that change the way care is delivered, target specific populations, and implement more collaborative, holistic care coordination processes. To access DSRIP funds, qualifying hospital providers and regional partnerships take on projects that relate to overall delivery system reform goals and report on a variety of metrics related to those goals.

Systems and Partnerships

Seven delivery system reform demonstrations build multi-disciplinary partnerships that include community-based organizations or social service agencies.

Delivery system reform demonstrations create specific cross-disciplinary regional partnerships or target specific types of entities, such as hospitals or safety net providers. These demonstrations often focus on a specific way to engage parties that can address SDOH. For example, **Washington's** demonstration features a type of regional partnership: Accountable Communities of Health (ACHs). ACHs include providers, MCOs, and “multiple community partners and [CBOs] that provide social and support services reflective of the social determinants of health for a variety of populations in the region,” including representatives from “transportation, housing, employment services, education, criminal justice, financial assistance, consumers, consumer advocacy organizations, childcare, veteran services, community supports, [or] legal assistance.”²²⁷ **California's** § 1115 demonstration introduces funding for Whole-Person Care (WPC) Pilots, which can include the following types of participating entities, in addition to MCOs: human services agencies; criminal justice/probation entities; housing authorities; and community-based organizations. **North Carolina's** § 1115 demonstration authorizes the creation of “Lead Pilot Entities” (LPEs) in each pilot region. The LPEs will develop, contract with, and manage a network of CBOs, social service providers, and health care providers to deliver case management and services relating to housing, food, transportation, and interpersonal violence. The state's Medicaid health plans must: (1) participate in the pilot program; (2) authorize, and

determine eligibility for, services; and (3) work in collaboration with the LPE to track the provision of pilot services.

Sometimes, demonstration projects indirectly, and perhaps unintentionally, limit the extent to which community-based organizations or entities outside the target provider organization can share in DSRIP funds. For example, **New York's** performing provider systems (PPS), which primarily represent safety-net providers, take on DSRIP projects. Non-safety net providers, such as community-based organizations, can participate in a PPS, but can only receive up to five percent of a project's total valuation, unless otherwise approved by CMS.²²⁸

Ten delivery system reform demonstrations advance projects or programs that encourage screening for social needs or linkages to community resources that address SDOH.

Delivery system demonstrations typically include a menu of potential projects and require the regional partnerships or certain providers to select projects across several categories from this menu. In CHCS' review, the delivery system reform projects that referenced SDOH typically involved enhanced care coordination for a target population or condition, including screening for social needs and providing linkages to community resources that address those social needs.

For example, **Washington's** ACHs work on projects related to the following objectives: (1) Health Systems and Community Capacity Building; (2) Care Delivery Redesign; and (3) Prevention and Health Promotion. Under the "Care Delivery Redesign" category are several potential projects related to SDOH. One project references care coordination for high-risk populations "impacted by social determinants of health such as unstable housing and/or food insecurity," and another project is related to "diversion interventions" that increase access to primary care and social services.²²⁹ ACHs conduct a "Regional Health Needs Inventory" to ensure that project selection "responds to community-specific needs" and "aims to reduce health disparities."²³⁰ ACHs receive DSRIP funds largely for meeting outcomes-based metrics related to selected projects in their project plan, with some pay-for-reporting measures. In another example, **California's** Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program includes several projects related to SDOH and wellness, such as the Obesity Prevention and Healthier Foods Initiative and the 1.5 Million Hearts Initiative.

North Carolina's § 1115 demonstration includes a pilot program related to "enhanced case management and other services," sometimes rebranded by the state as "Opportunities for Health" or "Healthy Opportunities." The service descriptions often include assistance with linkages, but can include actual services and support. The demonstration incorporates an evaluation strategy with rapid cycle assessments. In December 2023, the state will submit a plan to CMS outlining "how the state anticipates it will incorporate effective pilot program services into its managed care program." The pilot services include:

- **Housing.** Specific services include: tenancy support and sustaining services; housing quality and safety improvement services (e.g., repairs or remediation for issues such as mold or pest infestation, ramps, rails, grip bars in bath tubs); legal assistance; payments that secure housing (i.e., one-time payment for security deposit and first month's rent); and post-hospitalization housing for a short-term period due to an individual's imminent homelessness.
- **Food.** Specific services include Food Support Services (e.g., assistance with locating food banks, applications to SNAP and WIC, funding for meal and food support from food banks or other community-based food programs, such as "healthy food boxes"), and Meal Delivery Services.
- **Transportation.** Specific services include "non-emergency health-related transportation," including transportation to social services that promote community engagement and access to community-based and social services.
- **Interpersonal Violence (IPV)/Toxic Stress.** Specific services include transportation services to or from IPV service providers for enrollees transitioning out of a traumatic situation; linkages to community-based social service and mental health agencies with IPV expertise; support resources; legal assistance; and child-parent support (e.g., evidence-based home visiting services).

