

Opportunities and Challenges for Medicaid Managed Care Organizations, Community Health Centers and Their Partners in Addressing Social Determinants of Health in Five States

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The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

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Executive Summary

Interest in using Medicaid to address social determinants of health (SDoH) has grown in recent years, and practices to achieve this goal are still developing. We reviewed the most recently available state Medicaid managed care contracts for language on SDoH activities across 10 contractual domains. Based on our assessment of language pertaining to these domains, geographic diversity, and Medicaid expansion status we selected five states to focus upon in this case study: California, Colorado, Georgia, Illinois, and Pennsylvania. We interviewed Medicaid officials and Medicaid managed health plans across these five states in addition to community health centers, Primary Care Associations, and Community-Based Organizations. The main themes that emerged from these interviews are (1) Medicaid managed care contract language reflects an increasing, but still flexible, focus on SDoH that is in early stages; (2) The lack of direct Medicaid coverage of SDoH services requires providers to find alternative means of funding; (3) A delivery and/or financial model for integrating SDoH services could improve providers' ability to meet patient needs; (4) Inconsistent SDoH screening tools limit data cohesiveness across organizations; (5) MCO and CHC relationships with local CBOs, though frequently informal, are critical to address SDoH; (6) the COVID-19 pandemic enhanced the need for strong relationships with local CBOs to meet increased patient demand; (7) Flexibility in approaches to financing and delivering SDoH services is useful at this stage. Despite a need for financing reforms that better incentivizes addressing patient whole health and wellness, the lack of clear standardization of SDoH screening tools, interoperable data collection systems, lack of robust health-related social services expenditure data, and financing uncertainties and insecurities present significant challenges for value-based payment arrangements.

Background

Medicaid is health insurance, and as such, like other forms of insurance, it will not pay for basic social and economic supports such as rental assistance, food, daily transportation needs, or child care. The federal government has partnered with states to conduct an 1115 demonstration that enables that state to use a very limited amount of Medicaid funding as a means of paying for certain types of health-related services on a very limited basis.¹ Otherwise however, federal Medicaid financing must be spent on recognized categories of "medical assistance" and associated administrative costs.

At the same time, however, Medicaid is notable for its flexibility as a health insurer, because from its enactment, the program was designed to finance health care for populations experiencing poverty and its attendant health risks. This type of flexibility is particularly evident when it comes to creating advanced systems of community-based care for children and adults whose disabilities place them at risk of institutionalization. However, Medicaid enables states to design managed

¹ Center for Health Care Strategies. (2018). *Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations*. <https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf>

care systems and other health delivery reforms that include supportive health services, such as care management, social risk assessment, and intensive counseling as an integral part of primary health care. These services can be paid for as preventive services or case management or may be incorporated into a state’s pregnancy care bundle or its comprehensive early and periodic screening, diagnosis, and treatment (EPSDT) services for children and adolescents.

A broader array of assessment and supportive services furnished by counselors, social workers, psychologists, and other health professionals also can be incorporated into the definition of “Federally Qualified Health Center (FQHC)” services. FQHCs are widely recognized as essential to Medicaid programs because of the quality of their care, their focus on medically underserved communities and populations, and the key role they play across the country in enabling managed care systems, which depend on comprehensive primary health care. But beyond being a type of provider, the FQHC concept also reflects a bundled primary care payment consisting of the services of medical, nursing, and other health professionals as well as other “ambulatory services” furnished under a state’s Medicaid plan. Thus, care management, social risk assessments, and preventive counseling can be recognized as part of the diagnostic, treatment, and clinical management services offered by FQHC staff. States have the ability to adopt such “FQHC” coverage and payment policies both directly and as an expectation of their managed care contractors.

Interest in using Medicaid to address social determinants of health (SDoH) has grown in recent years. The Center for Medicare and Medicaid Innovation began to push for greater integration of health-related social needs in creation of Accountable Health Communities and greater promotion of payment models to address social determinants of care.² Today, state Medicaid programs primarily rely on managed care to provide efficient, comprehensive, quality care, with approximately seven in 10 Medicaid beneficiaries are enrolled in managed care.³ Reviews of Medicaid Managed Care Organizations (MCOs) suggest increasing MCO engagement with SDoH.⁴ Such increases may be due to the updated 2016 Medicaid managed care rule that the Centers for Medicare and Medicaid Services (CMS) released, in which the agency provided several mechanisms through which states and MCOs can address SDoH.⁵ These mechanisms include enabling states to mandate use of alternative payment models, financial incentives that could tie

² Shin, P., Rosenbaum, S., Somodevilla, A., Handley, M., Morris, R., Casoni, M. & Sharac, J. (2021). Review of Social Determinants of Health Terms in 2019-2020 State Medicaid Managed Care Contracts.

