

Building a Medicaid Strategy to Address Health-Related Social Needs

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IN BRIEF

State Medicaid agencies can use managed care and value-based payment initiatives to catalyze work relating to health-related social needs (HRSN) and drive better, more equitable health outcomes for Medicaid members. This resource, produced by the Center for Health Care Strategies with support from the Episcopal Health Foundation, is designed to guide state Medicaid agencies in developing a cohesive strategy to address HRSN. A robust HRSN strategy can help states achieve high-priority Medicaid goals — such as advancing health equity and value-based care — and can be part of a broader state strategy to improve community-level social determinants of health.

State Medicaid agencies are [increasingly pursuing opportunities](#) to address health-related social needs (HRSN) to improve health outcomes, reduce health care spending, and advance health equity. These efforts are accelerating in the current environment due to the COVID-19 pandemic, which has both [exacerbated and revealed](#) the profound health inequities experienced by people with low incomes and people of color. As states begin to design and implement efforts to address HRSN, state Medicaid agencies will need to determine how to align activities with health reforms, develop effective cross-sector partnerships with [defined roles and responsibilities](#), and coordinate with other state agencies overseeing food, housing, and transportation policy.

With support from the Episcopal Health Foundation, the Center for Health Care Strategies developed this resource to help state Medicaid agencies:

1. Design a cohesive HRSN strategy in the context of broader efforts to advance health equity and improve community-level social determinants of health (SDOH); and
2. Use Medicaid managed care and value-based payment (VBP) initiatives to advance that strategy.

Medicaid Benefits to Address Health-Related Social Needs

Note, this resource does not describe opportunities to add formal benefits relating to health-related social needs in detail. State Medicaid agencies interested in their options relating to Medicaid benefits can refer to the Centers for Medicare & Medicaid Services' (CMS) [state health official letter](#) (see [CHCS' policy cheat sheet](#) for an overview).

Plan to Address Health-Related Social Needs

1. Assess the Landscape

- **Gather and analyze data.** To develop state priorities and goals around addressing HRSN, states can first review data on the prevalence and depth of certain health disparities and social risk factors. Potential data sources include: [federal compendiums](#) and [geographic data sources](#); state and local departments of public health; Medicaid managed care organizations (MCOs) (including data aggregated from [required screening and assessment](#)); and external quality review organization reports. For example, states could build on analyses relating to the disproportionate impact of COVID-19 on communities across their state and, using a health equity lens, target HRSN that contribute to these disparities.
- **Review current state and health care organization efforts.** States may want to take an inventory of current state agency and health care organization efforts related to HRSN to better understand work already underway. For example, at the state agency level, Medicaid officials can reach out to state departments of public health and assess complementary efforts that have historically or can potentially be funded by federal grants, such as [social determinants of health accelerator plans](#), [community pilots](#), [initiatives to reduce COVID-19 health disparities](#), or [community infrastructure grants for network lead entities](#). As it relates to Medicaid MCOs, providers, and local communities, states can consider conducting surveys, experimenting with new types of community engagement events, or adopting existing structures for provider and MCO engagement, such as “roadshows” and advisory committees. For example, the **Pennsylvania** Department of Human Services conducted a [Medicaid Innovation Tour](#), which took stock of MCO initiatives addressing health-related social needs. This information can help identify common services and programs across certain geographic regions, in addition to dominant community-based referral resources.
- **Listen to communities.** States should provide a platform for community-based organizations (CBOs) and community residents to continually shape HRSN initiatives, during initial planning phases and well as implementation. For example, the state could consider ways to build on community engagement strategies developed by community-based convenors and regional health collaboratives, such as [Accountable Communities of Health](#) in **Washington** and [Regional Health Hubs](#) in **New Jersey**. These community engagement processes can serve to elevate and empower local communities, guide the prioritization of HRSN interventions, and enrich health equity initiatives.

