



SHO# 21-001
RE: Opportunities in Medicaid and CHIP
to Address Social Determinants of Health
(SDOH)

January 7, 2021

Dear State Health Official:

The purpose of this State Health Official (SHO) letter is to describe opportunities under Medicaid and CHIP to better address social determinants of health (SDOH)¹ and to support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing SDOH. This letter describes: (1) several overarching principles that CMS expects states to adhere to within their Medicaid and CHIP programs when offering services and supports that address SDOH; (2) services and supports that are commonly covered in Medicaid and CHIP programs to address SDOH; and (3) federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH. A table that summarizes the information on key federal authorities for addressing SDOH is also included in an appendix.

Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to over 76 million low-income Americans, including many individuals with complex, chronic, and costly care needs. Many Medicaid and CHIP beneficiaries may face challenges related to 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. There is a growing body of evidence that indicates that these challenges can lead to poorer health outcomes for beneficiaries and higher health care costs for Medicaid and CHIP programs and can exacerbate health disparities for a broad range of populations, including individuals with disabilities, older adults, pregnant and postpartum women and infants, children and youth, individuals with mental and/or substance use disorders, individuals living with HIV/AIDS, individuals living in rural communities, individuals experiencing homelessness, individuals from racial or ethnic minority populations,

¹ The Centers for Disease Control and Prevention (CDC) 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." 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](#).

and individuals with limited English proficiency. Examples of adverse health outcomes linked to social and economic factors include: asthma attributed to certain home environments; diabetes-related hospital admissions related to food insecurity; falls due to physical barriers, safety hazards, or absence of needed home modifications; frequent use of the emergency department due to homelessness; and a risk of stress-related illness resulting from unemployment, among many others.^{2,3}

SDOH have been shown to impact health care utilization and cost, health disparities, and health outcomes.⁴ Current research indicates that some social interventions targeted at Medicaid and CHIP beneficiaries can result in improved health outcomes and significant savings to the health care sector.⁵ These investments can also prevent or delay beneficiaries needing nursing facility care by offering services to facilitate community integration and participation, and help keep children on normative developmental trajectories in education and social skills.

While many states, managed care plans, and providers have recognized the importance of addressing SDOH for Medicaid and CHIP beneficiaries, the growing shift towards alternative payment models and value-based care has accelerated the interest in addressing SDOH within Medicaid and CHIP in order to lower health care costs, improve health outcomes, and increase the cost-effectiveness of health care services and interventions. In addition to their key roles in providing access to health care for many Americans, state Medicaid and CHIP agencies are in a unique position to address SDOH for Medicaid and CHIP beneficiaries, due to the broad range of services and supports, including home and community-based services (HCBS), that can be covered within Medicaid and CHIP programs and the high number of Medicaid and CHIP beneficiaries who face challenges related to SDOH because of low income and other reasons.⁶

This document is intended to supersede a 2015 CMCS Informational Bulletin on [Coverage of Housing-Related Activities and Services for Individuals with Disabilities](#). This letter does not describe new flexibilities or opportunities under Medicaid and CHIP to address SDOH, but rather describes how states may address SDOH under the flexibilities available under current law.

² Bachrach, D., Pfister, H., Wallis, K., Lipson, M., Addressing Patient’s Social Needs, An Emerging Business Case for Provider Investment, May 2014. The Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf

³ Pynoos, J., Steinman, B., et al, Assessing and Adapting the Home Environment to Reduce Falls and Meet the Changing Capacity of Older Adults. *J Hous Elderly*. 2012; 26(1-3): 137–155. Available from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6294465/pdf/nihms-953861.pdf>

⁴ Chisolm, D.J., Brook, D.L., Applegate, M.S. *et al*. Social determinants of health priorities of state Medicaid programs. *BMC Health Serv Res* 19, 167 (2019).

⁵ Lipson, D., Medicaid’s Role in Improving the Social Determinants of Health: Opportunities for States, June 2017. National Academy of Social Insurance. Available at: <https://www.nasi.org/research/2017/medicaid%E2%80%99s-role-improving-social-determinants-health>

⁶ Braveman, P., S. Egerter, and D. Williams (2011). “The Social Determinants of Health: Coming of Age.” *Annual Review of Public Health*, 32:381-398. https://www.annualreviews.org/doi/10.1146/annurev-publhealth-031210-101218?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Aacrossref.org&rfr_dat=cr_pub++0pubmed

Overarching Principles

State Medicaid and CHIP programs can utilize a variety of delivery approaches, benefits, and reimbursement methodologies to improve beneficiary outcomes and lower health care costs by addressing SDOH. Through several different federal authorities, CMS provides states with flexibility to design an array of services to address SDOH that can be tailored, within the constraints of certain federal rules, to address state-specific policy goals and priorities, including the movement from volume-based payments to value-based care, and the specific needs of states' Medicaid and CHIP beneficiaries. There are, however, several overarching principles that states are required to adhere to within their Medicaid programs in the context of providing services to address SDOH:

1. 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 to Medicaid beneficiaries based on individual assessments of need, rather than take a one-size-fits-all approach;
2. As required by section 1902(a)(25) of the Act and 42 CFR Part 433 Subpart D, Medicaid is frequently, but not always, the payer of last resort.⁷ This requirement ensures that Medicaid resources are not duplicating other available funding streams, including but not limited to certain other federal funding sources, and that Medicaid aligns with other programs and fills gaps where appropriate. 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 when developing a strategy for addressing beneficiaries' SDOH⁸;
3. As required by section 1902(a)(30)(A) of the Act, Medicaid programs must ensure methods and procedures relating to the utilization of, and the payment for, care and

⁷ There are a few exceptions to the general rule that Medicaid is the payer of last resort. These exceptions generally relate to federally administered health programs. For a federally administered program to be an exception to the Medicaid payer of last resort rule, the statute creating the program must expressly state that the other program pays only for claims not covered by Medicaid; or, is allowed, but not required, to pay for health care items or services. For more information on these exceptions, see <https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf>.

⁸ States are encouraged to review guidance and information from CMS, other federal agencies, and non-federal entities to learn more about other federal and non-federal funding sources that can address SDOH. For example, the Administration for Community Living's *Strategic Framework for Action: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities* (https://acl.gov/sites/default/files/programs/2020-06/ACL_Strategic_Framework_for_Action_v1_%20June%202020_final_508_v2.pdf) provides information on how states can leverage federal and state funded programs to address SDOH through networks of community-based organizations. As another example, the Joint HHS, Housing and Urban Development (HUD), and United States Department of Agriculture (USDA) Informational Bulletin, *Living at Home in Rural America: Improving Accessibility for Older Adults and People with a Disability* (<https://www.medicaid.gov/federal-policy-guidance/downloads/cib081920.pdf>) is intended to support state agencies with more effectively coordinating existing federal resources related to home accessibility across multiple sectors as part of their efforts to increase home safety and accessibility for older adults and people with disabilities living in rural communities.

services are consistent with efficiency, economy, and quality of care. This requirement ensures that Medicaid programs expend resources in a prudent manner. States should ensure that services provided to address SDOH are limited to those expected to meet the beneficiary's needs in the most economic and efficient manner possible and are of high quality; and

4. 42 CFR 440.230(b) requires that each Medicaid service be sufficient in amount, duration, and scope to reasonably achieve its purpose.

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. Beyond these specific federal requirements, CMS strongly encourages states to build in continuous evaluations of any services, interventions, or initiatives intended to address SDOH and to make changes, as needed and allowable under federal requirements, to meet programmatic goals. In addition, when requesting federal approval to cover services that address SDOH, such as when requesting federal waiver or demonstration authority, states should be prepared to support the request with evidence and explain how they will monitor and evaluate the effectiveness of the services, consistent with the requirements of the federal authority that the state is requesting to use to cover the services. These requests will be substantially strengthened if states can demonstrate that the services, programs, and interventions that they are proposing to cover have been demonstrated to improve quality of care, improve outcomes, and/or lower costs for Medicaid and CHIP beneficiaries.

Services and Supports that Can Be Covered Under Medicaid to Address SDOH^{9,10}

States have flexibility to design an array of services to address SDOH. However, the services and supports that states can cover tend to fall within several categories of services, including housing-related services and supports, non-medical transportation, home-delivered meals, educational services, employment, community integration and social supports, and case management. This section provides a high-level description of these service categories. Additional information on the extent to which the services and supports described in this section can be covered under different federal authorities is provided in the next section. When developing and implementing a strategy to address SDOH, the state Medicaid agency should

⁹ Additional flexibilities are available to states during public health emergencies and in response to natural and manmade disasters. See <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html> for guidance, resources, and other information available to states during the COVID-19 Public Health Emergency. See <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html> and <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home> for guidance, information, and other resources related to public health emergencies, natural disasters, and manmade disasters, generally.

¹⁰ The information included in this section is not an exhaustive list of all services and supports that can be covered under Medicaid. There may be other opportunities for states to claim Medicaid reimbursement related to the delivery of benefits and services discussed in this letter, such as for the cost of interpreter and translation services that are provided to people with limited English proficiency. See <https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html> for more information.

work with other state agencies to leverage all federal funding the state receives to address SDOH.

Except where noted, the Medicaid coverage options and services and supports described below can be utilized for children and youth, non-elderly adults (including adults with disabilities), and older adults. However, some services and supports are typically targeted at only certain populations or age groups, although they could be covered by states more broadly. In particular, home-delivered meals and some housing and tenancy supports are not generally targeted at children, employment supports are most commonly offered to non-elderly adults with disabilities, and educational supports are typically only available to children with disabilities and young adults with disabilities.

Following this section is a description of applicable Medicaid coverage provisions that could be used by CMS to give a state authority to implement the services and supports described below. CMS notes that the following services and supports must be provided in accordance with the parameters of the individual benefit authorizing the activity. For example, any service and support authorized under HCBS waiver or state plan provisions at section 1915(c) or (i) of the Act, respectively, must be articulated in a state-approved person-centered service plan based on an individual assessment of need. CMS has also indicated in published guidance¹¹ that services must be for the benefit of the Medicaid-eligible individual only, and not for “general utility.”¹² We further note the requirement at 42 CFR 441.301(c)(2)(xii) that the state-approved person-centered service plan prevents the provision of unnecessary or inappropriate services. Additional benefit parameters will be discussed throughout the remainder of this document, and should be taken into account when proposing Medicaid coverage of these services and supports.

