



Social Determinants of Health— Medicaid Coverage and Payment

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Introduction

Medicaid and the Children’s Health Insurance Program (CHIP) provide health coverage to over 76 million low-income Americans, including individuals with complex, chronic, and costly care needs. Medicaid and CHIP beneficiaries may face challenges related to social determinants of health (SDOH) including, but not limited to, access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social connections, quality education, and opportunities for meaningful employment.

Federally Qualified Health Centers’ (FQHCs or health centers) role as “safety net providers” presents a unique opportunity to adopt innovative strategies to improve care and reduce health costs for individuals with complex socioeconomic needs. Each health center offers a local solution for solving the most ingrained community problems that impact health, and for narrowing the most glaring health disparities. They have the commitment, experience, and tools necessary to respond to community problems. Effective primary care serves as the source of first and continuous contact with patients and is responsible for care coordination. The centerpiece of care coordination is an approach that identifies and attempts to address the SDOH for patients.

The purpose of this guidance is to highlight opportunities for FQHCs to address SDOH under Medicaid and CHIP. Our guidance distills information sourced from CMS’s **Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov)** issued January 7, 2021. Our summary of CMS guidance adopts CDC’s definition of SDOH, which refers to SDOH as “conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.”¹ For brevity, we refer only to Medicaid, however the contents of this guidance apply also to CHIP.

This guidance complements NACHC’s ongoing work to address SDOH through the **Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)**, a standardized screening tool that is part of a national effort to help health centers and other providers collect data needed to better understand and act on their patients’ social determinants of health.

1 See <https://www.cdc.gov/socialdeterminants/about.html> for CDC information on SDOH, including research on the impact of SDOH on health outcomes and health care costs. Healthy People 2030, which is managed by the Office of Disease Prevention and Health Promotion in the U.S. Department of Health and Human Services (HHS), uses a place-based framework that highlights the importance of addressing SDOH. Healthy People 2030 was released in 2020 and sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 SDOH objectives can be found here.

Contents

This guidance consists of:

- **Overarching principles** that CMS expects states to adhere to within their Medicaid and CHIP programs when offering services and supports that address SDOH;
- **Services and supports** that are commonly covered in Medicaid and CHIP programs to address SDOH; and,
- **Opportunities to address SDOH and receive Medicaid payment.**

Overarching Principles

CMS states in its SHO the overarching principles states must adhere to within their Medicaid programs in the context of providing services to address SDOH:

1. Services must be provided to Medicaid beneficiaries based on individual assessments of need, rather than take a one-size-fits-all approach.²
2. Medicaid is frequently, but not always, the payer of last resort. Accordingly, states must assess all available public and private funding streams, including Medicaid, to cover assistance with unmet social needs such as housing, nutrition, employment, education, and transportation.³
3. Medicaid programs must ensure methods and procedures relating to the utilization of, and the payment for, care and services are consistent with efficiency, economy, and quality of care.⁴
4. Each Medicaid service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.⁵

Certain federal Medicaid authorities also have specific evaluation, measurement, reporting, or other related requirements. These requirements are discussed below in the section on federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH.

- 2 As specified in sections 1915(c)(4)(B), 1915(i)(1)(D)(i), and 1915(k)(1)(A)(i) of the Social Security Act (the Act), and operationalized by state implementation of medical necessity criteria authorized under 42 CFR 440.230(d), services must be provided based on need.
- 3 As required by section 1902(a)(25) of the Act and 42 CFR Part 433 Subpart D, Medicaid is usually the payer of last resort.
- 4 As required by section 1902(a)(30)(A) of the Act, payment must be economic and efficient.
- 5 42 CFR 440.230(b) requires that each Medicaid service be sufficient in amount, duration, and scope to reasonably achieve its purpose.

Services and Supports that Can Be Covered Under Medicaid to Address SDOH

Services and supports tend to fall within these categories of service:

- housing-related services and supports,
- non-medical transportation,
- home-delivered meals,
- educational services,
- employment,
- community integration and social supports, and
- case management.

Opportunities to Address SDOH

In this guidance, NACHC highlights authorities which address SDOH, including case management services, Health Home services, and 1115 demonstrations. We also address managed care, including shared savings, state directed payments, incentive payments, coverage of waiver and non-traditional services, quality measurement and improvement, in lieu of services, and value-added services.