Health-Related Social Needs Strategy Planning Checklist

1. Assess the Landscape

- Gather and analyze data.
- Review current state and health care organization efforts.
- Listen to communities.

2. Set Goals

- Define the state Medicaid agency’s overarching HRSN and health equity goals.
- Outline how to achieve state goals through Medicaid managed care and value-based payment initiatives.
- Consider adding Medicaid benefits that address health-related social needs.

3. Strengthen Community Resources

- Think strategically about community-based organization capacity.
- Consider building upon existing databases and systems that enable referral to, and coordination with, community-based organizations.
- Encourage coordination among health care organizations and other entities interested in work related to HRSN and SDOH.



2. Set Goals

- **Define the state Medicaid agency's overarching HRSN and health equity goals.**

Using available data and community input, the state Medicaid agency can establish goals related to addressing HRSN of Medicaid members, improving population health, and advancing health equity. These goals could reflect the state's priority populations and desired outcomes and would serve to guide all subsequent policy decisions and guidance provided to Medicaid MCOs, accountable care organizations (ACOs), and Medicaid providers. These goals can be defined in the state's Medicaid managed care quality strategy, population health improvement strategy, or other programmatic roadmaps and vision documents.

Identifying goals and priorities outright can help state Medicaid agencies with limited resources drive a series of high-impact, system-level approaches to improving care for Medicaid members. For example, the state may build goals based on: (1) a high-priority social need, such as food insecurity; (2) Medicaid members with certain risk criteria, such as individuals experiencing homelessness; and/or (3) health equity goals, such as better, more equitable maternal and infant outcomes for [Black women](#). Based on these priorities, state Medicaid agencies can enhance existing relationships with related state and local agencies, including better data exchange — for example, Area Agencies on Aging for older adults; agencies and departments administering SNAP and WIC for pregnant moms experiencing food insecurity; and [Continuums of Care](#) for individuals experiencing homelessness.

- **Outline how to achieve state goals through Medicaid managed care and value-based payment initiatives.** Success in achieving statewide HRSN goals will require a multi-pronged approach that is aligned with Medicaid incentives and requirements. When considering an HRSN strategy, an important starting point is identifying HRSN domains that are of high priority (e.g., food insecurity), and then creating a mix of requirements and incentives at both the managed care and provider levels related to these priority domains. For example, HRSN requirements can be more effective when they are woven throughout an entire Medicaid managed care contract, including the selection of quality metrics, VBP requirements, and guidance relating to *in lieu of* services, value-added services, and activities that improve health care quality. To the extent that a state has specialized VBP initiatives, such as those associated with a [multi-payer primary care transformation model](#) or a [Medicaid ACO program](#), states will want to consider how to integrate HRSN in related requirements. For more on potential VBP and MCO requirements, see pages 7 and 9.

- **Consider adding Medicaid benefits that address health-related social needs.**

Although Medicaid is primarily a health care program, Medicaid services can address health-related social needs, especially as it relates to home- and community-based services. For example, states interested in services for individuals experiencing homelessness can offer pre-tenancy and tenancy supports through a [state plan amendment under Social Security Act § 1915\(i\), or pilot those services through an 1115 demonstration](#). Making HRSN-related services formal Medicaid benefits facilitates a stable funding mechanism for those services, enables the costs of services to be included in Medicaid managed care capitation rates, and generally allows services to be provided to all Medicaid members that meet certain risk or eligibility criteria, regardless of payer affiliation. Although this implementation pathway is not the focus of this tool, states interested in adding formal benefits relating to health-related social needs can refer to CMS' January 2021 [state health official letter](#), which provides a comprehensive menu of potential services that can be covered using Medicaid authorities.