A. Housing-Related Services and Supports

Federal financial participation is not available to state Medicaid programs for room and board (except in certain medical institutions¹³).¹⁴ However, federal financial participation is generally available under certain federal authorities for housing-related supports and services that promote health and community integration, including home accessibility modifications, one-time community transition costs, and housing and tenancy supports, including pre-tenancy services and tenancy sustaining services.

1. Home Accessibility Modifications

Home accessibility modifications are either temporary or permanent changes to a home’s interior or exterior structure to improve individuals’ ability to remain in their homes and

¹¹ <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>; see page 41, question 4.

¹² Examples of items that are of “general utility” include phone cards and minutes and central air conditioning.

¹³ Centers for Medicare & Medicaid Services. “Institutional Long Term Care.” 2019. Available at <https://www.medicaid.gov/medicaid/ltss/institutional/index.html>. Accessed on August 21, 2020.

¹⁴ This is codified in multiple regulatory provisions. See, for example, 42 CFR § 441.310(a)(2) and 42 CFR § 441.360(b).

communities.^{15,16} Depending on the home’s structural characteristics, temporary modifications could include the installation of a wheelchair ramp outside the home or grab bars in the shower. Permanent modifications could include enlarging a doorway to allow wheelchair passage. Homes that are more accessible and usable facilitate independent living, reduce the risk of social isolation, improve quality of life, and promote community integration.¹⁷ CMS notes that these services and supports must be specific to the individual’s needs based on his or her disabilities and/or health conditions and not of general utility in the home.

2. One-Time Community Transition Costs

Community transition costs can help to facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a community-based living arrangement in a private residence where the person is directly responsible for his or her own living expenses.¹⁸ One-time community transition costs may include payment of necessary expenses to establish a beneficiary’s basic living arrangement, such as security deposits, utility activation fees, and essential household furnishings, for example.

3. Housing and Tenancy Supports

Housing and tenancy supports include both pre-tenancy services, which assist individuals to prepare for and transition to housing, and tenancy sustaining supports, which are provided once an individual is housed to help the person achieve and maintain housing stability. Examples of pre-tenancy services include:

- conducting an individualized screening and community integration assessment that identifies the individual’s preferences for, and barriers to, community residence – including factors such as accessibility and affordability;
- developing a community integration plan based on the community integration assessment;
- assisting with the housing search, including training on how to: search for available housing; identify the adequacy and availability of public transportation in areas under

¹⁵ Depending on the type of home modification, three Medicaid coverage authorities could be relevant. Regulations at 42 CFR 440.70(b)(3)(ii) define medical equipment and appliances, as a component of the 1905(a) home health benefit, such that certain types of removable modifications could be encompassed when a beneficiary meets any state-defined medical necessity criteria. In the HCBS waiver program, section 1915(c)(4)(b) of the Act authorizes the Secretary to approve “other” services such as home modifications when there is a determination that but for these services the individual would require institutional placement, as documented in an approved plan of care. Home modifications could also be approved under the 1915(i) state plan option, for individuals who meet the state’s established needs-based criteria, when based on an assessed need and documented in the individual’s plan of care.

¹⁶ Joint HHS, HUD, and USDA Informational Bulletin, *Living at Home in Rural America: Improving Accessibility for Older Adults and People with a Disability*, issued August 19, 2020, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib081920.pdf>.

¹⁷ For more information on social isolation see: National Academies of Sciences, Engineering, and Medicine. 2020. *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25663>.

¹⁸ State Medicaid Director Letter SMD 02-008, *Transition Costs Covered under Home and Community-Based Services Waivers*, issued May 9, 2002, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd050902a.pdf>.

consideration; complete the application for housing assistance and for the residence itself; and review and sign a lease or rental agreement, consistent with the community integration assessment and plan;

- ensuring that housing units are safe and ready for move-in;
- assisting in arranging for and supporting move-in, including moving expenses and transportation expenses related to the move when necessary and unavailable through other resources and identified in the person-centered service plan; and
- connecting the individual to community-based resources that provide assistance with activities such as securing required documents and fees needed to apply for housing and making any reasonable accommodation request(s) related to the individual's disability to a housing provider.

Examples of tenancy sustaining services include:

- providing early identification and intervention for behaviors that may jeopardize housing (e.g., lease violations);
- education or training on the role, rights, and responsibilities of the tenant and landlord;
- connecting the individual to community resources to maintain housing stability; and
- individualized case management and care coordination (e.g., connecting the individual with needed Medicaid and non-Medicaid service providers and resources) in accordance with the person-centered care plan and the individual housing support plan.

B. Non-Medical Transportation¹⁹

Individuals who need Medicaid-funded home and community-based services (HCBS) may lack transportation to access community activities and resources. States have the option to cover non-medical transportation to enable individuals receiving Medicaid-funded HCBS to gain access to such activities and resources when other options, such as transportation by family, neighbors, friends, or community agencies, are unavailable. Examples include transportation to grocery stores and places of employment.