Table 10 provides an overview of the specific project activities related to SDOH; general goals for delivery system reform projects; and the types of performing providers and required partnerships, with a specific focus on social service organizations and CBOs. Table 11 provides examples of projects related to justice-involved populations.

Table 10

| Delivery System Reform Partnerships and Projects Related to SDOH | | | | | | |
|--|---|--|--|--|--|--|
| State | Incentive Program | Focus | Performing Providers / Lead Entities | MCO Participants | CBO/Social Service Participants | Specific References to SDOH/Target Populations Related to SDOH |
| CA ²³¹ | Whole Person Care Pilots under DSRIP | Integration (physical health (PH), behavioral health (BH), SDOH) | City, county, a health or hospital authority, or consortium of entities serving a county or region | Yes | Human services agencies, criminal justice/probation entities, housing authorities, and community-based organizations | WPC Pilots may target individuals at risk of or are experiencing homelessness who have a demonstrated medical need for housing or supportive services. Housing interventions may include tenancy-based care management services and county housing pools. County housing pools can incorporate state and local funds that directly fund support for long-term housing, including rental housing subsidies. Note that these funds are not eligible for federal match. |
| MA ²³² | DSRIP | Integration (PH, BH, LTSS, and health-related social services). | Accountable Care Organizations (ACOs) and Community Partners (CPs) | Yes | CPs, social service organizations | ACOs can pay for traditionally non-reimbursed flexible services to address health-related social needs, and Community Partners provide care management, care coordination, assessments, counseling, and navigational services. The state may provide a portion of flexible services funding directly to social service organizations to help them build infrastructure and capacity to better support ACOs in delivering flexible services. |
| NC ²³³ | Enhanced Case Management and Other Services Pilot Program (“Opportunities for Health”/ “Healthy Opportunities”) | Case Management, Housing, Food, Transportation, Interpersonal Violence | Lead pilot entity (LPE) | Yes | LPE contracts with CBOs, social services agencies | Enhanced case management services include housing support, legal assistance, food support services and delivery, transportation, and IPV aid and resources. |
| NH ²³⁴ | DSRIP | Integration (PH, BH, social services); SUD | Integrated Delivery Networks (IDNs) | No, but MCOs may provide performance-based IDN funding after the demonstration | CBOs that provide social and support services reflective of SDOH, such as transportation, housing, and employment services; peer-based support and/or community health workers | The IDN partners must together be able to provide the full spectrum of care and related social services that might be needed by an individual with a behavioral health condition. Demonstration refers to potential projects related to supportive housing and wellness programs targeting community-based organizations providing services related to health and wellness, exercise, nutrition, smoking cessation, and SDOH. |

| Delivery System Reform Partnerships and Projects Related to SDOH | | | | | | |
|--|---|--|--|---|--|---|
| State | Incentive Program | Focus | Performing Providers / Lead Entities | MCO Participants | CBO/Social Service Participants | Specific References to SDOH/Target Populations Related to SDOH |
| NY ²³⁵ | DSRIP | Safety Net System Transformation | Performing Provider Systems (PPS), made up of safety net providers | No, but MCOs may contract with PPSs and pay PPSs a VBP. | Social service providers, CBOs (optional) | To support the successful engagement of CBOs in DSRIP, the state will direct 5% of the demonstration year one administrative costs toward a CBO planning grant. |
| RI ²³⁶ | Medicaid Infrastructure Incentive Program | Integration (PH, BH, and social services) | Accountable Entities | Yes | Social service organizations, CBOs (affiliation or working relationship with AEs) | <p>Infrastructure funds can be used to build relationships with CBOs and develop capacity to provide services that address SDOH.</p> <p>At least 10% of Program Year 1 Incentive funds are allocated to partners that provide specialized services to support behavioral health care, substance use treatment, and/or address social determinants of health.</p> |
| WA ²³⁷ | DSRIP | Health Systems and Community Capacity; Care Delivery Redesign; Prevention and Health Promotion | Accountable Communities of Health (ACH) | Yes | Community partners, including housing, transportation, education, criminal justice, etc. | <p>Potential projects for ACHs include:</p> <p>Care coordination for high-risk populations, such as those impacted by SDOH; and</p> <p>Diversion strategies that provide opportunities to redirect individuals away from high-cost medical and legal avenues and into community-based health and social services that offer comprehensive assessment, care/case planning, and management to produce more positive outcomes.</p> |