<https://publichealth.gwu.edu/sites/default/files/RWJF%20MMC%20SDoH%20Contract%20Review%201213.pdf>

³ Kaiser State Health Facts. (2021). Total Medicaid MCO Enrollment. <https://www.kff.org/other/state-indicator/total-medicare-mco-enrollment>

⁴ Heiman, H. J., & Artiga, S. (2018). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

⁵ Machledt, D. (2017). Addressing the Social Determinants of Health Through Medicaid Managed Care. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/addressing-social-determinants-health-through-medicare-managed>

to population health metrics, and the inclusion of “in-lieu-of” and value-added services in medical loss ratio calculations.⁶

Recognizing the need to address underlying socioeconomic factors that impact health, most state Medicaid managed care contracts incorporate some requirement for addressing social determinants of care.⁷ A 2019 review of recent Medicaid managed care contracts⁸ show 30 states require use of a SDoH screening tool, 26 states requires care coordination or management for SDoH, 12 states requires value-added services related to social determinants or SDoH expenditure requirements or payment incentives, 17 states require collection and/or reporting of SDoH information or performance measures, and 25 states require provider training in SDoH, MCO staff dedicated to SDoH activities, or member education for SDoH services.

Under such managed care arrangements, Medicaid’s role as a payer of traditional clinical service encounters has evolved to be a purchaser of value-based care. Managed care organizations remain very much in the business of providing covered clinical services but could be incentivized or obliged to expand their benefits to include non-traditional forms of health-related SDoH services such as screening for underlying housing instability and food insecurity issues, reporting of SDoH-related performance metrics, and expanding care coordination to social service providers. More recently, in early 2021, the Centers for Medicare and Medicaid Services published clarifying guidance in support of state Medicaid agencies’ coverage and payment of SDoH activities.⁹ SDoH-related coverage, for example, can include housing support, home delivered meals, targeted case management. The various options present significant opportunities for states to address social determinants of health under Medicaid managed care.

Methodology

In order to better understand how such an environment can work to address SDoH, we interviewed Medicaid officials and Medicaid managed health plans across five states in addition to community health centers, Primary Care Associations, which represent the community health centers in their state or region, and community-based organizations. The community health center model, in particular, was historically designed to bridge health and social services for high-risk communities, populations, and patients.

⁶ Machledt, D. (2017). Addressing the Social Determinants of Health Through Medicaid Managed Care. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/addressing-social-determinants-health-through-medicaid-managed>

⁷ 35 of 39 states and the District of Columbia (DC) with Medicaid managed care contracts incorporate social determinants of health in their contracts. Four states (MO, ND, NV, UT) and DC do not include SDoH language in their contracts.

⁸ Based on publicly available Medicaid managed care contracts as of October 1, 2019.

⁹ Center for Medicaid and CHIP Services. (January 7, 2021). State Health Official (SHO) Letter: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). Centers for Medicare & Medicaid Services. <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>

This qualitative study follows on findings from our review of the most recently available state Medicaid contracts¹⁰ and our assessment of SDoH activities across 10 contractual domains – 1) a formal SDoH screening process, 2) discretionary value-added SDoH service, 3) data collection and reporting, 4) SDoH provider network, 5) financial incentives and support, 6) provider training, 7) SDoH service staffing, 8) SDoH quality measures, 9) care coordination with SDoH providers, and 10) member education.

Five states were selected for inclusion in the case study based on having a significant number of the SDOH domains incorporated into their contract and health centers in the state reporting at relatively significant capitated Medicaid managed care revenue (see appendix).¹¹ The interview states were also selected to provide diversity in geography and Medicaid expansion status, resulting in the inclusion of California, Colorado, Georgia (non-expansion state), Illinois, and Pennsylvania. Interviews were conducted between January and May 2021 as access to COVID-19 testing was widespread, COVID-19 vaccines became more readily available, and as patients increased their health care utilization as they returned to their health care providers for in-person visits.

In addition to the contract language, the selected sample states have different larger strategies and contexts in which they are working to address SDoH, such as:

California is the one of the five states with a DSRIP program,¹² with its first iteration running from 2010-2015 and its second (Public Hospital Redesign and Incentives in Medi-Cal [PRIME]¹³) approved for 2016-2020,¹⁴ with the latter's reporting metrics and funding then transitioned to Medi-Cal's managed care Quality Incentive Payment (QIP) program.¹⁵ In January 2022 (postponed a year due to the COVID-19 pandemic),¹⁶ the California Advancing and Innovating Medi-Cal (CalAIM) program will implement delivery and payment reforms to the Medi-Cal program, with a focus on SDoH that includes:

¹⁰ Shin, P., Rosenbaum, S., Somodevilla, A., Handley, M., Morris, R., Casoni, M. & Sharac, J. (2021). Review of Social Determinants of Health Terms in 2019-2020 State Medicaid Managed Care Contracts.

¹¹ Most CHCs do not participate heavily in risk-based Medicaid managed care arrangements.