C. Home-Delivered Meals

Older adults and individuals with disabilities who need Medicaid-funded HCBS may need additional assistance with meeting nutritional needs due to functional limitations or challenges that make it difficult to go shopping or prepare meals on their own. Home-delivered meals can

¹⁹ In addition to the opportunities for states to provide non-medical transportation that are described in this letter, states generally are required to assure necessary transportation to and from covered medical care. This does not necessarily mean the state is responsible for providing a ride, but unless this requirement has been waived or identified as inapplicable, the state must assure that a beneficiary without another reasonably available and appropriate means of transportation receives necessary transportation to and from covered services. Federal Medicaid regulations require states to detail the methods that the state will use to meet this requirement in the states' approved state plan. Each state is responsible for determining how to structure and administer transportation under broad federal requirements.

help to supplement the nutritional needs of these individuals when there is an assessed need and the services are identified in the person-centered service plan.^{20,21}

D. Educational Services

Under the Individuals with Disabilities Education Act (IDEA), children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in the child’s individualized education plan (IEP) or, for infants and toddlers (children under age three), the individualized family service plan (IFSP). These educational services can help children with disabilities achieve their educational goals. Medicaid reimbursement is available for covered services that are included in the child’s IEP and IFSP provided to eligible beneficiaries by qualified Medicaid providers.²² States also have the option to cover Medicaid services furnished to eligible Medicaid beneficiaries in the school setting if the children are determined to need those services, the services are furnished by qualified Medicaid providers, and the services meet all of the requirements set forth in the State Medicaid Director Letter 14-006.^{23,24}

E. Employment

Employment can help to lift low-income individuals and families out of poverty and, in doing so, address a broad range of social needs that can impact health. As discussed in SMDL 18-002, CMS supports states’ efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability.²⁵ States can test incentives that provide a pathway to coverage for certain individuals who may not be eligible for Medicaid through the state plan to opt into Medicaid coverage, or for some beneficiaries to receive enhanced benefits, through participation in work or other community engagement activities through a demonstration projects authorized under section 1115 of the Act.

²⁰ As noted previously, federal financial participation is not available to state Medicaid programs for room and board (except in certain medical institutions). CMS defines the term “board” to mean three meals a day or any other full nutritional regimen; see section 4442.3 of the State Medicaid Manual at www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927.

²¹ State NWD Systems employ person centered counselors that assist people in accessing home delivered meal programs and enrolling in Farmers Market voucher programs and other food and nutrition programs sponsored by the US Department of Agriculture and state Department of Agriculture programs.

²² As noted earlier, there are a few exceptions to the general rule that Medicaid is the payer of last resort and these exceptions generally relate to federally administered health programs. For a federally administered program to be an exception to the Medicaid payer of last resort rule, the statute creating the program must expressly state that the other program pays only for claims not covered by Medicaid; or, is allowed, but not required, to pay for health care items or services. As indicated by section 1903(c) of the Act, Parts B and C of the Individuals with Disabilities Education Act (IDEA) is one example of this exception to the payer of last resort rule.

²³ State Medicaid Director Letter 14-006, Medicaid Payment for Services Provided without Charge (Free Care), issued December 15, 2014, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>.

²⁴ Certain services authorized under sections 1915(c), (i), and (k) of the Act have restrictions on Medicaid coverage of educational services.

²⁵ State Medicaid Director Letter SMD 18-002, Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, issued January 11, 2018, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>.

These measures may also enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover, thereby maintaining the long-term fiscal sustainability of a state’s Medicaid program and enabling states to provide medical services to more Medicaid beneficiaries.

In addition, for individuals with disabilities, who are less likely to be employed than individuals without disabilities,²⁶ Medicaid-funded HCBS can provide supported employment services for individuals who need intensive on-going support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting. States may define other models of individualized supported employment that promote community inclusion and integrated employment. Supported employment can vary substantially depending on the individual’s needs and might include customized employment, job coaching to provide supports and services not specifically related to job skill training that enable the individual to successfully integrate into the job setting (e.g., instruction on how to ameliorate the impacts of a mental illness on the job), and personal care services to provide assistance at an individual’s place of employment.

Health care services and supports not generally available through programs other than Medicaid can constitute a barrier to employment. However, Medicaid “buy-in” programs, available in most states, and often described as “Working Disabled” programs, allow workers with disabilities access to Medicaid community-based services not available through other insurers, such as personal care attendant services, by paying into Medicaid on a sliding scale. These programs have higher (or no) asset limits to allow individuals with disabilities who need these services to retain them while working and earning salaries above the standard Medicaid limits.²⁷

F. Community Integration and Social Supports

Medicaid-funded HCBS provide opportunities for Medicaid beneficiaries to choose to receive services in their home or community rather than institutions. These programs serve a variety of targeted populations groups, such as older adults, people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. Examples of HCBS that facilitate community integration include instruction on how to utilize public transportation, and companion services to accompany the individual into places in the community to provide assistance. HCBS in non-residential settings also afford individuals opportunities to participate in the community by providing and/or facilitating access to community-based activities with individuals not receiving Medicaid HCBS. For example, companion services can provide critical socialization supports to assist individuals as they integrate into their broader community and develop relationships.

