

# Addressing the Social Determinants of Health Through Medicaid Managed Care

**David Machleedt, Ph.D.**  
Senior Policy Analyst  
National Health Law Program

## ABSTRACT

**ISSUE:** With its emphasis on coordinated care and prevention, managed care should be tailor-made to tackle social determinants of health. But various challenges discourage Medicaid health plans and providers from assisting beneficiaries with nonmedical concerns such as housing insecurity or parenting skills that are integral to improving health outcomes and lowering costs. To better address these social factors, the Centers for Medicare and Medicaid Services (CMS) updated its Medicaid managed care rule in early 2016.

**GOAL:** To explore the impact of several provisions of the new regulation that influence states' ability to address social determinants of health through managed care.

**FINDINGS AND CONCLUSIONS:** Several provisions in the new Medicaid managed care rule signal CMS's intent to increase access to high-value nonmedical interventions. For instance, the regulation financially incentivizes health plans to address these needs by allowing certain nonclinical services to be included as covered services when calculating the capitated rate and medical loss ratios. In addition, the regulation encourages states to improve care coordination, adopt alternative payment models, and provide long-term services and supports in the home and community for beneficiaries with functional limitations.

## KEY TAKEAWAYS

- ▶ Revised regulations for Medicaid managed care plans empower states to cover nonmedical interventions that address social and structural factors that influence health, including poverty, access to stable housing, and exposure to violence.
- ▶ The regulations support the provision of long-term services and supports in the home; reduce administrative barriers to population health investment; and require plans to coordinate with "community and social support providers."
- ▶ To sustain population-based health initiatives, policymakers must find ways to distribute savings so that health plans also realize benefits.



## BACKGROUND

In May 2016, the Centers for Medicare and Medicaid Services (CMS) finalized regulations modernizing Medicaid managed care's operations, accountability, and oversight. In doing so, the U.S. Department of Health and Human Services (HHS) sought to promote practices that look beyond clinical care to address the social and structural factors that profoundly shape health status: poverty, access to stable housing, social support networks, exposure to environmental toxins or community violence, and systematic discrimination.

Medicaid can, and in some areas already does, play an important bridging role between the federal, state, and community entities that support housing, environmental safety, nutrition, and health care.<sup>1</sup> This brief explores the impact of several provisions in the updated Medicaid regulations that influence states' ability to address the social determinants of health through managed care. Advocates and policymakers should be familiar with these new policy levers, which can help states establish stronger connections across these often siloed entities.

Managed care, with its emphasis on improved coordination and preventive care, should be tailor-made to situate health within a broader social context. That context, often referred to as the social determinants of health, includes such factors as family networks and community resources, as well as more systemic or structural influences like access to education and economic opportunities, environmental hazards, and various forms of discrimination.<sup>2</sup> The revised managed care regulations aim to bolster Medicaid's bridging role and facilitate investments in activities that address these issues.

For example, the regulations formally incorporate key principles from Medicaid's Home and Community-Based Services (HCBS) programs into the managed care context, particularly for long-term care. Medicaid HCBS programs allow states to provide community-based supports for beneficiaries with functional limitations, allowing these individuals to continue living at home and staying engaged with their communities. These programs typically espouse a holistic view of health centered on autonomy, person-centered care, and community

integration and thus have long addressed social determinants of health. The updated regulations also beef up care coordination standards, particularly by requiring the inclusion of community and social support providers and focusing attention on care transitions.

Finally, HHS encourages the implementation of payment models that promote value. This includes minimizing potential administrative barriers that could discourage activities focused on addressing nonmedical issues and creating a mechanism that, for the first time, allows states to direct and align how health plans pay their providers.

### UNDERSTANDING RECENT CHANGES TO MEDICAID MANAGED CARE REQUIREMENTS

In early 2016, HHS updated the Medicaid managed care regulations for the first time in over a decade.<sup>3</sup> Since the last update in 2002, managed care has become the predominant Medicaid delivery system. HHS's stated goals for this rule include supporting delivery system reform, improving care quality, strengthening beneficiary experiences and protections, improving transparency and accountability, and aligning Medicaid managed care requirements with other health programs.

The rule sets forth important protections for beneficiaries, including requirements regarding information, access to care, and the process for appeals and grievances. It also recognizes that Medicaid managed care has evolved since 2002 and provides states increased flexibility to pursue quality and accountability goals.