3. Strengthen Community Resources

- **Think strategically about CBO capacity.** HRSN, and the strategies used to address them in a given community, are defined by local context. To better understand and meet community needs and priorities, health care organizations should leverage the knowledge and connections of community-based partners. CBOs are often trusted members of their communities, with deep knowledge about the range of available community supports. They can serve as a single point of contact for health care partners, linking target populations to a full range of non-medical services. The state can encourage these partnerships by rewarding health care organizations that contribute financial resources to CBOs that address HRSN.

States, however, should be mindful of limited CBO capacity when (1) ramping up capacity to serve an influx of new referrals; (2) “making the case” for their interventions with multiple health care organizations; and (3) negotiating novel data agreements and contracts. States that have implemented community partnership requirements in the context of their managed care or VBP initiatives have also:

- » Started new capacity-building funds (such as the [Massachusetts Flexible Services Preparation Fund](#) and the [Moving Massachusetts Upstream Investment Program \(MassUP\)](#));
- » Explored ways to reduce administrative burden by developing [CBO networks](#) and nominating an intermediary that can broker relationships with health care organizations, such as **North Carolina's** [lead pilot entities](#).
- » Provided technical assistance to MCOs and CBOs entering into partnerships, such as [New York's VBP Bootcamp](#), and outlined key terms for related agreements, among [other tools](#).

- **Consider building upon existing databases and systems that enable referral to, and coordination with, CBOs.** Addressing social needs requires cross-sector collaboration and coordination with community partners. States can explore opportunities to bolster the current HRSN infrastructure, as well as potential opportunities to leverage federal funding (see, e.g., CMS' guidance describing [federal funding for Medicaid information systems](#) and the recently introduced bill [Leveraging Integrated Networks in Communities \(LINC\) to Address Social Needs Act of 2021](#)). States could consider how to leverage existing databases, such as 2-1-1; direct MCOs to identify ways to strengthen and expand existing screening and referral systems in targeted geographic areas on a pilot basis; or roll out standard screening and referral platform(s) statewide. [North Carolina](#) and [Virginia](#) use UniteUs in their statewide systems, and [Pennsylvania](#) is now using Aunt Bertha. [Rhode Island](#) developed the Unified Social Services Directory, a statewide directory of CBOs and public programs, and leveraged data from United Way's 2-1-1 system.
- **Encourage coordination among health care organizations and other entities interested in work related to HRSN and SDOH.** Over the last five years, many health care organizations have developed unique HRSN initiatives and partnerships. While the breadth of these projects and partnerships is encouraging, numerous unaligned HRSN initiatives in a region can lead to fragmentation and duplication. Without common goals and structures, health care organizations can miss opportunities to mobilize limited resources in a coordinated and community-informed way. By convening partners and [mindfully designing requirements and incentives](#), state Medicaid agencies can catalyze cross-sector efforts to pool financial resources, exchange data, and earn community trust. For example, **Oregon** requires its coordinated care organizations (CCOs) to [develop](#) a shared community health assessment and community health improvement priorities with local public health authorities, hospitals, other CCOs, among others. **New York** [encourages MCOs and providers](#) to collaborate with third party partners to identify and secure investment and support for HRSN-focused interventions. At the federal level, the Administration for Community Living recently published a funding opportunity for [network lead entities](#) developing a community-integrated health network that can blend and braid funding to address social needs.

Social Needs Screening: Key Decisions for States

Screening for HRSN is an essential first step in understanding the individual needs of Medicaid members and using that information to guide clinical decisions, care management activities, and design of interventions to improve health. Despite a significant increase in state Medicaid program interest in understanding how HRSN influence health spending and outcomes, efforts to screen Medicaid members for HRSN are still [relatively nascent](#). Medicaid agencies frequently require Medicaid MCOs, ACOs, and patient-centered medical homes to [identify and address HRSN](#) through care coordination and management activities.

