Medicaid's Role in Addressing Social Determinants of Health

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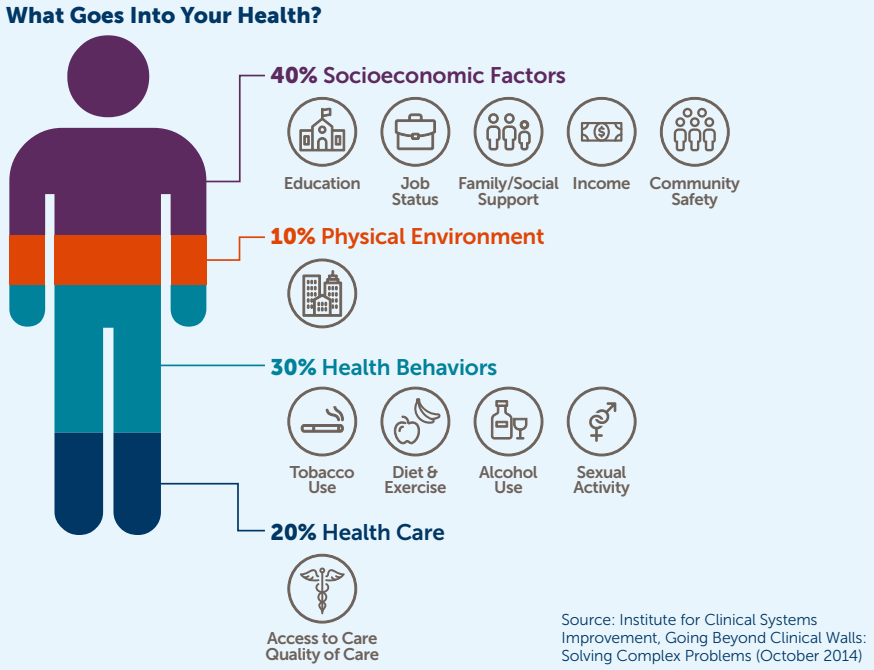
The Issue

Policymakers are increasingly recognizing the important role that social and economic factors, such as housing, healthy food, and income play in a "whole person" approach to health care, especially among Medicaid's low-income enrollees. Often referred to as "social determinants of health" (SDOH), these factors can drive as much as 80 percent of health outcomes.[1] States have a significant opportunity to cover some nonmedical services that directly impact health, as well as to connect people to housing and other social services not covered by Medicaid.

Why It's Important

Medicaid enrollees—low-income by definition—are particularly likely to struggle with basic needs, including food, clothing, and shelter. With state Medicaid programs increasingly looking to pay for health outcomes—not simply the volume of health care services delivered—there is an increased focus on strategies to address social needs that contribute to outcomes. To date, the evidence base for the cost-effectiveness of addressing social need is strongest for high-need populations. For example:

- Providing supportive housing to a seriously mentally ill person who otherwise would be homeless can significantly reduce medical expenditures on emergency department visits and inpatient care.[2]



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

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- Connecting low-income older adults with chronic conditions to the Supplemental Nutrition Assistance Program (SNAP) or providing home meal delivery can reduce health care costs and utilization.[3]

Considerations for State Policymakers

States are implementing a number of strategies to address SDOH and to integrate such efforts into the delivery of health care. New state officials will want to consider assessing current state policy to determine if these strategies are being or should be pursued, recognizing that ensuring access to physical and behavioral health care services is most essential, but that a whole person approach to health care delivery may well include addressing social issues through evidence-based interventions.

Covering Selected Nonmedical Services. States have the option to classify some community-based services as covered benefits in Medicaid, allowing them to receive federal Medicaid matching funds for these services. For example, Medicaid can cover the cost of helping people sign up for other social service programs (e.g., SNAP, housing vouchers) as part of "case management" services, an optional benefit in Medicaid. If a state pursues a Medicaid Section 1115 waiver, it can also potentially provide a broader array of nonmedical services.