Table 11

| DSRIP Projects Related to Justice-Involved Populations | |
|--|--|
| CA ²³⁸ | Transition to Integrated Care: Post-Incarceration. Participating PRIME entities work to improve the transition of care for the recently incarcerated individuals in this project. Project goals are to increase rates of enrollment into Medi-Cal and successfully establish coordination across primary care, behavioral health, and social services. Specific objectives include: (1) linking patients to necessary social services for housing, employment, and other services to reduce risk of recidivism; and (2) identifying a team member with a history of incarceration (e.g., community health worker) to support system navigation and provide linkages to needed services (e.g., social services and housing). |
| NH ²³⁹ | Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues. The community re-entry project assists adults with mental health conditions and/or substance use disorders who are leaving correctional facilities in maintaining their health and recovery in the community. The program, which is initiated pre-discharge and continues for 12 months post discharge, provides them with integrated primary and behavioral health services, care coordination, and social and family supports. By promoting the stability and recovery of participants, it is designed to prevent unnecessary hospitalizations and emergency department usage among these individuals. |
| WA ²⁴⁰ | Transitional Care. ACH projects target points of transition out of intensive services/settings, such as individuals discharged from acute care to home or supportive housing, beneficiaries with SMI discharged from inpatient care, or clients returning to the community from jail or prison. Transitional care services projects provide opportunities to reduce or eliminate avoidable admissions, readmissions, and jail use through access to reliable care and social services. |

Authority and Funding

Section 1115 demonstrations allow states to request waivers of specific Medicaid requirements. For example, delivery system reform demonstrations include common waivers of Medicaid requirements, such as waivers of “statewideness,” “service comparability,” and “freedom of choice.” In addition to these waivers, each demonstration approval usually includes lengthy “special terms and conditions” (STCs) that provide specific expectations about the operation of the program. Throughout the life of the demonstration, states may submit various documents requiring CMS approval such as roadmaps, attachments, evaluation plans, and protocols. These expectations are noted in the STCs.

Section 1115 demonstrations also give states specific expenditure authority for otherwise unallowable expenses. DSRIP demonstrations, for example, often include specific expenditure authority for a DSRIP program and funding for designated state health programs (DSHP),²⁴¹ such as **New York’s** Healthy Neighborhoods Program, which reduces the burden of housing-related illnesses and injury, and the Childhood Lead Poisoning Primary Prevention Program. Section 1115 demonstrations must be “budget neutral” to the federal government, “which means that, during the course of the project, Federal Medicaid expenditures will not be more than Federal spending without the demonstration.”²⁴²

States design delivery system reform demonstrations to drive investment in health care infrastructure and more holistic models of care for vulnerable populations. They often offer incentives to regional partnerships and other entities for meeting performance-based metrics

on specific projects related to these general goals. The demonstrations may make DSRIP or other targeted funds available to projects and programs implementing these care models, including those addressing social needs.

In addition to the general availability of new funds for delivery system reform projects, CHCS found that six delivery system reform demonstrations refer to SDOH in the context of the state’s overall transition to VBP or in the implementation of a specific VBP model. CHCS discusses some specific findings related to VBP and SDOH below (for further detail, see Table 12).

Two § 1115 demonstrations specifically fund Medicaid ACOs’ capacity to address SDOH.

Two § 1115 demonstrations, in Rhode Island and Massachusetts, created Medicaid ACO programs that specifically funded ACO capacity to address SDOH. **Massachusetts’** ACO program integrates a social needs screening measure into its ACO measure slate, which factors into an ACO’s quality score. The state’s demonstration also supports “Community Partners” (CPs), community-based organizations that offer members support and linkages to community resources that facilitate a “coordinated, holistic approach to care.” The two types of CPs—Behavioral Health and Long-Term Services and Supports CPs—receive DSRIP payments based on “a total number of members that the CP serves each DSRIP year, as well as other funding methodologies, such as a needs-based grant program for infrastructure and capacity building support.” These payments fund CP activities to help promote integration across physical health, behavioral health, and health-related social needs for members. In addition, the

demonstration refers to funding for flexible services, discussed in the next section.