The regulations became effective July 5, 2016, but the implementation is staggered for several elements. This means states and managed care entities will continue to make changes to implement the new rule in the coming years, including setting network adequacy standards and establishing beneficiary support systems. The rule includes other changes to support state efforts around integrating physical and behavioral health care, value-based payment models, and population health, including social determinants of health.

States can, for example, require plans to tie payments to performance on population health metrics. While the regulations do not resolve all logistical challenges related to managing and addressing social determinants of health, these changes take meaningful steps in the right direction.

## MANAGED CARE AND HOME- AND COMMUNITY-BASED SERVICES

For the past three decades, Medicaid has led the shift to providing long-term services and supports (LTSS) in the home and community, when possible, rather than in institutions. HCBS programs help people complete basic tasks of daily living, such as bathing, eating, and getting around the community. Participating providers routinely consider an enrollee's living environment, coordinate with family members, and provide care beyond the clinic. Over time, the HCBS approach has engendered a broad focus on nonmedical factors that influence health and well-being, which are commonly overlooked in acute care settings. HCBS also has proven to be cost efficient, with lower per-person costs and far better outcomes than institutional care.<sup>4</sup> As managed care increasingly expands into HCBS delivery, plans have been challenged to adapt and incorporate HCBS' more holistic vision of health. HHS's updated regulations attempt to preserve and reinforce this inclusive focus.

In 2013, CMS released guidance requiring managed care plans that cover LTSS to provide person-centered care that attends to an individual's health and well-being with the intention of maximizing opportunities for community and workforce participation.<sup>5</sup> That guidance also pushed states to realign payment structures to support broader health and community goals, partly by holding providers accountable through performance-based incentives or penalties.

The 2016 managed care regulations incorporate this earlier guidance, and define LTSS as having the "primary purpose of supporting the ability [of individuals] . . . to live or work in the setting of their choice."<sup>6</sup> The updated regulations also require states that integrate LTSS into Medicaid managed care services to assess the health plan's performance on improving quality of life, community

integration activities, and the relative share of LTSS provided at home.<sup>7</sup> These metrics should help hold plans accountable for a scope of care sensitive to social determinants of health.

## REDUCING ADMINISTRATIVE BARRIERS TO POPULATION HEALTH INVESTMENT

The updated regulations also clear pathways to promote investment in meeting the nonmedical needs of broader Medicaid populations (Exhibit 1).

### Using Alternative Payment Models to Pay Providers

The regulations formalize mechanisms for states to implement incentive-based payment systems for managed care entities and allow states to require managed care plans to implement alternative payment models (APMs) for their providers. While HHS has previously approved these mechanisms in several states, their codification in the new regulations helps reduce administrative obstacles and encourages further implementation. States could use these approaches to invest in broader community-level health interventions.

One new pathway codified in the regulation allows states to direct contracted health plans to implement APMs with targeted providers.<sup>8</sup> States may encourage or require specific APMs, including models that drive investments in practices that connect health with nonmedical factors, such as routine screening for domestic abuse, environmental hazards in the home, food security, housing stability, and other potential red flags. Asking such nonclinical questions can identify substantial health risks that a standard clinical evaluation might miss.

### Incentivizing Plans to Invest

Under another provision, states can create payment incentives for the health plans, including potentially establishing performance metrics related to social and structural determinants of health.<sup>9</sup> For example, a state could withhold part of a health plan's capitation rate unless it exceeds a state-set goal for reducing maternal mortality or improving lead screening for young children.

## Exhibit 1. Mechanisms in Medicaid Managed Care Regulations States Can Use to Reduce Administrative Barriers to Population Health Investment