¹² Kaiser State Health Facts. Delivery System Reform Incentive Payment Program (DSRIP) Waivers and Uncompensated Care Pools in Place. Timeframe: 2019. <https://www.kff.org/medicaid/state-indicator/delivery-system-reform-incentive-payment-program-dsrrip-waivers-and-uncompensated-care-pools-in-place>

¹³ California Department of Health Care Services. (March 2021). Public Hospital Redesign & Incentives in Medi-Cal Program. <https://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx>

¹⁴ MACPAC. (April 2020). Delivery System Reform Incentive Payment Programs. <https://www.macpac.gov/wp-content/uploads/2018/03/Delivery-System-Reform-Incentive-Payment-Programs.pdf>

¹⁵ California Department of Health Care Services. (August 2020). Medi-Cal 2020 Section 1115 Waiver Extension Proposal. <https://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal-2020-Public-Hearing-Presentation.pdf>

¹⁶ California Department of Health Care Services. (February 2021). California Advancing and Innovating Medi-Cal (CalAIM) Executive Summary and Summary of Change. <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Executive-Summary-02172021.pdf>

- The implementation of “in lieu of services, which are flexible wrap-around services... provided as a substitute to, or to avoid, other covered services”¹⁷ such as housing services, housing deposits, and meals.
- The inclusion of “a description of how it [each Medi-Cal managed care plan] will “[i]dentify and mitigate social determinants of health”¹⁸
- The inclusion of “[d]eveloping relationships with local community organizations to implement interventions that address social determinants of health (e.g. housing support services, nutritional classes, etc.)”¹⁹ within case management services

Colorado uses Regional Accountable Entities (RAE) to better coordinate care. Colorado Medicaid also operates two capitation reform initiatives in Denver and in western Colorado.²⁰ In the western region, the Rocky Mountain Health Plan, an MCO, serves as the RAE. For Denver Health Medicaid Choice Enrollees, Colorado Access serves the RAE which administers behavioral health benefits and, Denver Health Medicaid Choice, a capitated health plan, provides physical health benefits.²¹

Georgia’s Department of Community Health (DCH) expressly “seeks to demand and facilitate activities to address SDoH to improve health outcomes... [b]y holding the CMOS accountable for providing programs such as case management for members with chronic diseases and high-risk pregnancies; the provision of transportation to appointments; and integrated access to physical and behavioral care, DCH demonstrates its engagement in addressing the SDoH.”²² Care Management Organizations (CMOs) work with DCH to address health-related social needs (HRSNs) through screening, assisting members and providing resources to address HRSNs, using evidence-based interventions, identifying

¹⁷ State of California—Health and Human Services Agency Department of Health Care Services. (January 2021). California Advancing & Innovating Medi-Cal (CalAIM) Proposal (p. 9).

<https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf>

¹⁸ State of California—Health and Human Services Agency Department of Health Care Services. (January 2021). California Advancing & Innovating Medi-Cal (CalAIM) Proposal (p. 25).

<https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf>

¹⁹ State of California—Health and Human Services Agency Department of Health Care Services. (January 2021). California Advancing & Innovating Medi-Cal (CalAIM) Proposal (p. 35).

<https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf>

²⁰ Colorado Department of Health Care Policy and Financing. (September 1, 2020). Accountable Care Collaborative Payment Reform Program Report.

<https://hcpf.colorado.gov/sites/hcpf/files/Accountable%20Care%20Collaborative%20Payment%20Reform%20Program%20Report%20FY%202018-19.pdf>

²¹ Colorado Department of Health Care Policy and Financing. (January 2020). Denver Health Medicaid Choice Member Assignment in the Provider Web Portal.

<https://hcpf.colorado.gov/sites/hcpf/files/Denver%20Health%20Medicaid%20Choice%20Provider%20FAQs%20January%202020.pdf>

²² State of Georgia Department of Community Health. (May 2021). 2021–2023 Quality Strategy. (p. 31).

<https://dch.georgia.gov/document/document/ga2021-dch-quality-strategy-d2-final-version/download>

service and resource gaps that cause health disparities, and having both call-based and online resource platforms for members.²³

Illinois has enacted Public Acts 101-650 and Public Act 101-0655 to create the Hospital and Healthcare Transformation Program, also called Healthcare Transformation Collaboratives (HTCs).²⁴ The Department of Health and Family Services provides up to \$750 million over five years (\$150 million per fiscal year starting in FY2021) for its program “Healthcare Transformation Collaboratives... to encourage collaborations of healthcare providers and community partners to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities throughout Illinois... and address the social determinants of health in these communities.” Each collaborative must include at least one Medicaid provider.

Pennsylvania’s Whole-Person Health Reform Package recommended the establishment of Regional Accountable Health Councils (RAHCs) through the Medical Assistance Program (MAP) to identify health disparities based on MAP, SDoH, and community health needs data.²⁵ The RAHCs will create Regional Health Transformation Plans that aim to reduce these disparities. The nine priority domains for SDoH assessments and initiatives are: 1. Food Insecurity, 2. Health Care/Medical Access/Affordability, 3. Housing, 4. Transportation, 5. Childcare, 6. Employment, 7. Utilities: Emergency Assistance, 8. Clothing: Emergency Assistance, and 9. Financial Strain. Other recommendations included the procurement and implementation of a statewide resource and referral tool (R&RT) to better assist individuals in accessing social services and the inclusion of CBOS that provide social services in value-based payment (VBP) contracts. The HealthChoices Physical Health Agreement details the incorporation of CBOs into VBP strategies over 2021, from 25% by March 1, 2021 to 75% by September 1, 2021.²⁶ The CBOs must address one of the eight SDoH domains (all of those noted above except health/medical care access/affordability), are assessed for inclusion based on the accessibility and quality of their services, and are either contracted directly or through a network provider.