Section 1905(a) State Plan Authority

Section 1905(a) state plan services can assist Medicaid-eligible individuals gain access to needed medical and social services. Specifically, states can use state plan authority to cover services to address SDOH through rehabilitative services benefit, FQHC services, and case management. The following are examples of section 1905(a) state plan services that can address SDOH for Medicaid-eligible individuals.

Rehabilitative Services Benefit: Rehabilitative services specified at 1905(a)(13) and further defined at 42 CFR § 440.130(d) help individuals regain skills and functioning necessary to address SDOH. For example, a Medicaid beneficiary may need help restoring social interaction behaviors and problem solving. These skills are necessary when navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, negotiating with property owners or property managers, paying bills, and interacting with neighbors or co-workers. FQHCs could employ social workers to navigate community referrals and develop patient education materials to connect patients with services and other community organizations.

Case Management and Targeted Case Management (TCM) Services: Case management services, an optional state plan benefit, as defined under sections 1905(a)(19) and 1915(g) of the Act and 42 CFR § 440.169 and 42 CFR § 441.18, assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. Under 42 CFR § 440.169(d), case management services must include all of the following: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services; development and periodic revision of a specific

care plan; referral to services and related activities to help the eligible individual obtain needed services; and monitoring and follow-up activities. Case management services can also include assisting individuals transitioning from a medical institution to the community.

Under case management and TCM, states could pay for the administration of PRAPARE, inclusive of data analysis, plus activities necessary to link beneficiaries to non-medical services that address social determinants of health. Targeted case management is of particular interest because, as stated in the SDOH SHO, it allows FQHCs to leverage PRAPARE data to target the benefit to specific populations, as described in section 1915(g)(1) of the Act-- such as Medicaid-eligible individuals with serious mental illness (SMI) and/or substance use disorder (SUD) who are experiencing or at risk of experiencing homelessness, youth transitioning out of foster care, individuals transitioning from medical institutions, and older adults with chronic medical conditions.

Case management services offer flexible ways to assist individuals with medically and socially complex needs. As part of identifying the total needs of an eligible individual with significant social needs, case management services must include activities to help link the individual to community-based medical, social, and educational services. A multi-disciplinary team approach may be employed to furnish case management services.

Section 1945 Health Homes: The optional Health Home state plan benefit authorized under section 1945 of the Act includes various services that help to ensure the coordination of all primary services, acute care services, behavioral health (including mental health and substance use) services, and long-term services and supports (LTSS) for individuals with chronic conditions, and thus help to ensure treatment of the “whole person.” Section 1945 defines Health Home services as: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; individual and family support; and referral to community supports. CMS expects that health outcomes for Medicaid beneficiaries enrolled in Health Homes will improve and that Health Homes will result in lower rates of emergency department use, reduction in hospital admissions and readmissions, reduction in health care costs and less reliance on long-term care facilities, and improved experience of care for Medicaid beneficiaries with chronic conditions.

Federally Qualified Health Centers may enroll as Health Home providers and receive a per member per month (PMPM) amount when at least one qualifying service is delivered within the month.

States implementing the section 1945 Health Home benefit receive 90 percent federal matching under certain conditions for eight quarters. States can request an additional two quarters of enhanced federal match under SUD-focused Health Home State Plan Amendments (SPAs) approved on or after October 1, 2018. After the period of enhanced federal match ends, service expenditures are matched at the state’s usual service rate.

Section 1945 of the Act specifies that the Health Home state plan optional benefit is for “eligible individuals with chronic conditions,” and gives states authority to target eligibility for services based on the chronic conditions a beneficiary has. Please refer to **Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov)** for detail on how Medicaid beneficiaries may qualify for Health Home services.

Under the section 1945 Health Home option, states can provide comprehensive care management services that could include an assessment to identify the need for assistance with SDOH, such as housing,

transportation, employment, or nutritional services. Health centers, as Health Homes, can use the results to refer an individual to community and social support services. Health Home services must also include comprehensive transitional care, including appropriate follow-up, from inpatient to other settings, and can support individuals as they transition between settings.

State Example: Maine’s section 1945 Health Home SPA assesses housing needs and aids with coordination of resources that help participants in accessing and maintaining safe and affordable housing. California implemented a section 1945 Health Home SPA for individuals with chronic physical conditions and SUD, including individuals experiencing or at risk of experiencing homelessness. The State utilizes a housing navigator that develops relationships with housing agencies and permanent housing providers, including supportive housing providers, who refer and link Medicaid-eligible participants with community-based housing resources.

