How States Address Social Determinants of Health in Their Medicaid Contracts and Contract Guidance Documents

By Tina Kartika

In recognition of the impact that social circumstances, such as stable employment and housing, have on health and well-being,[1] states are increasingly interested in addressing social determinants of health (SDoH) to improve population health. One of the purchasing and regulatory levers that many states use to encourage investments in population health is the managed care and value-based contracting process.

The National Academy for State Health Policy (NASHP) convenes a state accountable health workgroup that evolved from a NASHP analysis of accountable health initiatives in 12 states (CA, CO, CT, DE, MA, MI, MN, NY, OR, RI, VT, and WA) that emphasize population health in their models. Because contract provisions vary from state to state, workgroup members wanted to learn how other states leverage Medicaid contracts to address SDoH. Specifically, they wanted to know the following:

- Which determinants states prioritized in their contracts;
- How they incorporated SDoH priorities into contractor requirements; and
- How states monitor and pay for these activities.

How this chart was compiled: From March to July 2018, NASHP analyzed publicly available Medicaid contracts and guidance documents that inform contract requirements (referenced below) in accountable health states using a keyword search.[2] NASHP attempted to identify which contracting process in each state provided the most leverage for the Medicaid agency.

- For some states, e.g. Michigan, managed care contracts were analyzed because they provide the best leverage for state Medicaid agencies to address SDoH.
- In other states, e.g. Oregon, contracts with new care delivery models (accountable care organizations, coordinated care organizations, regional accountable entities, and accountable entities) were analyzed because these contracts provide the most leverage. NASHP also analyzed state contracts with new care delivery models in states whose contracts with managed care organizations were not available online.
- In some states, e.g. New York, NASHP analyzed contract guidance documents, such as value-based purchasing roadmaps, that contain innovative components that may be of interest to states and provide the most leverage to explicitly address SDoH.

NASHP focused on language pertaining to the general Medicaid population, including children and pregnant women, and did not examine language referencing services and programs specifically for special needs populations, including individuals who are Medicare-Medicaid dual

eligible, disabled, in foster care, and requiring substance use disorder treatment services or long-term services and supports. Medicaid agencies in each state reviewed NASHP's findings.

		Managed Care Organization Contracts					New Care Delivery (e.g., Accountable Care Organization) Contracts				Contract Guidance Documents		
		CA	DE	MI	MN[3]	WA[4]	CO[5]	MA[6]	OR[7]	VT	NY	RI[8]	CT[9]
Social Determinants of Health Explicitly Mentioned	Criminal justice					✓	✓	✓	✓		✓	✓	✓
	Employment			✓		✓	✓				✓	✓	✓
	Focus on chronic disease		✓			✓	✓	✓	✓	✓	✓	✓	
	Housing services			✓	✓	✓	✓	✓			✓	✓	✓
	Transportation	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
	Primary care and behavioral health integration					✓	✓	✓	✓		✓	✓	✓
	Physical activity and nutrition	✓			✓[10]			✓				✓	✓
	Food access			✓			✓					✓	✓
	School/education			✓			✓		✓			✓	✓
	Child care						✓						✓
	Family/caregiver support and social isolation	✓[11]								✓		✓	✓
	Violence and trauma							✓				✓	
Common Elements of Contractors' Obligations	Develop relationships with local community organizations to implement social determinant interventions (e.g., housing support services, nutrition classes, exercise equipment)			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Contract with community organizations			✓		✓		✓	✓		✓	✓	✓
	Collaborate on community health needs assessments			✓	✓		✓	✓	✓				
	Develop or access a community resource directory		✓	✓			✓						
	Evaluate members' health-related social needs		✓[12]	✓	✓[13]	✓		✓				✓	✓
	Refer individuals to appropriate community services	✓	✓[11]	✓		✓		✓	✓			✓	✓

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	Follow-up and assist with access to community services		✓[11]	✓	✓			✓	✓			✓	✓
	Utilize data to address health disparities	✓		✓					✓			✓	
	Share information (e.g., health records) with community organizations			✓			✓	✓				✓	
Monitoring	Written policies and procedures	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓
	Demonstration of fund utilization					✓		✓	✓		✓		
	Evaluation to measure success of SDoH interventions			✓					✓		✓	✓	✓
Payment	Total cost of care risk adjustment							✓				✓	
	Flexible services payment							✓	[14]				
	Bonus payment for addressing SDoH			✓							✓	✓	
	Seed money for providers										✓		

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Please contact Jill Rosenthal (jrosenthal@nashp.org) or Amy Clary (aclary@nashp.org) with any questions related to this chart.