²⁶ Bureau of Labor Statistics, U.S. Department of Labor. Persons with a Disability: Labor Force Characteristics — 2019. February 26, 2020). <https://www.bls.gov/news.release/pdf/disabl.pdf>

²⁷ Section 201 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) (P.L. 106-170) includes the Medicaid Buy-In provision for working individuals with disabilities between the ages of 18 and 64. Forty-six states currently have Medicaid buy-in programs.

G. Case Management

Case management assists eligible individuals to gain access to needed medical, social, educational, and other services. Case management services are often a critical component of the services and supports described above, although case management can also be used to address a broader range of needs and to assist Medicaid and CHIP beneficiaries with accessing other Medicaid and non-Medicaid services.

Opportunities to Address SDOH under Medicaid and CHIP Authorities

Federal Medicaid law requires states to provide certain mandatory Medicaid state plan benefits under sections 1902(a)(10) and 1905(a) of the Act and 42 Code of Federal Regulations (CFR) §§ 440.210 and 440.220. Additionally, pursuant to section 1905(a)(4)(B) and (r)(5) of the Act, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requires that states provide all medically necessary section 1905(a) services coverable under the Medicaid program to eligible children and youth under age 21 in order to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.

In addition, states can choose to provide optional benefits under state plan authority, as well as through waiver authority under section 1915 of the Act, or they can offer non-mandatory benefits under demonstration project waiver or expenditure authorities under section 1115 of the Act. States have a certain degree of flexibility in determining which non-mandatory benefits to provide under these authorities. In most cases, state flexibility is limited by section 1902(a)(1) of the Act and 42 CFR § 431.50 (statewideness), section 1902(a)(17) of the Act and 42 CFR § 440.230 (requirements regarding the amount, duration, and scope of covered services), and section 1902(a)(10)(B) of the Act and 42 CFR § 440.240 (comparability of services within and among eligibility groups), among other provisions. These requirements apply unless the statute makes them inapplicable to the specific benefit or CMS waives or makes them inapplicable.

More information on some of these coverage authorities and how they can address SDOH, as well as other opportunities for states to address SDOH in their Medicaid and/or CHIP programs, is provided below. Except where noted or otherwise clarified, states can receive federal financial participation for the services, benefits, and other opportunities described in this section, assuming they meet the requirements of the coverage authority. It is important to note that many of the services outlined throughout this document may be provided using telehealth modalities in addition to in person visits. States are strongly encouraged to assess their telehealth frameworks to determine if there are unnecessary restrictions preventing maximum utilization of telehealth for the services appropriate to be delivered via telehealth.

Appendix A also provides a summary of key authorities, the characteristics of beneficiaries who are eligible to receive services under that authority, and the types of SDOH that each authority can be useful to address. Appendix B provides a summary of services and supports that can be covered under Medicaid and CHIP to address SDOH, including a description of the services and supports, examples, potential target populations, and federal authorities that can be used to cover the services and supports. States may have additional flexibility to cover additional services and supports under some of the authorities listed below, including section 1115 demonstrations,

managed care programs, CHIP Health Services Initiatives (HSIs), and the Money Follows the Person demonstration.

A. Section 1905(a) State Plan Authority

Section 1905(a) state plan services can assist Medicaid-eligible individuals to gain access to needed medical and social services. The following are examples of section 1905(a) state plan services that can address SDOH for Medicaid-eligible individuals.

1. Rehabilitative Services Benefit

Description: The rehabilitative services benefit is an optional Medicaid state plan benefit authorized at section 1905(a)(13) of the Act and codified in regulation at 42 CFR § 440.130(d) as “medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.”

Who Is Eligible: Individuals who meet any state-defined medical necessity criteria for covered services.

How Rehabilitative Services Can Address SDOH: Rehabilitative services may include services to help eligible individuals regain skills and functioning necessary to address SDOH. For example, a Medicaid beneficiary may need help with 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. Practitioners who furnish rehabilitative services must meet a state’s qualifications, including any licensure, certification, education, training, experience and supervisory arrangements the state requires.

Rehabilitative services may include services furnished by peers. For beneficiaries with serious mental illness (SMI) or substance use disorders (SUD) in particular, peer supports can be effective at helping individuals coordinate care and social supports and services. Peer supports can facilitate linkages to housing, transportation, employment, nutritional services, and other community-based supports. In addition to section 1905(a)(13) rehabilitative services, states may choose to deliver peer support services through section 1915(b) and 1915(c) HCBS waiver programs and under section 1115 authority.

For additional information, CMS published State Medicaid Director Letter (SMDL) #07-011²⁸ in 2007, providing policy guidance on supervision requirements, care coordination, and minimum training criteria for peer support providers.

State Example: New Jersey added peer support services to its rehabilitative services benefit ([State Plan Amendment \(SPA\) 19-0015](#)), which allows peer support specialists to provide

²⁸ Centers for Medicare & Medicaid Services. State Medicaid Director Letter SMD 07-011, issued August 15, 2007. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD081507A.pdf>

nonclinical assistance and support throughout all stages of the SUD or SMI recovery and rehabilitation process. Services include but are not limited to: participating in the treatment planning process; mentoring and assisting the beneficiary with problem solving, goal setting and skill building; initiating and reinforcing a beneficiary's interest in pursuing and maintaining treatment services; providing support and linkages to specialty support services; sharing experiential knowledge, hope, and skills; advocating for the beneficiary; and being a positive role model.