Mechanism	Description	Example
<b>Ensuring provider payments reinforce a commitment to addressing social determinants of health (42 C.F.R. § 438.6(c)).</b>	Allows states to direct contracted plans to implement alternative payment models with targeted providers. Previously, states had little control over how plans pay their providers. Often plans still use a fee-for-service model with network providers.	State requires health plans to provide incentive payments to network providers who routinely screen for nonmedical problems such as food security, domestic abuse, or environmental hazards.
<b>Directly incentivizing health plans to invest in efforts to meet nonmedical needs (42 C.F.R. § 438.6(b)).</b>	Allows states to create financial incentives, such as quality withholds or quality incentive arrangements, that hold health plans accountable for state-specified performance metrics. These can include measures tied to population health outcomes.	States withhold part of a plan's capitation rate contingent on meeting quality metrics linked to specific population health interventions, such as improved lead screening or reduced maternal mortality.
<b>Making it easier for health plans to cover nontraditional services (42 C.F.R. § 438.3(e)).</b>	"In-lieu-of" services can be covered by health plans and count toward capitation rate-setting and the services side of the medical loss ratio (MLR).	Offering in-home prenatal visits as an alternative to traditional clinical office visits can help flag potential risks or issues.
	Value-added services are plan services not included in the capitation rate. These services do count as services for the purposes of the MLR, which removes a potential disincentive for plans to cover them.	Putting a shower grab bar in an older adult's home can reduce the risk of a fall. A plan may pay for this even if it is not covered under its contract and count the expense as a service for the purposes of the MLR.
<b>Strengthening care coordination across clinical and nonclinical contexts and improving care transitions (42 C.F.R. § 438.208(b)).</b>	Requires health plans to coordinate an enrollee's services with services provided by community and social support providers, as well as services covered by other managed care entities and Medicaid FFS providers. The full implications of this requirement will depend on subsequent CMS guidance.	State policies promoting such coordination could include performance metrics that track referrals to social services, inclusion of social or community health workers in care coordination teams, or requirements to ensure adequate data-sharing across providers.

### Nontraditional Services

Generally, managed care plans can pay for nontraditional services outside their contractual obligations. This flexibility allows plans to focus on simple preventive solutions, like installing a shower grab bar for an older adult to avoid a costly fall. These "extra" services come in two flavors: "in-lieu-of" services and "value-added" services.<sup>10</sup> Both preexist the updated regulations, but the revisions more clearly define how states can use them.

"In-lieu-of" services are services or settings a plan substitutes for a similar service covered under the contract.<sup>11</sup> For example, as a substitute for a typical prenatal clinic visit, a plan could offer home visits for pregnant mothers to provide preventive health, prenatal support, training in parenting skills, and assistance connecting other key community services.<sup>12</sup> The new regulations clarify that such in-lieu-of service

expenditures qualify as covered services for rate-setting unless a statute or regulation explicitly requires otherwise.<sup>13</sup> If they did not, plans would likely favor the regular covered services so their claims would count toward the capitation rate.

Unlike in-lieu-of services, value-added services are extras unrelated to contracted services.<sup>14</sup> Typical examples include nutrition classes, peer-support services for individuals with substance use disorders, and home-delivered meals for individuals discharged from a hospital. These services provide considerable flexibility for plans to go beyond services defined in the Medicaid state plan to address social needs. However, although the regulation generally broadens the definition of services for the purposes of rate-setting, it clearly prohibits value-added services from factoring into a plan's capitation rate, which may discourage health plans from paying for them.<sup>15</sup>

### Social Determinants and the Medical Loss Ratio

The new regulations apply a medical loss ratio (MLR) to all capitated Medicaid managed care plans.<sup>16</sup> This oversight tool sets a threshold for the minimum proportion of expenditures that health plans should dedicate to enrollee services, as opposed to administrative costs. However, poorly conceived MLRs can discourage plans from covering nonclinical services. For instance, several states counted care management as administrative services when implementing a Medicaid MLR, which meant that health plan investments in care management negatively impacted the plans' MLRs.<sup>17</sup>

Similar issues could impact value-added services because they are not contracted services. However, to avoid creating such unintended disincentives, the new regulations explicitly classify value-added services, in-lieu-of services, nonemergency medical transportation, and LTSS on the clinical services side of the MLR ledger.<sup>18</sup> Other nonclinical services, such as activities that support community integration for people with disabilities, may fall under the regulatory definition of a "quality improvement activity," which also counts as a service for the MLR.<sup>19</sup> These clarifications allow plans to more freely invest in population health-oriented programs without concern about the MLR impact (although value-added services are not included in the rate-setting process.)

Taken together, these provisions open doors for states to promote delivery system reforms that tie payments more closely to population health outcomes, and create impetus to move care "outside the clinic walls."

