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In Pursuit of Whole Person Health: Leveraging Medicaid Managed Care & 1115 Waivers to Address SDOH

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Editor's Note: In a new report, Manatt explores how states are using two key tools—Medicaid managed care contracts and 1115 waivers—to address the unmet social needs of people with Medicaid coverage. The findings have important implications for Medicaid managed care organizations (MCOs), providers, patients, community-based organizations (CBOs) and other healthcare stakeholders. Key highlights are summarized below. Click here to download our free infographic—drawn from the report's findings—to learn about common, emerging and leading-edge practices to advance whole person health across the country.

The ability to live a healthy life is influenced by a multitude of factors that extend beyond medical care. Access to stable housing, healthy foods, safe neighborhoods, reliable transportation, educational resources and other nonmedical drivers of health—often called social determinants of health (SDOH)—has a profound impact on health and longevity, driving as much as 80 percent of health outcomes.[1] The current COVID-19 crisis has shone a bright light on the extent to which addressing SDOH is integral to ensuring the health of vulnerable individuals and communities. Those hardest hit by the pandemic are low-income communities as well as communities of color—who not only have experienced higher rates of infection, hospitalization and death, but also have been disproportionately impacted by downstream job loss and socioeconomic instability.[2],[3] The crisis has underscored just how critical the linkages between economic and social services and healthcare are to the well-being of both individuals and their communities.

Medicaid, which currently provides health coverage for 1 in 7 adults and 2 in 5 children across the country,[4] is the largest payer for healthcare for low-income populations. Because Medicaid by definition serves those most affected by social and economic challenges, states have a particularly strong imperative to address SDOH. As states seek to improve overall health for Medicaid beneficiaries and derive more value for their healthcare dollars, they are increasingly seeking to integrate strategies to address health-related social needs into their care delivery models.

States' ability to pay for nonmedical services—such as food or housing—with Medicaid dollars is limited by federal statute. However, states have a variety of tools to support the health-related social needs of their Medicaid beneficiaries, including Medicaid managed care contracts and 1115 waivers.

Manatt reviewed the contracts of each state and territory with Medicaid managed care, as well as their 1115 waivers, to identify SDOH-related provisions in six areas of focus: Care Management: Workforce; Data Development, Collection and Evaluation; Quality Metrics and Strategy; Financing; and Community Initiatives.

Summary of Key Findings

- It is now commonplace for states to require MCOs to make efforts to address the unmet social needs of their members. Of the 39 states and territories in this analysis, 38 include at least one contractual requirement related to SDOH.[5]
- SDOH requirements are most common in the realm of care management. It is now the norm for states to require MCOs to screen for SDOH (27 states), refer to social services (35 states), coordinate social services for their members (37 states), coordinate with other state and federal programs (21 states), and even partner with CBOs to support members' unmet social needs (23 states).[6]
- With respect to workforce, a majority of the states with Medicaid managed care (21 states) are requiring MCOs to implement specific staffing requirements—for instance, having a housing specialist on staff—and many require staff training on SDOH topics and resources (19 states), though only a handful require MCOs to use community health workers as part of their workforces (8 states).
- Requirements for MCOs to collect and report on SDOH data are still emergent (12 states), and requirements to incorporate SDOH metrics into quality programs are only seen in a few states (7 states), as are requirements around data sharing, which can raise thorny privacy challenges (8 states).
- With financing critical to the deployment and sustainability of whole person approaches to care, 12 states are using innovative financing mechanisms—such as value-based payment requirements (5 states), SDOH-related in-lieu-of or value-added services (4 states), risk adjusting for social factors (4 states) and withholds or incentive payments (1 state)—to prompt MCOs to address members' unmet social needs. Some states are experimenting with multiple of these mechanisms at the same time, while others focus only on one.
- At the leading edge, eight states require MCOs to participate in SDOH-focused pilot programs, and two (Arizona and Oregon) explicitly direct MCOs to invest in their communities.
- With many states facing homelessness crises, housing is by far the most common SDOH domain to be addressed in contracts (34 states), with food and employment also quite common (24 and 23 states, respectively) and initiatives related to transportation and interpersonal violence/toxic stress (15 and 14 states, respectively) emerging across the country. Initiatives focused on MCO coordination with schools and educational systems, addressing social isolation and/or income inequity, are catalogued under the domain of "Other" in the report's detailed state profiles.
- Many states use their contracts to target SDOH initiatives to specific subpopulations, with women, children and members with high needs the most common (29, 27 and 24 states,

respectively). Other identified populations include the homeless (14 states), members with substance use disorders (13 states), members with developmental and physical disabilities (13 states) and justice-involved members (10 states).

- Sixteen states are leveraging 1115 waivers to test out new SDOH models, primarily via pilot programs (8 states), and as part of delivery system reform efforts (7 states), with two states testing out enhanced Medicaid benefit packages (Delaware and Virginia). Section 1115 waivers addressing the social needs of Medicaid beneficiaries vary greatly in terms of scope and size. The majority of states launching pilot programs are focused on a very narrow swath of the population in one or two areas of the state. The majority of 1115-waiver initiatives are focused on housing, employment and addressing interpersonal violence.

These trends have important implications for people enrolled in Medicaid, CBOs, MCOs, state Medicaid programs and other stakeholders. The full report discusses these implications and provides insights into anticipated developments in the pursuit of whole person care for people with Medicaid, over the next months and years.

NOTE: The full report, which includes detailed state profiles, is available for purchase as a stand-alone PDF or through a subscription to Insights@ManattHealth, Insights@ManattHealth, which also gives you access to an interactive SDOH map and database, filterable by area of focus, intervention, domain and target population, as well as ongoing access to Manatt Health's premium content information service. Insights@ManattHealth Insights@ManattHealth leverages Manatt Health's knowledge in the Medicaid, Medicare, Marketplace, life sciences, litigation, digital health and privacy arenas to bring you a roundup of each week's federal and state policy changes; detailed regulatory and subregulatory guidance summaries; and 50-state surveys across a range of topics, including 1115 waivers, 340B policies and telehealth. To learn more about our new SDOH report or to schedule a demonstration of Insights@ManattHealthInsights@ManattHealth, please contact Barret Jefferds at bjefferds@manatt.com.

[1]https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/BCBS.HealthOfAmericaReport.Moodys_02.pdf.1 Moody's Analytics. "Understanding Health Conditions Across the U.S." BlueCross BlueShield Association. December 2017. Available: https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/BCBS.HealthOfAmericaReport.Moodys_02.pdf.

[2]https://www.hrw.org/news/2020/03/19/us-address-impact-covid-19-poor#2 US: Address Impact on COVID-19 on Poor: Virus Outbreak Highlights Structural Inequities. Human Rights Watch. March 19, 2020. Available: https://www.hrw.org/news/2020/03/19/us-address-impact-covid-19-poor#.

[3]https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html3 COVID-19 Hospitalization and Death by Race/Ethnicity. Centers for Disease Control and Prevention. Cases, Data & Surveillance. Available: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

[4]http://files.kff.org/attachment/fact-sheet-medicaid-state-US4 “Medicaid in the United States.” Kaiser Family Foundation. October 2019. Available: http://files.kff.org/attachment/fact-sheet-medicaid-state-US

[5]5 North Dakota’s contract did not have any provisions that fit within the scope of this survey, whether required, encouraged or optional.

[6]6 The requirements to refer to social services and coordinate social services would imply that MCOs have to screen for SDOH. In select states, Manatt found requirements for coordination and/or referral without screening.