2. Rural Health Clinics/Federally Qualified Health Centers

Description: Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) services are defined in section 1905(a)(2)(B), 1905(a)(2)(C), and 1905(l)(1) and (2) of the Act, and include certain services listed in section 1861(aa) of the Act, as described in section 1905(l)(1) and (2). FQHC and RHC services are mandatory Medicaid state plan services for categorically needy populations. FQHCs and RHCs generally serve medically underserved populations and areas. Medicaid-covered services provided by FQHCs and RHCs include primary and preventive services provided by physicians, nurse practitioners, physician assistants, clinical psychologists, and clinical social workers, as well as other ambulatory services included in the state plan.

Who Is Eligible: Individuals who meet any state-defined medical necessity criteria. FQHC and RHC services are mandatory for beneficiaries in the categorically needy eligibility groups.

How RHCs/FQHCs Can Address SDOH: RHCs/FQHCs' 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. For example, RHCs/FQHCs could be reimbursed under Medicaid to screen individuals to identify social needs, collect and analyze SDOH data to inform interventions, and co-locate social services, as long as these activities are delivered as part of a Medicaid-covered RHC/FQHC service (see the RHC/FQHC description above for more information).

State example: Under Washington State's approved [section 1115 demonstration](#), entitled "Medicaid Transformation Project-Foundational Community Supports," the state partners with FQHCs that administer Health Care for the Homeless²⁹ programs to provide supportive housing and supported employment supports to eligible participants. These "Foundational Community Supports," or "FCS," are services that would otherwise be allowable under section 1915(c) or 1915(i) of the Act.

3. Case Management and Targeted Case Management Services

Description: Case management services, as defined under sections 1905(a)(19) and 1915(g) of

²⁹ The Public Health Service Act, section 330(h), 42 USC 254b(h), provides that the U.S. Department of Health and Human Services, Health Resources Services Administration may award grants "for the planning and delivery of services to a special medically underserved population comprised of homeless individuals, including grants for innovative programs that provide outreach and comprehensive primary health services to homeless children and youth, children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness." Section 330(h)(2) further provides that "in addition to required primary health services, an entity that receives a grant under this subsection is required to provide substance abuse services as a condition of such grant." For a list of the more than 200 Health Care for the Homeless grantees, see: <https://nhchc.org/directory/>.

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.

Who Is Eligible: Case management services are an optional Medicaid benefit. If a state elects to cover case management under the Medicaid state plan, the state can also opt to provide this benefit without regard to the statewideness and comparability requirements at section 1902(a)(1) and (a)(10)(B) of the Act, in which case the benefit is referred to as targeted case management (TCM). As a result, states can target the benefit to specific populations, as described in section 1915(g)(1) of the Act, such as Medicaid-eligible individuals with SMI and/or 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. Additionally, states are not required to furnish TCM services statewide.

How Case Management and Targeted Case Management Services Can Address SDOH: Case management services offer several 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. For example, case managers can coordinate the team's resources and expertise to inform a comprehensive, medical, educational, and social assessment, as well as to create and implement a comprehensive plan of care. States may also reimburse for services based on case or task complexity to reflect the need to draw on additional resources to develop and implement comprehensive assessments, care plans, and follow through services.

State Example: Colorado added TCM services as a state plan benefit ([SPA 18-0021](#)) to provide case management to individuals who are transitioning from a nursing facility, intermediate care facility for individuals with intellectual and developmental disabilities (ICFs/IID), or Regional Centers, which serve people with intellectual and developmental disabilities who have intensive needs or who have recently transitioned to a community setting. The TCM services support individuals to successfully integrate into community living by facilitating linkages to needed assistance.

B. Home and Community-based Service (HCBS) Options

Medicaid-funded HCBS provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions. These programs serve a variety of targeted populations groups, such as older adults, people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses, and can be particularly effective in addressing SDOH for Medicaid beneficiaries. For example, HCBS programs can play an important role in

coordinating medical and non-medical services and supporting an individual with achieving community living goals.

Medicaid’s HCBS authorities require the development of a person-centered service plan, outlining an individual’s goals and preferences, and their service and support needs to pursue them. Services and supports that may address SDOH are authorized based on an assessment of need and are identified in that person-centered service plan. The person-centered planning process reflects any needed services, including non-Medicaid community resources.

States have options to determine the ways in which these optional HCBS are provided, and the role Medicaid beneficiaries play in the provision of those services. HCBS can be provided under agency-delivered models, in which the provider agency uses employed or contracted staff to furnish services. HCBS can also be provided under self-directed models. Self-direction allows individuals to have the authority to employ staff of their choosing and/or control a defined budget that can be used to purchase goods and services and hire direct service workers and other providers necessary to remain in community-based settings based on the goals in the person-centered plan.

As indicated earlier, HCBS authorities such as the section 1915(c) waiver and section 1915(i) state plan option include defined benefit parameters that must be met. Additional information is described in the following sections.