Rhode Island’s demonstration creates funding opportunities for Accountable Entities (AEs), multidisciplinary provider organizations responsible for an attributed population. Rhode Island’s AEs must develop and demonstrate capacity in integrating social determinants of health, physical health, and behavioral health. They receive payment incentives related to SDOH through two sources: the Medicaid Infrastructure Incentive Program (MIIP); and the shared savings program. The MIIP includes incentives for both AEs and MCOs. AE incentive funds can be used to develop: defined affiliations with community-based organizations (CBOs); a full continuum of services, including services that address SDOH; and an integrated strategic plan for population health that recognizes SDOH. For example, AEs must demonstrate that “at least 10% of Program Year 1 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment, and/or social determinants.”²⁴³ As in Massachusetts, one of the standard quality measures used in the AEs’ shared savings arrangements relates to the percentage of members screened for SDOH. That SDOH screen is an evaluation of “health-related social needs in order to determine the need for social service intervention,” including: housing stabilization and support services; housing search and placement; food security; support for those who experience violence; utility assistance; and physical activity and nutrition.²⁴⁴ An AE’s quality score, which includes performance on the SDOH screen measure, determines the share of realized savings the AE receives.

Services to Address Lead Poisoning

Two § 1115 demonstrations discussed services that address lead in the home.

One of Michigan’s § 1115 demonstrations allows the state to offer targeted services to eligible children and pregnant women who were served by the Flint water system during a specified period. Under the targeted case management service, beneficiaries with potential lead exposure receive assistance with medical, educational, social, and other services. They are screened for lead poisoning, and their homes are evaluated for lead risks.

Rhode Island’s § 1115 demonstration authorizes window replacements for homes that are the primary residence of children who are lead poisoned.

Table 12

| Funding for SDOH Activities -- Examples from Two States with Medicaid ACOs | |
|---|---|
| Massachusetts | Rhode Island |
| <ul style="list-style-type: none"> ■ ACOs receive a per member per month payment funded by DSRIP to support the provision of “flexible services” (contingent on CMS approval of flexible services protocol). ■ CPs receive funding to support linkages to community resources and enhanced care coordination. ■ ACOs report on the rate of screening for social needs. This measure factors into the ACO’s quality score, which is used to determine the ACO’s shared savings distribution. ■ Rate of social service screening is a pay-for-reporting measure in 2018 and 2019, and a pay-for-performance measure in 2020 through 2022. | <ul style="list-style-type: none"> ■ AEs receive infrastructure incentive funds that can be used to develop defined affiliations with CBOs; a “full continuum of services,” including services that address SDOH; and an integrated strategic plan for population health that recognizes SDOH. ■ At least 10 percent of Program Year 1 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment, and/or social determinants. ■ AEs report on the rate of screening for social needs. This measure factors into AE’s quality score, which determines the AE’s shared savings distribution. |

Three § 1115 demonstrations created new types of services related to SDOH and linked those services to VBP initiatives.

Three § 1115 demonstrations created new types of services related to SDOH and linked those services to VBP initiatives. **Massachusetts'** demonstration includes support for ACOs to pay for “traditionally non-reimbursed flexible services to address health-related social needs.” Flexible services include assistance for maintaining a safe and healthy living environment, services relating to physical activity and nutrition, and violence support. ACOs receive a per-member-per-month payment to support the provision of flexible services. However, CMS has not yet approved the protocol related to these services.

Oregon's § 1115 demonstration implements a specific model of managed care, with a particular focus on SDOH, VBP, and an evaluation of community needs. The state's coordinated care organizations (CCOs)—sometimes referred to as Medicaid ACOs—must consider using alternative services, including *in lieu of services* and “health-related services.” Health-related services “are intended to promote the efficient use of resources and, in many cases, target social determinants of health.” They include two types of services:

1. “Flexible services,” which are cost-effective services offered as an adjunct to covered benefits; and
2. “Community benefit initiatives,” which are community-level interventions focused on improving population health and health care quality.

The STCs also note that, unlike *in lieu of services*, “health-related services are not substitutes for state plan services.” CCO expenditures for health-related services are not considered in setting capitation rates, except to the extent that such services may result in performance-based incentives or savings. Health-related services that meet the regulatory definition for “activities that improve health care quality”²⁴⁵ can be included in the numerator of the MLR. In an effort to address premium slide concerns, the demonstration also notes that the state will develop capitation rates that allow high-performing CCOs to have a higher percentage of profit margin than lower performing CCOs, as opposed to a fixed percentage of premium for each CCO.

North Carolina's § 1115 demonstration requires the state to create a “pathway” to VBP for its SDOH-focused pilot program, “increasingly linking payments for pilot program services to health and socioeconomic outcomes based on the pilot services” and “gathering the required data and experience needed for more complex risk-based models.” By pilot year five, the LPEs responsible for pilot program services will be eligible to receive shared savings from a Medicaid health plan.²⁴⁶

Two DSRIP demonstrations referred to SDOH in the context of the state's overall approach to sustain delivery system reform investments through managed care and VBP.