Section 1115 Demonstrations: States can utilize section 1115 demonstration authority to test new strategies to promote the objectives of the Medicaid and CHIP programs, including certain strategies that are not available under other authorities. Under section 1115 authority, the Secretary of HHS may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act, including Medicaid and CHIP.

In addition, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable (i.e., costs not otherwise matchable, CNOM) expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary. Pursuant to section 2107(e)(2) of the Act, section 1115 applies similarly to CHIP. NACHC interprets that CNOM may potentially cover costs of services that address SDOH and are not covered as state plan services. Depending on the circumstances, states may seek section 1115 demonstration authority and seek other authorities, as needed, or apply for a section 1115 demonstration without requesting flexibilities under other authorities. States can test ways to address SDOH through 1115 demonstrations if their proposals “advance the Medicaid program.”

Currently, CMS will not approve a demonstration project under section 1115(a) of the Act unless the project is expected to be budget neutral to the federal government. A budget neutral demonstration project does not result in Medicaid or CHIP costs to the federal government that are greater than what the federal government’s Medicaid or CHIP costs would have been absent the demonstration. CMS currently approves section 1115(a)(2) expenditure authority for services or populations that could not be covered under other authorities.

PRAPARE is structured to identify issues with housing, food insecurity, and transportation. FQHCs must keep in mind that FQHC services and reimbursement can be, and have been, waived in section 1115 demonstration programs. Thus, in any discussions between PCAs/FQHCs and state Medicaid agencies relating to an 1115 waiver demonstration, health centers and PCAs need to be sure that these FQHC protections are not put in jeopardy.

NACHC encourages health centers to work with their states to analyze care needs using PRAPARE data that will support demonstration proposals.

State Example: North Carolina’s approved section 1115 demonstration entitled “North Carolina Medicaid Reform Demonstration” authorizes the provision of the Enhanced case management and

Other Support Services Pilot Program to improve health outcomes and lower health care costs. The state is piloting evidence-based interventions, such as those for housing, transportation, and food. Beneficiaries eligible for enhanced case management are high-need adults aged 21 and over, pregnant women, and children who must meet at least one state-defined needs-based criteria and at least one risk factor. Under the pilot program, North Carolina is developing an incentive payment fund to incorporate value-based payments to incentivize the delivery of high-quality care. The State achieves this by increasingly linking payments for pilot program services to health and socioeconomic outcomes based on the pilot services provided during the demonstration and gathering the required data and experience needed for more complex risk-based models.

State Example: California’s “Whole Person Care” (WPC) pilot program aims to coordinate care (physical, behavioral health, and social services) for high-risk, high-utilizing Medi-Cal enrollees and increase integration and data sharing among county agencies, health plans, and other community-based organizations.⁶ The goals and strategies of the program are to increase, improve, and achieve integration among county agencies, health plans, providers, and other participating entities; coordination and appropriate access to care; access to housing and supportive services; health outcomes for the WPC population; data collection and sharing among local entities; targeted quality and administrative improvement benchmarks; and, infrastructure that will ensure local collaboration over the long term.⁷ California reported 232, 216 unique enrollees in the program as of June 2021.⁸

Managed Care Programs

Under risk-based managed care arrangements, states provide Medicaid covered benefits through a managed care organization, pre-paid inpatient health plan, or pre-paid ambulatory health plan, hereinafter referred to as a managed care plan. Managed care plans enter into contracted arrangements with state Medicaid agencies to provide all the services covered under the risk contract for a set amount, called a capitation payment, (typically, per member per month), regardless of whether the enrollee uses services. When services are provided through managed care, FQHCs must receive at least the prospective payment system (PPS) rate.

There are a variety of mechanisms described in the managed care provisions of the Medicaid statute, and regulations at 42 CFR part 438, that states may use to address SDOH. These include:

- **Section 1915(b)(3) Services:** Section 1915(b)(3) of the statute allows a state to share the savings resulting from the use of more cost-effective care with Medicaid beneficiaries in the form of additional health-related services. These savings must benefit Medicaid beneficiaries enrolled in the section 1915(b)(3) waiver and may be used to provide services for enrollees to address a wide range of SDOH.