States requiring providers and/or MCOs to screen for HRSN either typically require the use of a specific HRSN screening tool or encourage ACOs and MCOs to screen members using an approved tool. To ensure standardized data collection across MCOs/providers, **North Carolina** developed a [single standardized screening tool](#) to be used by the state's MCOs. **Rhode Island**, on the other hand, requires their [Accountable Entities](#) (the state's ACOs) to screen members using a tool approved by the state's Executive Office of Health and Human Services. In addition, the [Social Interventions Research and Evaluations Network](#) developed helpful Screening Tool Comparison Tables for the most widely used social health screening tools for [adults](#) and [children](#). **Oregon** has also explored the creation of a HRSN screening measure in the context of its [Social Determinants of Health Measurement Workgroup](#).

As states look to develop a strategy around HRSN screening and quality measurement, key questions include:



Which populations should be screened? Some states prioritize screening for all Medicaid enrollees while others identify high-priority populations, including high-risk patients.



Which HRSN factors should be prioritized for screening? States often identify a set of factors to screen for, which may be large or narrow depending upon a range of considerations — such as populations screened and perceptions of screening burden for providers or enrollees. States may also leave this decision to the entities responsible for screening.



Which health care entities are responsible for screening? States frequently specify the entities that are responsible for screening, which typically include primary care practices, hospitals, and/or MCOs. Guidelines on a screening strategy can reduce patients' burden related to repeated screening and promote a more efficient data collection and reporting infrastructure.



Should a standardized screening tool be required and if so, which tool? States may require the use of a standardized screening tool or leave it to the responsible entities to determine which set of questions to include in the screening.

Additional decisions to guide state HRSN screening approaches include: (1) whether screening should occur at **individual level or at the family level**; (2) the **frequency** of HRSN screens, such as on an annual basis or during primary care visits; (3) whether screenings will occur **as part of other assessments**, such as a health risk assessment, **or be a standalone screen**; (4) **reporting requirements and systems** that will help capture trends over time, enable tracking on performance on screening or interventions to address HRSN needs, and can be used to guide clinical decision making; and (5) ensuring that policies and practices are **trauma-informed**, align with enrollee perspectives on social risk screening, and build upon established trust, whenever possible.

Design the Strategy: Using Value-Based Payment to Support Health-Related Social Needs

Many states require their Medicaid MCOs to increase adoption of VBP over time, at contractually established levels, or to advance particular care models and associated shared savings and risk models, like [Medicaid ACOs](#). These payment models can indirectly incent providers to address HRSN to improve health outcomes at a lower cost.

Addressing HRSN aligns with VBP's Triple Aim goals — improving the care experience, improving health outcomes, and reducing per capita costs of health care — and can help providers reap greater financial rewards within VBP arrangements. However, VBP models [do not make a provider more likely to consider HRSN in their practice](#). Clearly aligning HRSN and VBP strategies presents opportunities for state purchasers to strengthen adoption of these activities and increase likelihood of success. But to date, most states have not directly linked the two, and there are untapped opportunities to address HRSN through VBP initiatives.

Generally speaking, states may directly link their VBP requirements to HRSN activities in three ways:

1. Embed measures relating to HRSN activities into a VBP model;
2. Reward providers for undertaking a defined set of social care activities within the VBP arrangement; and
3. Hold providers accountable for HRSN activities as part of VBP requirements.

Rhode Island and **Massachusetts** take the first approach within their Medicaid ACO programs, linking payment to HRSN screening efforts. **Minnesota** has deployed the second method: in [one iteration](#) of its [integrated health partnership](#) program, ACOs could earn a higher percentage of shared savings if they suggested a health equity measure and partnered with a CBO to address an identified set of social needs. The state now uses the proposed equity measures in the calculation of the ACO's [population-based payment](#). **New York** has taken the third approach, [requiring providers in advanced VBP agreements](#) to implement at least one HRSN intervention and a partnership with one CBO. The state provides a [menu of potential HRSN interventions](#) to help guide providers and plans in this process.