DSRIP demonstrations are intended to be time-limited federal investments and require states to submit documentation demonstrating sustainability of the delivery system reform work after the § 1115 demonstration has ended. These sustainability plans typically include a discussion of VBP and managed care initiatives. This planning exercise is particularly relevant for states, given that CMS has signaled that some common practices in DSRIP demonstrations may be discontinued in favor of more targeted investments. For example, CMS has noted that it plans to discontinue funding for DSHP.²⁴⁷ CMS has also revised cost neutrality guidelines, which may impact how savings are calculated for use in DSRIP demonstrations in the future.²⁴⁸

Two § 1115 demonstrations specifically referred to SDOH in the context of the state’s overall approach to ensure sustainability of DSRIP investments through managed care and VBP. **New York** includes a specific SDOH initiative in its VBP Roadmap, submitted for CMS approval in response to demonstration requirements on sustainability planning.²⁴⁹ One of the guiding principles for this payment reform initiative is to “[f]inancially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health.”²⁵⁰ In furtherance of this goal, New York requires providers in advanced VBP agreements to implement at least one SDOH intervention, with the VBP arrangement also including at least one CBO. The state offers providers a comprehensive menu of possible SDOH interventions, such as a Housing First program to address homelessness or mold abatement to alleviate respiratory issues. MCOs must provide a funding advance for providers investing in the required intervention, as well as bonuses to providers in less-advanced VBP arrangements that invest in an SDOH intervention voluntarily.

In an effort to prepare providers to sustain transformation efforts through VBP and managed care, **Texas** will transition from project-based reporting in its DSRIP program to provider-level reporting.²⁵¹ In addition to reporting on quality and system performance measures, providers will report on “core activities,” which can include the “provision of services to individuals that address [SDOH].”²⁵² As this transition is taking place, Texas will prepare a sustainability plan that includes milestones relating to “alternative payment models, the state’s adoption of managed care payment models, payment mechanisms that support providers’ delivery system reform efforts, and other opportunities.”²⁵³

Healthy Behavior Incentives

Some demonstrations seek to incentivize certain healthy behaviors, such as weight management and access to preventive services, and deter risky behaviors, such as substance use and tobacco use. Healthy behavior incentive programs often involve a health savings account or the payment of members’ premiums—concepts that are prevalent in the commercial sector, but not in Medicaid due to restrictions in federal law. To enable these premiums or cost-sharing requirements, these demonstration projects often request a specific waiver of statutory restrictions on cost sharing and premiums.

Section 1115 demonstrations that refer to healthy behavior incentives largely do not discuss the ways in which MCOs or the state can address the SDOH that influence health-related behaviors.

SDOH and health behaviors are separate and distinct concepts. Nonetheless, given the interconnectedness between SDOH and health-related behaviors, CHCS includes an overview of these demonstrations below (Table 13). These provisions did not contain specific references to SDOH, but sometimes refer to MCO activities that can help beneficiaries with these health behaviors.