For example, states could obtain approval to add housing-related services under section 1915(b)(3) authority and have managed care plans provide those services for enrollees to identify, transition to, and sustain their housing. States could also add home-delivered meals as a service under this authority and have managed

care plans provide this service to individuals with chronic conditions.

6 Source: [Medicaid Authorities and Options to Address Social Determinants of Health \(SDOH\) | KFF](#)

7 Source: [PowerPoint Presentation \(ca.gov\)](#)

8 [JUL20 – JUN21 WPC Monthly Cumulative Unique Enrollees Chart \(ca.gov\)](#)

As another example, states could add various environmental modifications as a service under section 1915(b)(3) authority and have managed care plans provide these services, such as humidifiers for individuals with asthma or other complicated respiratory conditions.

- **State Directed Payments (42 CFR § 438.6(c)):** Federal Medicaid managed care regulations include requirements for how states may direct plans to implement specific delivery system and provider payment initiatives under Medicaid managed care. These types of payment arrangements permit states to direct specific payments (“state directed payments”) made by managed care plans to providers under certain circumstances⁹ and can assist states in furthering the goals and priorities of their Medicaid programs, including to reinforce a state’s commitment to addressing SDOH. For example, a state may require managed care plans to implement alternative payment models or incentive payments that incentivize providers to screen for socioeconomic risk factors, provided all regulatory requirements are met.

NACHC is available to provide technical assistance on the review of managed care contract language that entails shared savings or allows state directed payment for the administration of PRAPARE and related activities.

- **Managed Care Plan Incentive Payments (42 CFR §§ 438.6(b)(2), 438.5(e)-(f), and 438.7(b)(3)-(4)):** States may use incentive payments to reward managed care plans that make investments and/or improvements in SDOH in line with performance targets specified in the managed care plan contract, including implementation of a mandatory performance improvement project under 42 CFR § 438.330(d) that focuses on factors associated with SDOH. These incentive payments represent additional funds over and above the capitation rates. States have established caps on plans’ profit margins and require that profits beyond the cap be reinvested in SDOH efforts.
- **Coverage of Waiver and Nontraditional Services:** Under 42 CFR § 438.3(c), the final capitation rate for each managed care plan must be based only upon services covered under the state plan and represent a payment amount that is adequate to allow the managed care plan to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. In the 2016 final rule (81 FR 27537), CMS clarified that services approved under a waiver (e.g., sections 1915(b)(3), 1915(c), or 1115 of the Act) are considered state plan services and are encompassed in the reference to state plan services in 42 CFR § 438.3(c). Therefore, if services to address SDOH (e.g., peer support services, home-delivered meals) are approved under these waiver authorities for the state Medicaid program, and the services are included in the managed care contract, then the covered services must be incorporated in the final capitation rates as well as the numerator of a plan’s Medical Loss Ratio (MLR).¹⁰
- **Quality Measurement and Improvement:** States can leverage managed care quality requirements in

⁹ State directed payments must meet the requirements under 42 CFR 438.6(c), including obtaining prior approval. Approval under 42 CFR § 438.6(c) provides authority for states to include contract requirements directing a plan’s expenditures. Among other requirements, the payments must tie to the delivery of services that occurs during the rating period (e.g., not historical utilization). Approval under § 438.6(c) does not grant authority to cover services; states must already have Medicaid authority for the underlying services either under the Medicaid state plan or through a Medicaid waiver or demonstration program. Additional guidance and the preprint form states must use to obtain prior approval are available on Medicaid.gov: <https://www.medicaid.gov/>

¹⁰ Under 42 CFR § 438.8(e), the numerator of a managed care plan’s MLR for an MLR reporting year is the sum of the managed care plan’s incurred claims, the managed care plan’s expenditures for activities that improve health care quality, and fraud prevention activities.

42 CFR §§ 438.310 through 438.370, including Quality Strategies, quality assessment and performance improvement (QAPI) requirements, and external quality review to address SDOH within their managed care programs. States are required to develop, and update at least every three years, a managed care Quality Strategy. The Quality Strategy is the state's public-facing vision statement and roadmap for improving quality and access to care within its managed care program. States are required to ensure through their managed care contracts that Medicaid and CHIP managed care organizations, prepaid health plans, and certain primary care case management entities implement QAPI programs to conduct the types of performance measurement and performance improvement projects (PIPs) that are necessary to realize the goals and objectives articulated in the Quality Strategy. States are also required to conduct an External Quality Review (EQR) to validate managed care organization (MCO) performance measures and PIPs and include these findings in an annual EQR technical report, which states post on their websites annually.