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[1] J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs* 21, no. 2 (March/April 2002), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.2.78.

[2] The author conducted a keyword search throughout the managed care contracts and VBP roadmap linked in this chart. The keywords used were: population health, social determinant, criminal justice, incarceration/incarcerated, employment, housing, transportation, physical activity, exercise, nutrition, food, school, child care, community, violence, trauma, assess, evaluate, fund utilization, total cost of care, flexible services, in lieu of services, bonus, seed. Connecticut is not included in this analysis because the state does not have managed care. NASHP only examined documents linked in the chart and endnotes; there may be other relevant documents not analyzed.

[3] Minnesota uses both MCO and Integrated Health Partnership (Medicaid ACO) contracts to advance SDoH.

[4] In addition to the Apple Health (Medicaid) managed care model contract (https://www.hca.wa.gov/assets/billers-and-providers/model_contract_ahmc.pdf), NASHP also examined the Apple Health Fully Integrated Managed Care model contract (https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf). Statewide implementation of Integrated Managed Care, which coordinates physical and behavioral health,

is rolled out in a few stages, and the state expects to complete the process by 2020. For more information, please see https://www.hca.wa.gov/about-hca/hca-announces-managed-care-plans-offering-integrated-care-starting-2019-and-2020.

[5] Information under this column comes from Colorado's Regional Accountable Entity (RAE) contract with Rocky Mountain Health Plans (https://www.colorado.gov/pacific/sites/default/files/Rocky%20Mountain%20Health%20Plan%20%28Region%201%29.pdf). Colorado has independent contracting processes for MCOs and RAEs.

[6] There are three models of Medicaid Accountable Care Organizations (ACOs) in Massachusetts: Accountable Care Partnership Plans (an MCO that partners with an ACO and contracts with the state Medicaid agency), Primary Care ACO (ACO contracts directly with the state Medicaid agency), and MCO-Administered ACO (ACOs contract with MCOs, which in turn contract with the state Medicaid agency). The contracts examined here are the model contracts for Accountable Care Partnership Plans (https://www.mass.gov/lists/accountable-care-partnership-plan-model-contract-and-model-appendices) and the MCO-Administered ACOs (https://www.mass.gov/lists/mco-administered-aco-model-contract-and-model-appendices). The model contract for Primary Care ACOs is at this link: https://www.mass.gov/lists/primary-care-aco-model-contract-and-model-appendices.

[7] Oregon's managed care organizations were brought together under the umbrella of Coordinated Care Organizations (CCOs). CCOs contract with the state and may have a delegated arrangement with health plans.

[8] The primary document analyzed for Rhode Island is the Accountable Entity Certification Standards; however, the author also examined the Total Cost of Care Requirements and Incentive Program Funding Requirements. Rhode Island is in the process of amending its Medicaid managed care (RIte Care) base contract to include requirements regarding the Health System Transformation Project/Accountable Entity program. NASHP will conduct analysis of the amended contract when it is available.

[9] Connecticut is not a managed care state. However, Connecticut's Person-Centered Medical Home Plus (PCMH+) program provides shared savings to contractually-participating providers that meet specified quality standards and generate savings for Medicaid.

[10] Limited to children and pregnant women

[11] Included in complex case management for members "who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services."

[12] Only for members with highest risk for adverse health outcomes

[13] Only for high utilizers

[14] There is no separate payment for health-related services. Oregon's Section 1115 waiver clarifies the ways in which "non-traditional services that improve health" are accounted for in global budgets. CCOs are encouraged to invest in those services. According to Oregon Health Authority's *Health-Related Services* brief, health-related services can be included as medical expenditures in the medical loss ratio calculation and are also considered in rate development within the non-benefit load of the CCO's rate if they result in a decrease in the rate of the CCO's per-capita expenditure growth over time.