States also recognize the role of MCOs in advancing HRSN work tied to VBP arrangements. **New York**, which created its [Bureau of Social Determinants of Health](#) in 2017, requires MCOs to provide a funding advance for HRSN interventions embedded in its advanced VBP arrangements and classifies these expenses as a medical expense for the purpose of rate setting. MCOs also must develop a quality measurement framework to track these interventions, and report data to the state. **North Carolina** will expect its MCOs to submit a written plan on how it will incorporate HRSN-related activities into its [VBP strategy](#) to align financial incentives and accountability around total cost of care and overall health outcomes.

Tips for Using Value-Based Payment to Support Health-Related Social Needs



- ✓ **Create flexibility to address HRSN by adopting more advanced alternative payment models (APMs).** States want to see progression along the [Health Care Payment Learning & Action Network APM framework](#). Under prospective risk-based payment arrangements, such as a global budget, it is easier for providers to invest in HRSN.
- ✓ **Explore social risk adjustment of payment rates.** In **Massachusetts and Minnesota**, payment rates for ACOs are [risk-adjusted for HRSN](#), which seeks to account for additional costs of care for those with complex social and clinical needs. **Minnesota** uses various elements of Medicaid claims data and administrative data tied to Medicaid members from within the Medicaid agency and other departments, such as data on disability status and housing instability. **Massachusetts** created a geographically based index of HRSN using data from the U.S. Census Bureau's [American Community Survey](#). The state also began using ICD-10 Z-codes for homelessness as part of its methodology for risk adjusting based on social factors. Although Z-codes for homelessness already existed, using them as part of the state's risk adjustment methodology — which informs payments to health care providers — gives providers an incentive to reliably screen for and document whether individual patients are experiencing homelessness.
- ✓ **Require MCOs to report on VBP-related HRSN initiatives.** As in **North Carolina**, states can require each MCO to develop a written plan describing how it will integrate HRSN-related activities into its overarching VBP strategy. MCOs would develop VBP strategies that align with state HRSN goals and priorities, and would be encouraged to link related measures, risk adjustment strategies, and referral supports to their VBP arrangements. The MCOs would report on accomplishments, challenges, and lessons to help inform long-term state policy. The state could also consider modifying existing VBP data collection tools to capture related provider HRSN initiatives, interventions, and measures.
- ✓ **Integrate HRSN quality measures into VBP measure sets.** Some states have developed a common measure set to reduce provider burden associated with participation in multiple MCOs' APMs, or to support a particular initiative, such as a Medicaid accountable care organization. States developing a HRSN strategy may consider including an [HRSN screening measure](#) or other HRSN-related measure in this sort of core measure set.

Design the Strategy: Using Managed Care Organizations to Support Health-Related Social Needs

Medicaid MCOs can advance a state’s HRSN strategy. For example, MCOs are well-positioned to: factor HRSN into care coordination and management programs; support network providers in their HRSN strategies through payment, training, and specialized tools; partner with CBOs and local and state agencies; and directly invest in services that address HRSN.

States can use managed care contracts and related guidance to advance goals to address HRSN. For example, a state may:

1. **Define specific care coordination functions related to HRSN**, including appropriate screening and referral programs; partnerships with state, local, and community programs; and designated staff (e.g., a required housing coordinator).
2. **Outline HRSN-related expectations for population health management programs**, such as collecting and analyzing social needs data, understanding social risk factors underlying racial and ethnic disparities, and expanding access to community health workers.
3. **Require MCOs to consider HRSN and health disparities** within Quality Assessment and Performance Improvement (QAPI) strategies and through targeted Performance Improvement Projects (PIPs).
4. **Provide guidance on flexibilities to provide services outside Medicaid covered benefits** (e.g., value-added services, *in lieu of* services, and activities that improve health care quality) and how an MCO can get credit for those services in the calculation of rates or medical loss ratio (MLR).
5. **Tailor incentive and withhold arrangements** to reinforce state priorities relating to HRSN and whole person care models.
6. **Incent or require MCOs to invest in community reinvestment activities** — a novel approach implemented (or soon to be implemented) in **Arizona, North Carolina, Oregon, and Ohio**.