Key Findings

This section describes the main themes that emerged from our interviews with representatives from Medicaid agencies, Medicaid managed care organizations (MCOs), Primary Care Associations (PCAs), community health centers (CHCs), and community-based organizations

²³ Ibid.

²⁴ Illinois Department of Healthcare and Family Services. (October 22, 2021). Healthcare Transformation Collaboratives: FAQs. <https://www2.illinois.gov/hfs/Pages/htcfaqs.aspx>

²⁵ Interagency Health Reform Council. (December 2020). Health Care Reform Recommendations. <https://www.governor.pa.gov/wp-content/uploads/2021/01/IHRC-HCR-Recommendations.pdf>

²⁶ HealthChoices Physical Health Agreement effective January 1, 2021. <https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/HC%20Agreement%202021.pdf>

(CBOs). Illustrative quotes that demonstrate or provide examples of the main themes are included below. For confidentiality purposes, we refer to the general organization type.

Medicaid managed care contract language reflects a stronger push towards addressing social determinants of health. Interview participants noted SDoH was historically much more entrenched in behavioral health care management services. Interviewees noted this language was much needed to meeting whole health needs. As a result, each health care organization believed it to be their responsibility to address them. However, interviewees also noted that contract terms did not specify how such services were to be organized. The variation in their approaches tended to reflect the diverse needs of their unique service area.

... we have been very conscientious about moving our agreements forward in a manner that encourages and requires that our MCOs focus on those issues that really contribute to individuals' overall health, particularly food insecurity, workforce training, and housing. That's been our overarching philosophy.—State Medicaid official

What if our members aren't accessing care and they get sick and they can't go to work? ...If people can't go to work or school, it's a chicken and the egg problem. Medicaid has a core responsibility to deliver services so that other pieces of members' lives don't unravel.—State Medicaid official

Before, [our health plan] was either [focused on] medical or behavioral health, but it couldn't be both. I feel like there is a lot more focus now that it all goes hand-in-hand as whole-person care. If a person is hungry or has no place to sleep, it's more of a whole-person approach. The state recognizes now that this is a whole-[person] issue where medical and behavioral health needs to work together.— MCO

[Community health centers] have always dealt with [social determinants of health]. It's whole-person health care and dealing with barriers to people receiving health care.— CHC

We maintain a resource list around food, housing, transportation, utilities, and nutrition, in order to help people who are feeling socially isolated. We coordinate with clinics and provide support... What's been great is the collaboration has been brought in more between clinics and social services organizations.— CBO

All interviewees believed the states were providing enough flexibility to allow each organization to assess and address the varying community, service area, patient, and member needs. None of the interviewees recommended clearer language on the structure or organization of SDoH services. They all believed it was still too early in the stage of understanding and assessing best

approaches to addressing health-related social needs. Both MCOs and health centers appreciated the flexibility to adapt their own organizational approach at this time.

Medicaid needs to directly cover SDoH services. Interviewees generally acknowledged that much of their SDoH services are not directly reimbursed by Medicaid. Medicaid capitation and Per-Member Per-Month (PMPM) payments provides coverage of care management and coordination generally for medical and behavioral health services, and costs for addressing SDoH is not reflected in the payment calculation. Instead, community health centers stated that they rely largely on foundation grants, as well as HRSA grant funding, to support such services as SDoH screening and data collection. CBOs also noted similar reliance on public and private funding. Both health centers and CBOs also received funding from MCOs; MCOs provide funding via grants or through their charitable arm of their organization.²⁷ MCOs and CHCs noted they also fund their own SDoH work from their internal reserves and profits.

The MCO agreement language identifies CBOs as the main entities for addressing SDoH. They are 501C3 organizations that are not healthcare providers and that address the elements identified in the SDoH tool...To clarify, we don't give the MCOs extra funding to pursue those relationships. —State Medicaid official

Right now, SDoH screening is not reimbursable, but it is incentivized. There are indirect ways it's supported... a lot of FQHCs [CHCs] use PRAPARE, but that's incentivized by HRSA. —State Medicaid official

From the financial side, it [SDoH screening] is funded through operations, so we pay for that and we absorb all of that...so it's not funded but I don't want this to be a barrier—CHC

Despite non-direct payment for SDoH activities, state Medicaid programs recognize CBOs are critical care partners in addressing SDoH. However, states currently lack understanding of SDoH expenditures and how they can be incorporated into a health services payment arrangement.