### CARE COORDINATION AND SOCIAL DETERMINANTS

Care coordination and case management undergird many interventions addressing social determinants of health. Hot-spotting, for example, targets individuals with complex care needs for intensive case management, including securing resources for housing, food, education, and employment.<sup>20</sup> Such models emphasize "bridging," or improving care coordination, managing transitions, and finding ways to provide individuals and their communities with more stability to reduce or prevent serious health episodes and promote health.

The updated managed care regulations improve Medicaid's standards for bridging, specifying that health plans must coordinate services during transitions between care settings and when enrollees receive services under fee-for-service Medicaid. The regulations also newly require plans to coordinate with "community and social support providers" and fee-for-service providers.<sup>21</sup> This latter requirement has the potential to dramatically improve connections between clinical care systems and community needs, but will likely need more guidance and oversight from HHS to become a reality.

For enrollees with special health care needs, including LTSS, the care coordination requirements apply stronger Medicaid standards for person-centered care planning, including conducting mandatory needs assessments and ensuring a central decision-making role for enrollees.<sup>22</sup>

As with other Medicaid provisions, the federal standards establish only a floor. Advocates can push states to add enforcement mechanisms or additional requirements to strengthen care coordination, linking traditional health care with community supports. Oregon requires its Coordinated Care Organizations (CCOs), a version of accountable care organizations, to coordinate with Area Agencies on Aging and regional offices for people with disabilities. CCOs also must make community health workers, peer wellness specialists, and other nontraditional health workers available to enrollees to coordinate services, provide health education, and help ensure culturally competent care.<sup>23</sup>

### THE CHALLENGES

The new regulations may encourage plans and providers to confront the social determinants of health, but significant logistical challenges remain.

For example, a program that improves access to behavioral health treatment may save money and improve outcomes by reducing incarceration. In this case, the criminal justice system spends less but the managed care plan must invest more. Effective and sustainable population-based health initiatives depend on anticipating such effects and finding ways to distribute savings across programs so the health plan also sees benefit.

The investment–benefit relationship also can be mismatched in time. Benefits from a preventive screening or diabetes management program may manifest years later. Sustained coverage and long horizons for return on investments are crucial so both the health plan and the enrollee benefit from their initial investments down the road. Recent efforts to change Medicaid’s financing structure or otherwise roll back coverage would lead to state budget shortfalls that both exacerbate churn and discourage long-term investments in preventive health.

Initiatives also can become victims of their own success. Take, for instance a managed care plan that helps children access better housing and in doing so reduces asthma-related emergencies and hospitalizations. While it may realize immediate savings, the reduced hospital and emergency department spending might lower the plan’s capitation rates the following year. This could create longer-term disincentives to engage in value-based payment methodologies.<sup>24</sup>

The managed care regulations do not resolve these challenges, but neither are these problems insurmountable. Ultimately, more needs to be done to structure population-based programs so resulting benefits can be shared or reinvested in ways that do not undermine the incentive to invest in social determinants of health today to realize better health tomorrow.

## CONCLUSION

As Medicaid’s scope has grown, the “health care only” model has become increasingly anachronistic. The new Medicaid managed care regulations help remedy this problem by empowering states to cover nonmedical interventions and invest at the community level. In areas like care coordination, the regulations set important mandates. Elsewhere, they strengthen options for states to pursue activities centered on social determinants of health.

Ultimately, Medicaid cannot shoulder the whole burden of our social infrastructure. But the program can and should help bridge the divide between health care and health more broadly defined. This means connecting Medicaid to other safety-net systems and looking within Medicaid to facilitate more effective care delivery. In addition, it means promoting preventive care and population health, not just treating disease and disorder. If states leverage their new regulatory authority to pursue these activities, and even raise the bar, Medicaid will significantly improve health in America.