These requirements can emphasize state policy priorities and health outcomes of targeted populations. For example, **Michigan** has a [“focus bonus” program](#) related to low birth weight and a specific goal to advance “evidence-based, integrated models that address [low birth weight] through management of medical and social determinants of health,” and explicitly ties this initiative back to its health equity programs. In its [new managed care program](#), **Ohio** will integrate a kindergarten readiness quality measure, as well as a targeted “quality strategy population stream” related to women’s health.

Tips for Using Managed Care Organizations to Support Health-Related Social Needs



- ✓ ***Incorporate questions relating to HRSN into the state’s next managed care request for proposal (RFP).*** This approach would signal the state’s strategic priorities and ensure that the state has innovative partners for its initiatives. HRSN efforts could be recognized in the evaluation and scoring of each MCO’s programmatic proposal.
- ✓ ***Outline HRSN-related care coordination and population health management requirements.*** For example, the contract could specify targets and requirements relating to: (1) HRSN screening; (2) closed-loop referrals; (3) expansion of community health worker programs; (4) coordination with entities developing community health needs assessments; and (4) data-informed, tailored interventions for target populations with HRSN-related needs.
- ✓ ***Require MCOs to establish HRSN-related initiatives in the context of their QAPI programs.*** For example, the state could require HRSN-related PIPs. In response, MCOs could incorporate and assess the impact of HRSN-related initiatives in the context of their QAPI programs and relate their efforts back to the state’s broader HRSN and health equity goals.
- ✓ ***Provide guidance on reporting and classifying costs associated with additional services that address HRSN.*** This guidance could provide examples of common HRSN-related services and activities, and how MCOs can classify those as quality improvement activities, value-added services, and *in lieu of* services. Specifically, MCOs may be interested on how they can “[get credit](#)” for services and activities as it relates to rate development and the MLR. Value-added services and quality improvement activities, for example, [can be included in the numerator of the MLR](#), and *in lieu of* services can be used for rate development.
- ✓ ***Align MCO incentives with the state’s HRSN goals.*** The state could incorporate HRSN-related metrics into direct and indirect financial incentives for MCOs, such as through a pay-for-performance program or a quality-based auto-assignment algorithm. Metrics could include: voluntary community reinvestment initiatives; implementation of interventions to address specific needs, as identified by the state (e.g., food insecurity, housing); HRSN screening rates; or submission of MCO reports on efforts to address targeted populations or areas. For example, the state can tie a MCO financial incentive to an initiative relating to HRSN and members with severe mental illness. The state could also align these MCO incentives with corresponding changes to the state’s VBP initiatives.
- ✓ ***Encourage or require MCOs to reinvest in communities.*** For example, [Arizona](#), [Oregon](#), and [Ohio](#) require a certain percentage of MCO profits to be reinvested in communities. The state could also take a less prescriptive approach, similar to [North Carolina](#) — allowing MCOs to invest in CBOs and other HRSN-related resources *in lieu of* an MLR-related remittance to the state and awarding MCOs an auto-assignment preference for their investments.

Conclusion

As a health care payer and program, Medicaid cannot unilaterally advance work relating to individual-level HRSN and community-level SDOH. There are ample opportunities, however, for state Medicaid agencies to partner with MCOs, providers, community-based organizations, and other agencies to identify and address health-related social needs. CHCS created this tool to help states advance this work in the context of two dominant Medicaid trends: increases in [Medicaid managed care enrollment](#) and the proliferation of [value-based payment models](#). This tool offers only one potential starting point on an iterative journey to improve health outcomes by collaborating across sectors, defining equity-oriented goals, and engaging communities.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center committed to improving health care quality for people with low incomes. CHCS 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.