We have requirements for them [health plans] to have relationships [to address SDoH]...We know addressing SDoH can reduce costs of care. We're not specifying how much money has to go to CBOs, just that they have to be incorporated. Within the [proposed] VBP, we are working with the CBOs downstream where they are

²⁷ Indeed, a number of states require or incentivize plans to reinvest some of their margins back into the community. For example, Oregon recently amended its 2021 contract requiring its regional health plans (also referred to as Coordinated Care Organizations [CCO]) to subcontract or have an MOU with a SDoH partner and to reinvest a portion (unspecified) of their profits and reserves to address health disparities and SDoH. Oregon Health Authority. (January 1, 2021). 2021 CCO Contract Template.

<https://www.oregon.gov/oha/HSD/OHP/Documents/2021-CCO-Contract-Template.pdf>

used to address SDoH. That is separate from the community-based care management that has its own funding stream...—State Medicaid Official

Our core business, whether you're an MCO or whether you are health center, is health care and how much of that focus, can you expand and not lose quality in your primary purpose. And finding that balance, and I think everyone knows we can't move the needle, on any of the social determinants of health alone. And you can't do it without resources and that's people, as well as financial resources...but there really isn't anything other than the managed care contract to support the requirement, so there is this desire to have all of the managed care organizations and the providers in a region work together on social determinants of health...The jury is still out on whether the approach that they're taking will have any significant impact.—PCA

In the real world, MMC [Medicaid managed care] premiums are razor-thin. Many health plans don't have access to a chunk of capital...We have to make sure we're in good communication with the state to make sure we're paying Medicaid dollars to cover Medicaid services. If we are ever using funds to pay for housing, we have to put that under community reinvest funds, like funds from shared savings. That is an active area of conversation with the state. There are pretty intense requirements on SDoH deliverables built into our state contracts. We have a business case of expecting a return on using community reinvestment funds for housing and other SDoHs, in terms of tax credits and also better health outcomes. These are harder to evaluate in terms of their returns and we are trying to find better ways to evaluate their value.— MCO

MCOs stated that they report on their SDoH activities and expenditures to state Medicaid agencies. Interviewees noted the collection of SDoH expenditures will be needed if states move to focus on social determinants and opt to pursue value-based payment (VBP) options. However, none of the interviewees understood how the state may be using the data to risk adjust their payments for social determinants.

We report the information [on money spent on transportation and SDoH], but we get paid to deliver certain services. The state gets the information but doesn't give us credit for it or take account of it in rate-setting... We track how much is spent on these services. We look at what's effective and what's attractive to the membership, but quite frankly no one has asked us and asked to see the additional cost that we incur to service the Medicaid or government programs.— MCO

That's [SDoH activities] a benefit that managed care provides. They can do value-based payments. One of the troubles that MCOs encounter is that everything they do has to be tied to a billable encounter... We want to work with MCOs on [developing] VBP to provide services in a better way and address SDoH, criminal justice involvement, employment and housing, but not everything is a traditional Medicaid health service. Because of that, there is not always a traditional Medicaid funding platform.— PCA

Interviewees noted the need of adding coverage of health-related social needs expenditures in the alternative payment model or capitation calculations and also believed value-based purchasing model has potential for impacting SDoH. However, they acknowledge that restructuring payment approaches required a good understanding of the expenditures/investments and performance data.

Greater integration of SDoH, similar to ACO models, is needed. Interviewees frequently referenced Accountable Care Organizations (ACO) and Accountable Communities for Health (ACH) as potential delivery and financial models that can be adapted to better address a patient's SDoH issues and, more generally, whole-person needs. ACOs consist of providers who share financial responsibility to provide coordinated, high-quality care with the aim of reducing health care costs.²⁸ ACHs involve a group of providers and other community stakeholders working collaboratively to address health-related social needs. Medicaid managed care organizations' participation in such efforts would provide some structure and financial stability for ACH.²⁹

The ACO has [numerous] FQHCs and [multiple] hospitals. We all operate under thin margins and lean operations and pretty much all our SDoH work is funded through grants and we don't even break even on our medical services so we have to supplement everywhere we can... We have great relationships with local hospitals and 3-4 provide annual community benefit grants to us. Some are explicit about supporting SDoH work.— CHC

We [state CHCs] have an ACO, so between the ACO, Medicaid managed care plans, etc. they're all looking at the same indicators so we're looking for common reporting elements. We're well into that process. A part of the reason is to cut

²⁸ Mahadevan, R., & Houston, R. (2015). Supporting Social Service Delivery Through Medicaid Accountable Care Organizations: Early State Efforts. Center for Health Care Strategies. https://www.chcs.org/media/Supporting-Social-Service-Delivery-Final_0211152.pdf

²⁹ Hughes, D. L., & Mann, C. (2020). Financing the Infrastructure of Accountable Communities for Health Is Key to Long-Term Sustainability: A Legal and Policy Review to Identify Potential Funding Streams Specifically for Accountable Communities for Health Infrastructure Activities. *Health Affairs*, 39(4), 670-678. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01581>

*down on confusion for providers. The commonality will result in better reporting.—
PCA*

*We are seeing a greater emphasis on true healthcare integration. Not just taking
an assessment of needs but connecting them with services.— PCA*