Table 13

| Healthy Behavior Incentive Programs | |
|-------------------------------------|--|
| AZ ²⁵⁴ | <p>The state can release funds in a flexible spending account with collected premiums to members who meet preventive health targets or targets related to managing chronic disease. For example, the member can develop an asthma action plan with their primary care provider that includes guidance on avoiding asthma triggers.</p> <p>The state may make the return of the premium conditioned upon incurred expenses for certain health-care related items.</p> |
| FL ²⁵⁵ | <p>The state must require all managed care plans to have a Healthy Behavior program that addresses at minimum: smoking cessation, medically directed weight loss, and substance use treatment.</p> |
| IA ²⁵⁶ | <p>The state can waive or reduce premiums for beneficiaries who make progress on Healthy Behaviors targets, including measures that address tobacco use and obesity.</p> |
| IN ²⁵⁷ | <p>Beneficiaries enrolled in HIP Plus who are identified as tobacco users will have a tobacco user surcharge applied to their POWER Account contribution amount. This amount will be equal to a 50 percent increase in individual contribution amount. The Healthy Indiana Plan MCO will identify tobacco users and apply the surcharge as a distinct line item separate from the regular POWER Account contribution amount in the monthly invoice.</p> <p>The tobacco surcharge will be waived for the first year of enrollment in order to provide the individual the opportunity to take advantage of tobacco cessation benefits offered through HIP.</p> |
| KY ²⁵⁸ | <p>Beneficiaries will receive incentives for healthy behaviors and community engagement in their My Rewards Account. The incentives have a dollar value equivalent and can be used to obtain additional benefits: vision benefits, dental benefits, over-the-counter medications, and limited fitness-related services, such as a gym membership.</p> |
| MI ²⁵⁹ | <p>Managed care members who complete a health risk assessment (HRA) with a primary care provider and agree to address or maintain healthy behaviors will be eligible for a reduction in copays or a gift card. Members who complete an HRA and initial appointment and acknowledge that changes are necessary but who have significant physical, mental or social barriers to addressing them at this time are also eligible for the incentives.</p> <p>All managed care plans are required to have robust care management programs to assist members in attaining their goals (e.g., diabetes case management program). The HRA can be used by plans to determine program suitability or referral for other covered services that will assist members with healthy behaviors.</p> |
| NM ²⁶⁰ | <p>Beneficiary Rewards Program allows beneficiaries to earn credits if they participate in state-defined healthy behaviors. Credits from this program can be used for health-related expenses.</p> |
| WI ²⁶¹ | <p>Certain beneficiaries are eligible for a 50% reduction in premiums if they demonstrate that: (1) they do not engage in behaviors that increase health risks (“health risk behaviors”); or (2) attest to actively managing their health risk behaviors or related condition.</p> <p>To identify beneficiaries who are engaging in health risk behaviors, individuals will be asked to complete an HRA. Health risk behaviors include, but are not limited to, excessive alcohol consumption, failure to engage in dietary, exercise, and other lifestyle (or “healthy”) behaviors in attempt to attain or maintain a healthy body weight, illicit drug use, failure to use a seatbelt, and tobacco use.</p> |

Work and Community Engagement Requirements

Because CMS has specifically identified employment as a “determinant of health” in its guidance documents and approval letters relating to work and community engagement requirements, CHCS reviewed the five approved and currently effective demonstrations with work and community engagement requirements in the following states: Arkansas, Indiana, Kentucky, New Hampshire, and Wisconsin. One of these states, Arkansas, does not have a risk-based Medicaid managed care program, but provides certain adult Medicaid beneficiaries with premium assistance to purchase Qualified Health Plans (QHP) coverage through the Health Insurance Marketplace.

Two demonstrations referred to potential health plan activities that could satisfy work and community engagement requirements.

CHCS specifically sought information on how health plans are directed to help members meet community engagement requirements or identify community resources. Two of the three states with approved community engagement requirements included information on potential health plan activities related to community engagement. Beneficiaries in **Arkansas** can satisfy that state’s community engagement requirement through participation in classes on: health insurance; using the health system; or healthy living (up to 20 hours per year). Similarly, MCO employment initiatives in **Indiana** can satisfy that state’s work requirement. In addition, **Arkansas** Works QHPs are involved in the development of the Arkansas Works Interactive Resource Map, which assists beneficiaries in finding resources to satisfy community engagement requirements and information on other community resources such as transportation and public technology.

Section § 1115 demonstrations with work and community engagement requirements included requirements on connecting beneficiaries to community resources.

In addition, these demonstrations frequently included standard “state assurances” related to SDOH and linkages to community resources. For example, these demonstrations often referred to alignment between work requirements in other programs, such as SNAP, and coordination with other agencies to identify and link members to existing community supports, such as “available non-Medicaid assistance with transportation, child care, language access services and other supports.” In addition, the state typically provided assurances that it will “assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions or alternative compliance standards from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet in impacted areas.”

CHAPTER 6

Policy Recommendations

Common barriers to social determinants of health work include: (1) premium slide; (2) fragmented, siloed health and social systems; (3) eligibility and enrollment churn and the reduced incentive for MCOs to invest in upstream prevention; and (4) the ability or capacity of health care organizations to identify and address social needs. Building upon the findings in its review, CHCS presents the following recommendations for advancing SDOH work, with a specific focus on potential approaches at the federal policy level.

| Systems and Partnerships | Authority and Funding |
|---|---|
| <ul style="list-style-type: none">■ Make it easier for vulnerable populations to access needed health care services and care coordination.■ Enhance agency collaboration at the federal level. | <ul style="list-style-type: none">■ Provide additional guidance on how states can encourage and incent MCOs to invest in SDOH.■ Approve § 1115 demonstrations that test strategies to address SDOH.■ Support outcomes-based payment for SDOH interventions. |

Systems and Partnerships

CHCS' review captured states' attempts to remedy barriers to SDOH-related services and enhance care coordination across disciplines through cross-sector partnerships, infrastructure and workforce investments, and value-based payment. Many states took similar approaches, but placed more emphasis on policies to incentivize work and healthy behaviors at the member or beneficiary level. To help these reforms succeed, CMS could assess ways to make health care more accessible and responsive to the needs of low-income populations.