1. Section 1915(c) HCBS Waiver Program

Description: Waiver authority found at section 1915(c) of the Act gives states the option to offer long-term services and supports (LTSS) in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act. However, those waiver services must not cost more than what would have been incurred to care for waiver participants in an institution.

Who Is Eligible: States can enroll individuals who meet the state’s institutional level of care (meaning individuals could be admitted to a nursing facility, hospital, ICFs/IID), and the need for services must be based on an assessed need and identified in a state-approved service plan. Section 1915(c) allows states to waive certain Medicaid requirements (i.e., statewideness, comparability, income and resource rules applicable in the community), and, thus, allows states to furnish services to target populations by age or diagnosis, including children, adults with physical disabilities, individuals with intellectual or developmental disabilities, individuals with traumatic brain injuries, individuals with mental illnesses, and older adults, among others.

How Section 1915(c) Waiver Programs Can Address SDOH: Under section 1915(c) waiver programs, states can cover a range of services that address SDOH while supporting individuals to achieve community integration goals and to maximize independence and safety in the home. Examples of services that states can cover within section 1915(c) waiver programs to address SDOH include:

- Service coordination or case management in order to facilitate access to supports and services to address SDOH, including during transitions from hospital to home;
- Home accessibility adaptations to the private residence of the beneficiary or his or her family that are required by the beneficiary’s service plan and necessary either to ensure the beneficiary’s health, welfare, and safety or to enable functioning with greater independence in the home³⁰;
- One-time community transition costs, which are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a living arrangement in a private residence where the person is directly responsible for his/her own living expenses³¹;
- Housing and tenancy supports to:
 - assess the individual’s community integration needs and present options;
 - assist in finding and securing housing, including assistance in the completion of housing applications and in securing required documentation (e.g., Social Security card, birth certificate, prior rental history);
 - assist the individual in communicating with the property owner and/or property manager regarding the participant’s disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the property owner and/or property manager; and
 - help the individual to remain in their community housing, such as through assistance with housing recertification, and assistance with dispute resolution with property owners and neighbors;
- Habilitation services,³² which can include a wide variety of activities related to social supports and needs that impact health, such as interpersonal skills training to help an individual acquire and maintain employment or to successfully engage with the community-based housing system, particularly when interacting with neighbors, negotiating with landlords, and managing a household budget. This may also include assistive technology that enable a person to acquire and/or maintain employment;
- Non-medical transportation to support the individual with gaining access to home and community-based services, activities, and resources such as unpaid community supports

³⁰ Such adaptations could include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that accommodate the medical equipment and supplies that are necessary for the welfare of the beneficiary. However, they may not include those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.

³¹ One-time community transition costs may only be covered more than once in an individual’s lifetime if s/he returns to an institutional and/or congregate setting and, as a result, loses the more integrated residence. Allowable expenses are those necessary to enable the person to establish a basic household that do not constitute room and board and may include: security deposits required to obtain a lease; essential household furnishings including furniture, window coverings, food preparation items, and bed/bath linens; moving expenses; set-up fees or deposits for utilities; services necessary for the individual’s health and safety such as pest eradication; necessary home accessibility adaptations; and activities to assess need, arrange for, and procure needed resources. Please note that one-time transition costs under section 1915(i) state plan benefits are the same as under section 1915(c) waivers.

³² Defined at section 1915(c)(5) of the Act, “habilitation services means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.”

which will assist the individual in establishing a presence in his/her community, consistent with and documented in his or her service plan³³;

- Home-delivered meals, including in home and community-based settings other than private residences (e.g., assisted living facilities), as long as the meals do not constitute a full nutritional regimen and the individuals receiving the service have an assessed need for home-delivered meals documented in their person-centered service plan;
- Supported employment services,³⁴ which are ongoing supports to individuals who, because of their disabilities, need intensive on-going support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting.³⁵
- Assistive technologies to facilitate communication between the individual, the individual's support network, and the larger community.

Under section 1915(c)(4)(B), states can also propose “other” types of services that may assist in diverting individuals from institutional placement and supporting community living for eligible individuals. These services can include a broad array of supports and activities designed to address social and economic factors that affect health. However, it is critical to note that Medicaid coverage does not extend to supporting room and board costs or other benefits that are not directly related to the provision of HCBS. CMS also notes that these services and supports must be specific to the individual's needs based on his or her disabilities and/or health conditions and not of general utility.

State Example: Maryland's [section 1915\(c\) Community Supports Waiver](#) targets individuals with developmental disabilities of all ages who have an Intermediate Care Facility for Intellectual Disabilities (ICF/IID) Level of Care (LOC). It is designed to provide support services to participants and their families, to enable participants to work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across their lifespans. The section 1915(c) Community Supports Waiver is the foundation for the Increased Community Services (ICS) program, which is authorized through the Maryland HealthChoice section 1115 demonstration. The ICS program mirrors the Community Supports Waiver in all aspects except eligibility. The Community Supports Waiver service package includes support to individuals with varying medical needs, support to individuals transitioning from institutional settings and significant employment support to uphold the state's Employment First, Meaningful Day program outlook. Services can support integrated life domains that are important to a good quality of life, including daily life, safety and security, community living, healthy lifestyle, social and spirituality, and citizenship and advocacy. This waiver allows services to be delivered through both traditional and self-directed service delivery models.