*For a long time, the way they [Medicaid] addressed this [SDoH] was through care
coordination. There is not much else from the state around SDoH, with the
exception of some scattered stuff like MCOs working on a housing initiative to fund
housing for some Medicaid members. On care management side, [the state] has
been pretty prescriptive on how the MCOs had to do this, like staffing ratios, and I
think MCOs have by and large met the requirements in name but it's not
particularly meaningful work... It's often duplicative of our own case management
services. Our patients don't know who their care coordinator is. The exception is
our ACO that works directly with a Medicaid plan... We get paid a monthly PMPM
fee so have care coordinators and managers in-house at [the health center] so
patients get warm handoffs, and they know the behavioral health and physical
health providers, so that's a very different beast for our patients. The providers
love it. It's meeting all state requirements for the plan, but we're big believers in
this model, but aside from that I'm not sure how that [additional MCO] care
coordination is that useful.— CHC*

*[The CBO] is the lead of a demonstration project at CMMI the Accountable Health
Communities Model. We have [multiple] clinics and hospitals asking those SDoH
questions. For that project, if they have two or more ER visits and at least one
SDoH, they are referred to care coordination and they get help, either through [the
health] plan or otherwise. — CBO*

Interviewees noted that such collaboration and integration of clinical and non-clinical services is needed for effectively addressing social determinants. Greater coordination of resources and dedicated reinvestment in those resources is likely to not only improve community and population health but also to lead to significant and sustained health care savings.

Greater standardization of SDoH screening is needed, particularly for more efficient care management and enhanced/risk-adjusted payment. Providers and MCOs often do their SDoH screening on their own and use varying screening tools. Interviewees noted that health centers and plans have their own preferred and customized screening tools and maintain a separate data collection systems. Each either uses or customizes their screening tools based on national instruments, including the PRAPARE tool from the National Association of Community Health

Centers and CMS's Accountable Health Communities (AHC) screening tool.³⁰ Although both may share common elements, health centers and MCOs noted their screening data are not shared with each other.

The system will have 3 different SDoH assessments. We're not requiring the same assessment tool but we are requiring the same 9 domains.— State Medicaid official

Our patient navigator will reach out to every patient who goes to the hospital and will do their own assessment and connect the patient to a nurse or social worker. [The patient navigator] looking for chronic diseases, like congestive heart failure or diabetes, as well as any social services that are needed like housing, clothes, food, or free cell phone.— MCO

It's [using an SDoH screening tool] primarily PRAPARE, but some are using [other assessment tools]... [one assessment] is not actually a SDoH screening tool but they said they're using that as an assessment...Some folks [CHCs] have developed their own tool.— PCA

We do use PRAPARE but not for every patient, it's just too long. It may be a home-grown tool that we developed over the past year that is one question.— CHC

It [SDoH screening] usually starts with a health plan. They have their own SDoH assessment. I don't believe it's the PRAPARE tool. I think that's a barrier in terms of using different tools.— CHC

Although MCOs and CHCs may share some common elements from various screening tools, they noted their adaptation or administration may not necessarily align. The lack of standardization has also led to each organization developing their own unique data collection systems. The lack of a standardized screening tool and shared data system likely make it difficult for state to consider adjusting payment rates for social determinants.

We may refer members for services but we don't know if they received the service unless the member or organization lets us know.— MCO

The ACO was able to contract jointly for [data sharing]. It gives us the ability to refer for any services they need. We screen patients to ask if there is anything else they need, like healthy food, so we can use that tool to connect patients, and track

³⁰ Center for Medicare and Medicaid Innovation. (2019). The Accountable Health Communities Health-Related Social Needs Screening Tool. Centers for Medicare & Medicaid Services. <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

data to where patients are referred, which partners do we need to meet needs, and now we have a tool on our website so patients can refer to themselves. Our ACO has an alerting tool that many local hospitals use so when a patient goes to the hospital it immediately alerts the care coordinator.— CHC

Ideally, interviewees seek to develop systems that would allow them to better assess how well they are able to “close the loop” on referrals. Some of the organizations had such a system but did not allow access for MCOs or providers. Interviewees noted the challenges of developing and maintaining a SDoH data collection system especially given screening and data collection systems are financially supported internally and varying screening tools.

MCO and CHCs generally address SDoH in their own space. In most cases, CHCs have long-standing relationships with local CBOs upon which they can rely. Many CHCs noted they do not rely on health plans to connect their patients to local CBOs. While health plans can help bridge local resources for some of their network providers who are unfamiliar with SDoH issues, they generally acknowledge CHCs to be more resourceful and self-sufficient. Health plan interviewees also noted that other network providers, such as larger pediatric practices, are likely to have extensive relationships with CBOs on SDoH issues and similarly are less reliant on health plans. At the same time, CHCs noted that MCOs can help address some service gaps, such as transportation. Others noted coordination of care can be bidirectional where a case manager at CHC or an MCO may notify the other about the need for a referral if they cannot find a community partner.