## NOTES

- <sup>1</sup> Home- and community-based services (HCBS) and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, which has long centered on preventive care, the physical environment, and broad access to treatment, are two areas where Medicaid has already linked health care with social determinants.
- <sup>2</sup> Capitated plans receive fixed monthly payments to cover all contracted Medicaid services for each enrollee. This should create strong financial incentives for plans to invest in their enrollees' health, as healthy individuals use fewer services and, ultimately, cost less. They also have more flexibility than fee-for-service (FFS) Medicaid to spend creatively to improve health outcomes.
- <sup>3</sup> [Medicaid and Children's Health Insurance Program \(CHIP\) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule](#), 81 *Fed. Reg.* 27498, May 6, 2016; and [Medicaid and Children's Health Insurance Program \(CHIP\) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Corrections](#), 82 *Fed. Reg.* 37, Jan. 3, 2017.
- <sup>4</sup> Mathematica Policy Research, [Money Follows the Person 2014 Annual Evaluation Report](#) (Mathematica, Dec. 2015), pp. 68, 73; and A. Bohl, J. Schurrer, W. Lim et al., [Reports from the Field: The Changing Medical and Long-Term Care Expenditures of People Who Transition from Institutional Care to Home- and Community-Based Services](#) (Mathematica Policy Research, Sept. 2014), p. 15.
- <sup>5</sup> Centers for Medicare and Medicaid Services, [Guidance to States Using 1115 Demonstration or 1915\(b\) Waivers for Managed Long Term Services and Supports Programs](#) (CMS, May 20, 2013), p. 3.
- <sup>6</sup> 42 C.F.R. § 438.2 broadened the definition of "health care services" to clearly encompass LTSS and behavioral health.
- <sup>7</sup> Ibid.
- <sup>8</sup> 42 C.F.R. § 438.6(c).
- <sup>9</sup> 42 C.F.R. § 438.6(b).
- <sup>10</sup> 42 C.F.R. § 438.3(e).
- <sup>11</sup> States must identify and authorize "in-lieu-of" services in the managed care contract, while individual plans decide whether to offer them to enrollees. 42 C.F.R. § 438.3(e)(2).
- <sup>12</sup> U.S. Health Resources and Services Administration, [Home Visiting](#) (HRSA, n.d.); and S. Rosenbaum, "Twenty-First Century Medicaid: The Final Managed Care Rule," *Health Affairs Blog*, May 5, 2016.
- <sup>13</sup> 42 C.F.R. § 438.3(e)(2)(iv).
- <sup>14</sup> 2 C.F.R. § 438.3(e)(1).
- <sup>15</sup> For example, if a value-added service reduces utilization of covered services, it might reduce the plan's capitation baseline over time.
- <sup>16</sup> 42 C.F.R. § 438.8.
- <sup>17</sup> Plans that fail to reach the minimum MLR threshold may have to pay state or federal penalties, though the managed care regulations do not require such sanctions. 42 C.F.R. § 438.8.
- <sup>18</sup> Specifically, they are defined as "incurred claims" for the purposes of MLR. 81 *Fed. Reg.* 27526.
- <sup>19</sup> 45 C.F.R. § 158.150(b). Cross-referenced at 42 C.F.R. § 438.8(e)(3)(i). Note: If HHS does not carefully define an "activity that promotes quality," plans may exploit this exception to mask administrative expenses as "services," thus undercutting the MLR's effectiveness.
- <sup>20</sup> A. Gawande, "The Hot Spotters," *The New Yorker*, Jan. 24, 2011.
- <sup>21</sup> 42 C.F.R. § 438.208(b)(2). The previous standards only applied to health care specific services.
- <sup>22</sup> 42 C.F.R. § 438.208(c). For person-centered planning standards, see 42 C.F.R. § 441.301(c)(1) & (2).
- <sup>23</sup> M. Crawford, T. McGinnis, J. Auerbach et al., [Population Health in Medicaid Delivery System Reforms](#) (Milbank Memorial Fund, March 2015), pp. 8, 11.
- <sup>24</sup> New York State Department of Health, Medicaid Redesign Team, [A Path Toward Value Based Payment: Annual Update: New York State Roadmap for Medicaid Payment Reform](#) (NYS DOH, June 2016), p. 7.

## ABOUT THE AUTHOR

**David Machledt, Ph.D.**, is a senior policy analyst for the National Health Law Program (NHeLP). His work at NHeLP centers on issues surrounding implementation of the Affordable Care Act, Medicaid waivers and demonstrations, health care affordability, and long-term supports and services. Machledt has a Ph.D. in medical anthropology from the University of California, Santa Cruz, with a focus on immigration and public health policy. He received his A.B. in anthropology from Princeton University.

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### **For more information about this brief, please contact:**

David Machledt, Ph.D.  
Senior Policy Analyst  
National Health Law Program  
[machledt@healthlaw.org](mailto:machledt@healthlaw.org)

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