Make it easier for vulnerable populations to access needed health services and care coordination.

An effective SDOH strategy often requires health care organizations to engage members over a sustained period of time. States have built on this general concept both by building a specialized workforce for care coordination, such as community health workers, and introducing whole-person approaches to care.

In this spirit, CMS may wish to carefully review and suggest revisions to § 1115 demonstrations that make access to, and eligibility for, health care and coverage more complex and, in so doing, cause lapses in

coverage. These policies can exacerbate existing issues in Medicaid programs such as eligibility churn and member engagement. To the extent that CMS is committed to approving community engagement demonstration projects, CMS could consider the important role MCOs can play in helping members maintain their eligibility and satisfy community engagement requirements.

Enhance agency collaboration at the federal level.

In a recent report funded by CMS,²⁶² the National Quality Forum recommended increased information sharing among state government agencies as a way to address food insecurity and housing instability. Similarly, federal agencies could continue to collaborate on ways to coordinate federal health and social programs, prioritizing easier navigation for beneficiaries. Targeted partnerships and cross-agency councils, such as the United States Interagency Council on Homelessness, can make collaboration on SDOH more commonplace.

Authority and Funding

Currently, the bulk of SDOH-related requirements and incentives in § 1115 demonstration projects and MCO contracts relate to care coordination and care management. In their contracts, states may require MCOs to screen for social needs and link members to needed community resources, but do not often establish specific expectations around the direct provision of services that address those needs. Through § 1115 demonstration projects, provider organizations and MCOs take on projects with specific target populations and programmatic goals, but those projects again focus on linkages to community resources—not the provision of actual SDOH interventions. This focus on care coordination has developed familiarity with SDOH, but may not drive adequate investment in the SDOH interventions themselves.

Because many SDOH interventions may be outside the scope of traditional Medicaid services (as defined in statute²⁶³ and state plans), CMS has historically been less comfortable with funding the actual provision of services that address SDOH. For example, Medicaid can pay for housing-related activities and services through discrete HCBS programs, but not room and board.²⁶⁴ Similarly, an MCO's capitation rate must be based only upon those services covered under the state plan, with few exceptions.²⁶⁵ Nonetheless, states do have some flexibility under existing law, and CHCS' review of managed care contracts suggests that states have, for the most part, not taken full advantage of this flexibility.

Provide additional guidance on how states can encourage and incent MCOs to invest in SDOH.

When CMS puts out guidance on Medicaid flexibilities, states listen. Most recently, states responded to specific guidance on work requirements²⁶⁶ by submitting 14 related demonstration applications. In response to another letter to state Medicaid directors on strategies to address the opioid epidemic,²⁶⁷ states responded similarly, submitting § 1115 demonstration projects targeting behavioral health and substance use disorder.

If CMS published guidance on how states could address SDOH through their Medicaid managed care programs and value-based payment initiatives, states would be more inclined to build upon these flexibilities in demonstration projects and contracts. This guidance could help states design programs that address perceived barriers to investment in SDOH, such as premium slide.

Sometimes, states and MCOs just need a roadmap—an assurance that CMS will be receptive to their more innovative proposals. States would benefit from specific guidance on the following:

Upstream Services and In Lieu of Authority. CMS could publish additional clarification on *in lieu of* services relating to SDOH. Some SDOH-related services are evidence-based, cost-effective interventions that improve health outcomes, but may typically be provided in addition to, and not as a substitute for, a covered service. For example, environmental remediation of asthma triggers or lead paint improves health outcomes, but is not typically provided *in lieu of* medical services—except to the extent that the service is inherently preventive. CMS could clarify whether *in lieu of* authority can be used for an upstream service that has been proven to reduce expenditures on state plan services, but is nonetheless not a direct substitute for a state plan service. In addition, CMS could also clarify that services that do not qualify as *in lieu of* services can nonetheless be value-added services, included in the numerator of the MLR under either “incurred claims” or “activities that improve health care quality.”²⁶⁸

Rate-setting. CMS can signal acceptance of innovative state models by approving relevant contracts and rates, but states would also benefit from proactive guidance or technical assistance on rate-setting approaches that address premium slide concerns and incent investments in SDOH. CMS has provided similar support through the Innovation Accelerator Program (IAP) and could consider creating a targeted IAP for this purpose.