FQHCs should become familiar with their state's managed care Quality Strategy to assist in the development of a SDOH strategy that links payment to performance.

- **States can require MCOs to focus on SDOH in their QAPI programs and/or PIPs.** MCO performance in these QAPI programs and/or PIPs could also be integrated into the payment methodologies for certain managed care payments, such as managed care plan incentive payments. In addition, states can contract with external quality review organizations (EQROs) to conduct optional EQR-related activities, such as calculation of additional performance measures focused on SDOH or to conduct studies to gain a fuller understanding of how SDOH affect health outcomes among their beneficiaries. The Medicaid and CHIP Adult and Child Core Set measures are useful quality measures to demonstrate whether addressing SDOH has improved the health and health care of beneficiaries.¹¹

State Example: Under the District of Columbia's Managed Care Organization federal fiscal year 2020 Contract, the QAPI language specifically addresses SDOH. The QAPI requires MCOs to analyze SDOH data to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to enrollees. MCOs identify and measure disparities in health services and health outcomes between subpopulations/groups (race/ethnicity and language), identify SDOH needs, and identify the causes for health disparities. MCOs then develop a plan of action and a timeline to remediate the SDOH and health disparities identified through targeted interventions.

- **In Lieu of Services:** Managed care plans may voluntarily choose to cover "in lieu of services" to address SDOH for their members. These are services deemed appropriate and cost-effective substitutes for the covered services or settings under the state plan. They must be provided in accordance with 42 CFR § 438.3(e)(2), which requires, for example, that services in lieu of alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan and that the enrollee is not required to use the alternative service or setting. An example of in lieu services cited by CMS is in-home prenatal visits for at-risk pregnant beneficiaries as an alternative to a traditional office visit. The cost in lieu of services is included in the capitation rate.
- **Value-Added Services:** Under 42 CFR § 438.3(e), a managed care plan may voluntarily cover, for

¹¹ <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>

enrollees, services that are in addition to those covered under the state plan, although the cost of these services is not included in the capitation rate; these services are often referred to as value-added services. Such value-added services, such as installation of a shower grab bar or healthy play and exercise programs, are plan services that are not included in the capitation rate.

State example: To focus Medicaid managed care plans on improving asthma care, Maryland established a statewide PIP using the Asthma Medication Ratio measure. Each Medicaid managed care plan in the state implemented several interventions to improve asthma care. Interventions that addressed social determinants included referring members to the Green and Healthy Homes Initiative to conduct home assessments of asthma triggers and minimizing barriers to transportation by providing transportation to office appointments, providing prescription pharmacy delivery, and offering asthma adherence monitoring through retail pharmacies.

State example: To improve the state's performance on the Postpartum Care Visit Core Set measure (PPC-AD), Michigan conducted a quality improvement project called the Maternal Infant Health Project (MIHP) that used a health equity focus, identifying racial or ethnic disparities in the PPC visit rate and identifying strategies to improve health equity. Four of Michigan's Medicaid health plans implemented enhanced care coordination and transportation benefit interventions. For example, they created a transportation worksheet which prompted plans to consider how the health plan, pilot clinics, and maternal infant health programs would refer patients for transportation scheduling assistance and how to track the transportation services. Women who participated in MIHP were 1.5 times more likely to receive an appropriately timed postpartum care visit than women who did not participate. This is important because the postpartum visit offers an important opportunity to (1) assess a woman's physical recovery from pregnancy and childbirth, (2) provide breastfeeding support, (3) manage preexisting or emerging chronic health conditions, (4) evaluate her psychological and mental health status, and (5) discuss family planning options and set the stage for well-women care between pregnancies.

Summary

NACHC encourages health centers to develop a plan of action to address SDOH that uses the data made available through PRAPARE to identify the needs of clinic users individually and on a population basis. We also encourage you to leverage PRAPARE data--and information gained from this SDOH guidance--to work with your state on improving coverage and payment appropriate to the needs of all your patients, regardless of insurance status. In support of this goal, NACHC will continue to engage in activities that foster a culture of learning and collaboration among health centers and states. We encourage you to reach out to NACHC for technical assistance to support your health center's SDOH work.