Integrating Social Supports Into Health Plan Care Management. If they operate a Medicaid managed care program, states can require Medicaid managed care organizations (MCOs) to connect beneficiaries to social supports as part of their care management obligations. Twenty-four states now require MCOs to screen beneficiaries for unmet social needs and help them to address those needs.[4] In North Carolina, for example, MCOs are obligated to refer people to food, housing, transportation, domestic violence resources, and to track the outcome of their referrals. For high-need beneficiaries, the state requires that the MCO offer in-person help filling out social service applications and hire a specialist who can offer housing expertise.

Using Value-Based Payments to Support Social Interventions. States cannot use Medicaid to directly finance the cost of providing housing, and a number of other social services, but they can offer and encourage their providers to make such expenditures. Value-based payments reimburse providers for achieving specified outcomes and containing costs, rather than the volume of services that they provide. When reimbursed on this basis, a state can essentially "free" a provider to give a beneficiary whatever services are required—regardless of whether they are medical or nonmedical—to achieve the necessary outcomes. Arizona, for example, requires its MCOs to make 50 percent of their reimbursement to providers through value-based payments.[5] This has allowed providers to offer housing to homeless beneficiaries instead of paying for the medical bills they would have incurred if they continued to live on the streets.[6]

Evaluating the Impact of SDOH Interventions. With evidence of the impact of addressing SDOH still emerging, states should systematically evaluate the effectiveness of their SDOH initiatives. In particular, it is important to assess whether SDOH interventions work outside of high-need and high-cost populations. If a state uses a Medicaid waiver as the basis for their SDOH strategy, CMS will require such evaluations as part of the waiver. States that rely on managed care-based strategies can also conduct evaluations. Michigan, for example, requires MCOs to develop and submit a multiyear SDOH plan. As part of this plan, MCOs must articulate how they will use data to support their efforts and what SDOH-related measures they will report.

Conclusion

The interest in addressing SDOH via Medicaid continues to rise, reflecting the growing focus among states on paying for improving health outcomes and containing costs. While none of the tools at states' disposal can single-handedly resolve underlying gaps in the social safety net, they provide important opportunities to offer social support that will have direct impact. For more information on Medicaid's role in SDOH, please refer to the resources below.

Additional Resources

Resources for Social Determinants and Medicaid Managed Care

- Bachrach, D., Guyer, J., Meier, S., et al. Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools. The Commonwealth Fund. January 2018. *www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review*
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Resources for State Medicaid Options for Addressing Social Determinants

- Bachrach, D., Guyer, J., Levin, A. Medicaid Coverage of Social Interventions: A Road Map for States. Milbank Memorial Fund. July 2016. *www.milbank.org/publications/medicaid-coverage-social-interventions-road-map-states/*
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- Spencer, A., Lloyd, J., McGinnis, T. Using Medicaid Resources to Pay for Health-Related Supportive Services: Early Lessons. The Center for Health Care Strategies. December 2015. *www.chcs.org/media/Supportive-Services-Brief-Final-120315.pdf*

Endnotes

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2. Dohler, E., Bailey, P., Rice, D., et al. Supportive Housing Helps Vulnerable People Live and Thrive in the Community. Center on Budget and Policy Priorities. May 2016. *www.cbpp.org/sites/default/files/atoms/files/5-31-16hous.pdf*
3. Samuel, L. J., Szanton, S. L., Cahill, R., et al. Does the Supplemental Nutrition Assistance Program Affect Hospital Utilization Among Older Adults? The Case of Maryland. Population Health Management, 21(2), 88-95; 2018. *https://doi.org/10.1089/pop.2017.0055*
4. Manatt analysis of state managed care contracts.
5. Arizona Medicaid Managed Care Contract Amendment. Arizona Health Care Cost Containment System (AHCCCS). Phoenix: AHCCCS; 2018. *www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_Contract_Amend_1.pdf*
6. Bachrach, D., Guyer, J., Meier, S., et al. Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools. The Commonwealth Fund. January 2018. *www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review*