We just did training to the MCOs on how to identify the stronger CBOs, how to go about identifying outstanding needs in the communities so they're not duplicating what's already in existence. I still am not aware of any of the MCOs that have already actually signed an agreement with a CBO, but I know for most of them they're still trying to figure out how they're going to go about it. —State Medicaid official

A big part of what the social work department does is keeping up the master list of community resources which are constantly changing. Community providers come to us and let us know what they have to offer...We work with them to make sure the members get there. We'll [also] provide information to members over the phone. The connections do, however, depend on the specific community resource. We don't have contacts with all of them. Like if it's food banks... we'll give members a list of food banks near them. We'll follow up to make sure the member gets the service.— MCO

Relationships are really important to develop with community partners. We don't do a lot of the SDoH work on our own. Because of this, we have to know where those food banks are and who provides childcare. — MCO

A lot of the work I'm focused on is working on creating relationships within the community. Medicaid managed care is transactional and hyper-contractual, most MMC plans are not very good at figuring out how to partner with a whole set of community providers and organizations, that are more critical to our members' success than actual providers. — MCO

Our position is that CHCs should be seen as the forefront of this change. We are the largest primary care provider in the state. We do an excellent job of meeting the needs of our consumers. Many of our organizations are pillars in their community and if CHCs don't already offer housing, food, or employment services, they have established relationships with other CBOs. We are seeing a greater emphasis on true healthcare integration. Not just taking an assessment of needs but connecting them with services. — PCA

...they [MCOs] don't go as deep or broad as we go [on SDoH]...That is the challenge with MCOs. We don't care about insurance. — CHC

The health plans do start the work on SDoH. We have a pretty good relationship with the health plans. They do provide SDoH to patients. For example, they provide transportation, care coordination, and they have a process depending on patients' needs. They are triaged and a case manager calls them and makes sure they are linked to social services and we take over and continue the care coordination. — CHC

We have a lot of MOUs with [CBO] partners. They tend to be typical referral relationships where we can refer patients for services with preferential access. What we're trying to move forward with key partners, if we can make sure our [CHC] patients can get access to your services, we can make sure that their [CBO] patients can get access to medical care here at our health center. — CHC

MCO and CHC interviewees noted much of their relationships are based on long-standing trust, personal relationships, and community standing. The relationships between CBOs and CHCs also tend to be informal. None of the interviewees viewed the lack of a formal arrangement as a problem, yet interviewees understood current payment policies and rates limited their ability to pay for SDoH-related services.

The COVID-19 pandemic opened new opportunities for innovation and stronger relationships.

Provider and MCO interviewees generally acknowledged the public health emergency necessitated a need to better connect with local partners to address the disparate effects on access to food, housing, and income. While most local resources were operating at capacity pre-pandemic, some organizations found ways to stretch themselves to do more, e.g. “found extra bed or room.” However, there were obvious limits to local resources especially with housing issues being the most difficult to address.

COVID has been helpful in breaking through historic barriers...as an example, there is a persistent problem of people in hospitals who can't discharge somewhere even though they don't need hospital care, because they can't go home, for example, if they are violent in their own home they can't go back, they are unhoused or there is some other social determinant of health issue. Suddenly, with the pandemic, we found that people could be found places... — State Medicaid official

The need for resources is more than ever or at least, we're identifying them more. [MCO] employees are in the community, so there is a relationship with these folks, but the needs are huge and the resources are limited. So people are being very creative in how they work. For example, we work with farms to get fresh fruits and vegetables out. — MCO

Especially housing and food insecurity has been exacerbated with COVID. Food insecurity is easier to stay on top of because there are many community partnerships. Before the pandemic, housing was a nightmare so I can't imagine what it's like now. Years-long waiting lists etc. are harder to deal with than getting people groceries. — PCA

It's extremely difficult to find affordable housing in safe neighborhoods. There are waiting lists...It's gotten worse obviously with COVID. It was never easy to get some housing now with the pandemic, it's extremely difficult. — CHC

Despite devastating impacts on low-income communities and vulnerable populations, some interviewees were hopeful that the various creative approaches found toward addressing some of the most urgent health-related social needs during the pandemic reflects potential for more innovative use of local health and social service resources. However, others noted Medicaid and its providers cannot overcome the limits of local resources.

Contract language, particularly in reference to payment and terms, should specify coverage of SDoH services but allow flexibility for various approaches. As noted earlier, interviewees most commonly recommended improved funding and reimbursement, and generally payment

structures that increase their capacity for and engagement in SDoH activities. Interviewees noted the general contractual terms allow for flexibility to focus or broaden their care delivery. Although no specific recommendations for refining contractual SDoH language were recommended, interviewees noted that a shift from encounter-based payment models to an alternative payment or value-based payment model, including the use of telehealth or virtual visits, would help to expand the use of team-based care and to strengthen SDoH services. Others suggested gain-sharing and use of SDoH quality measures to incentivize providers to ensure patients are receiving needed services.