QAPI. Given CMS' focus on evaluation for various health care reforms, states many benefit from CMS guidance that illustrates how QAPI can be used to develop an evidence base for a particular SDOH intervention. Many states have incorporated SDOH into the required QAPI terms of their contracts, and the QAPI process requires that the impact of the performance improvement program be formally assessed. Explanation of how states are authorized to use the QAPI process to address members' SDOH would encourage innovation at the state and plan level to develop interventions, and would create a body of knowledge on the effectiveness of SDOH-related interventions to improve the quality of members' health. This evidence base could, in turn, be used to fulfill the requirements for other managed care authorities, such as *in lieu of* services, which require that the intervention be medically appropriate and cost-effective.

Approve § 1115 demonstrations that test strategies to address SDOH.

The purpose of § 1115 demonstrations is to test innovations that promote objectives of the Medicaid program. CMS has approved many demonstrations that include projects related to care coordination and linkages to social services, as well as community engagement demonstrations that require states to provide assurances regarding linkages to community resources. In addition, CMS will test, through the Accountable Health Communities model, “whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries’ through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.”²⁶⁹ However, with the exception of some elements in North Carolina’s and Massachusetts’ demonstrations, CMS does not typically approve direct funding for SDOH interventions outside the confines of HCBS programs.

To build on this portfolio, CMS may consider approving demonstrations that increase investment in, and access to, targeted SDOH interventions and work-related supportive services. This focus is consistent with the general push toward VBP, upstream prevention, and cross-sector collaboration.

Experimentation at the intersection of managed care and SDOH particularly makes sense; § 1115 demonstrations must be budget neutral, and managed care programs infuse more flexibility and budgetary certainty into Medicaid programs through the use of capitation payments. For example, a state may wish to include expenses related to select SDOH interventions in the calculation of the capitation rate, but closely monitor cost growth and health outcomes—tackling premium slide head on.

Support outcomes-based payment for SDOH interventions.

Pay for Success is a set of tools that allows entities to pay for the outcomes associated with SDOH interventions, rather than paying for actual services. The Social Impact Partnerships to Pay for Results Act (SIPPPRA) will enable federal funding of outcomes payments for health-related projects, including: (1) improving birth outcomes and early childhood health and development among low-income families and individuals; (2) reducing rates of asthma, diabetes, or other preventable diseases among low-income families and individuals to reduce the utilization of emergency and other high-cost care; (3) reducing the rate of homelessness among the most vulnerable populations; (4) improving the health and well-being of those with mental, emotional, and behavioral health needs; and (5) improving the educational outcomes of special-needs or low-income children.

CMS could consider building upon this precedent—through approval of § 1115 demonstrations or guidance on appropriate use of these outcomes-based payments in the managed care environment. For example, in a recent informational bulletin, CMS noted that states could require MCOs to institute multi-year payment arrangements for delivery system reform. This guidance was a significant clarification of an existing rule, and could help states design payment programs that accommodate the longer time frames in which SDOH interventions generate health outcomes.²⁷⁰ To the extent that this authority could be used to advance outcomes-based payment for select SDOH interventions, CMS could proactively present this as an option to states.

CHAPTER 7

Conclusion

In an effort to improve health outcomes and provide more efficient care, states have increasingly incentivized or required Medicaid MCOs and other health care organizations to develop specific systems and processes to address social needs and build partnerships with CBOs and social service agencies. States have used specific authority in federal managed care rules and § 1115 demonstrations to advance this

work and open up new funding streams. As state Medicaid agencies and innovative health plans continue to experiment with ways to realign incentives and advance value-based care, many Medicaid stakeholders will continue to test innovative SDOH strategies, while watching for signals from CMS and other federal policymakers.

Appendix 1

Included § 1115 Demonstrations

- 1 Arizona Health Care Cost Containment System (AHCCCS) (December 2017). Arizona Medicaid Section 1115 Demonstration. Accessed from <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list?entry=8142>
- 2 Arkansas Department of Human Services. (March 2018). Arkansas Works Section 1115 Demonstration. Accessed from <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list?entry=15033>
- 3 California Health and Human Services (June 2018). California Medi-Cal 2020 Demonstration. Accessed from <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list?entry=8157>
- 4 Delaware Department of Health & Social Services (December 2017). Delaware Diamond State Health Plan. Accessed from <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list?entry=8408>
- 5 Florida Agency for Health Care Administration (June 2018). Managed Medical Assistance Program. Accessed from <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list?entry=8450>
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Included Managed Care Contracts

CHCS analyzed model managed care contracts when available. If a model contract was not accessible, the most standardized version of the contract was sought out for analysis. Only publicly-available contracts have been linked below.

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