I do think as SDoHs gain more interest in integrated models of care, states will think about how to allow certain things to be allowed. Some services are related to health more, whereas with other services, there's a question about whether this is preventive or not. Not all companies want to be public health organizations; they want to be a health plan. A little money with a lot of flexibility will drive us to where we need to be.— MCO

How do you contribute more to the actual resources and needs, not just by having a process of referring, but how do you fund projects in the communities that provide resources. I would hope the [health plans] of the world would do this, invest in community resources, whether in housing or in education to develop a way where folks have more opportunity so they don't land in this situation where there always is this generational gap.— CHC

We're still stuck in volume-based care...So I think payment reform, shifting to PMPM model, and a capitated model with gain-share attached to it. If state Medicaid department paid us a gain-share, 90% of the time health centers will invest that money back into those [SDoH] services.— CHC

With our quality programs, there could be more SDoH measures to incentivize us or give us a PMPM to follow up with patients who had an ED admission or were discharged from hospital. Maybe we could have a payment arrangement to make sure our patients are getting the services they need. I do think there is a return on that, but it's not immediate. MCOs have a short-term horizon because members move in and out of their plans. It's just hard to do in the Medicaid environment.— CHC

I don't think it necessarily has to be put in law or contract. I would like the ability for CHCs and MCOs to enter into VBP methodologies. APMs that allow us to provide services in a better way and not tie everything to a billable encounter. The whole point of moving away from encounter-based payment methodology is to

allow more team-based care and to make better use of telehealth. What proves to be difficult with MCOs is they are of different sizes. When we are trying to negotiate with 5 or more payers, we need to have consistency in developing claims and billing and quality standards. It can be too much for an organization to meet all the different standards of each MCO. CHCs have to be accountable and we're afraid it will be a barrier if you have multiple MCOs with different standards that do not align with other payers.— PCA

Conclusion

State Medicaid programs and its plans and providers are increasingly focusing on addressing social determinants of health, but each in their own way. While this fragmented approach likely reflects still the early stages in which Medicaid managed care is engaged in addressing SDoH and the limits of traditional payment policies (and lack of SDoH-related service cost data to better adjust payment rates), state Medicaid officials as well as managed care organization and health center representatives indicate both the need and desire to undertake the various actions for ensuring or incentivizing SDoH focus as they consider staffing and data reporting requirements related to SDoH and developing value-based purchasing payment models that better reflect SDoH expenditures. For those participating in larger care delivery organizations, value-based payments considerations appear to be the most attractive for integration of clinical and health-related social service needs. Smaller practices may be less prepared or inclined to participate in value-based arrangements. Alternative payment structures include capitation and enhanced per member per month payments that reflect higher costs of more intensive care coordination and access to local social services. States can also require health plans to portion part of health plan reserves and profits to address social determinants. Many of our health plan representatives noted they are already making investments in community social determinants. While such investments provide for much needed resources and flexibility for providers, they are often a patchwork of services that are not well monitored and may not be sustainable without additional investments. Reforming Medicaid payment methods is likely to be much more effective for ensuring a more integrated and efficient approach to addressing social determinants of health.

Appendix

Appendix Table A1 provides details on the Medicaid managed care environment and community health centers in the five case study states.

Table A1

	California	Colorado	Georgia	Illinois	Pennsylvania
Number of SDoH domains (out of 10) included in the MMC contract ³¹	6	7	6	3	6
Number of Medicaid MCO plans ³²	24	2	4	7	9
Share of Medicaid beneficiaries in risk-based managed care ³³	81%	9%	75%	81%	89%
Number of community health centers ³⁴	175	19	35	45	42
Number of Medicaid patients at community health centers	3,270,048	310,727	157,934	734,871	350,073
Total capitated Medicaid managed care revenue reported by community health centers (2020)	\$2,165,298,648	\$35,947,900	\$227,216 (2019)	\$57,360,684	\$1,443,229

³¹ Shin, P., Rosenbaum, S., Somodevilla, A., Handley, M., Morris, R., Casoni, M. & Sharac, J. (2021). Review of Social Determinants of Health Terms in 2019-2020 State Medicaid Managed Care Contracts.

³² Kaiser State Health Facts. (2021). Medicaid MCO Enrollment by Plan and Parent Firm, March 2021. <https://www.kff.org/medicaid/state-indicator/medicaid-mco-enrollment-by-plan-and-parent-firm-march-2021>

³³ Kaiser State Health Facts. (2021). Share of Medicaid Population Covered under Different Delivery Systems. <https://www.kff.org/medicaid/state-indicator/share-of-medicicaid-population-covered-under-different-delivery-systems>

³⁴ Health Resources & Services Administration. (2021). 2020 Health Center Data: Uniform Data System state reports for California, Colorado, Georgia, Illinois, and Pennsylvania, <https://data.hrsa.gov/tools/data-reporting/program-data/state/CA/table?tableName=Full>; <https://data.hrsa.gov/tools/data-reporting/program-data/state/CO/table?tableName=Full>; <https://data.hrsa.gov/tools/data-reporting/program-data/state/GA/table?tableName=Full>; <https://data.hrsa.gov/tools/data-reporting/program-data/state/IL/table?tableName=Full>; <https://data.hrsa.gov/tools/data-reporting/program-data/state/PA/table?tableName=Full>