³³ Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge should also be utilized.

³⁴ See <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-16-2011.pdf> for more information.

³⁵ Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment. Job coaching can also provide supports and services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. For example, a job coach may provide instruction on how to ameliorate the impacts of a mental illness on the job. Additionally, personal care attendants may provide hands-on assistance at an individual's place of employment.

2. Section 1915(i) State Plan Benefit

Description: Section 1915(i) is an optional state plan benefit that allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target group criteria) as set forth in 42 CFR Part 441 Subpart M.

Who Is Eligible: Under section 1915(i), eligible individuals are those who are eligible for medical assistance under the state plan, meet state-defined needs-based criteria, and reside in the community. Section 1915(i) also offers states the option to target the benefit to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group (e.g., pregnant women, individuals receiving Supplemental Security Income, children in foster care). The lower threshold of needs-based criteria must be “less stringent” than institutional and section 1915(c) HCBS waiver program level of care. Needs-based criteria are factors used to determine an individual’s requirements for support that can only be ascertained for a given person through an individualized evaluation of need and may include but cannot only include state-defined risk factors, such as risk of or experiencing homelessness, risk of food insecurity for individuals with diabetes, or risk of social isolation for older adults with chronic conditions. Section 1915(i) services must be offered statewide.

How Section 1915(i) State Plan Services Can Address SDOH: States have the option to cover any services permissible under section 1915(c) HCBS waivers, which include services necessary to live in the community (see Section 1915(c) HCBS Waiver Programs above for more information).³⁶

State Example: Minnesota’s section 1915(i) State Plan Amendment ([SPA 18-0008](#)) covers housing stabilization services for individuals with disabilities who are experiencing or at risk of experiencing homelessness and individuals with a disability with mental illness or substance use disorders who are living in institutions or other segregated settings or are at risk of living in those settings. Under Minnesota’s section 1915(i) SPA, housing stabilization services include supports that help people plan for, find, and move to homes of their own and supports that help a person to maintain living in their own home. Minnesota’s needs-based criteria targets individuals who are assessed to require assistance with at least one need in the following areas resulting from the presence of a disability and/or a long-term or indefinite condition: communication, mobility; decision-making; and/or managing challenging behaviors and is experiencing (risk factor) housing instability.

3. Section 1915(j) Optional Self-Directed Personal Assistance Services

Description: Section 1915(j) self-directed personal assistance services (PAS) means personal care and related services, or HCBS otherwise available under the state plan or a section 1915(c) waiver program that are provided to an individual who has been determined eligible for the PAS option.

³⁶ The one-time transition costs under section 1915(i) state plan benefits are the same as under section 1915(c) waivers.

Who Is Eligible: Individuals must be eligible for state plan personal care services or a section 1915(c) waiver program

How Section 1915(j) Optional Self-Directed Personal Assistance Services Can Address SDOH: Self-directed PAS also includes, at the state’s option, items that increase the individual’s independence or substitute for human assistance (such as a microwave oven, grab bars, or an accessibility ramp) to the extent that expenditures would otherwise be made for the human assistance. Individuals’ budgets may be used to purchase goods and services, supports, or supplies related to a need or goal identified in the individuals’ state-approved person-centered service plans. Services authorized under the section 1915(j) state plan option facilitate beneficiary autonomy and assist individuals in participating in their communities, thereby reducing the likelihood that individuals will experience challenges related to SDOH.

4. Section 1915(k) Community First Choice Optional State Plan Benefit

Description: The section 1915(k) Community First Choice (CFC) state plan benefit provides certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. States receive an extra six percentage points of federal match for CFC state plan expenditures.

Who Is Eligible: Individuals who meet the state’s institutional level of care (meaning the individual could be admitted to a nursing facility, hospital, ICF/IID)

How Section 1915(k) Community First Choice Can Address SDOH: There are required services that must be included in all CFC programs, as well as additional services that may be included at the state’s option.³⁷ States electing CFC are required to cover the following services, subject to the conditions described above: (1) services and supports to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks, through hands-on assistance, supervision, and/or cueing; (2) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks; (3) back-up systems or mechanisms to ensure continuity of services and supports; and (4) voluntary training on how to select, manage, and dismiss attendants. Section 1915(k) services must be offered state-wide.

Optional services states may cover in their CFC benefit include: (1) expenditures for transition costs (such as first month’s rent and utilities, bedding, and basic kitchen supplies) necessary for an individual transitioning from an institutional setting to a home and community-based setting; and (2) expenditures relating to a need that increases an individual’s independence or substitutes for human assistance, to the extent that Medicaid expenditures would otherwise be made for human assistance.

As with section 1915(j), services authorized under the section 1915(k) state plan option facilitate beneficiary autonomy and assist individuals in participating in their communities, thereby reducing the likelihood that individuals will experience challenges related to SDOH.

³⁷ For more information on section 1915(k), see <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html>.

State Example: Connecticut’s section 1915(k) [Community First Choice SPA](#) provides non-recurring transitional services to enable a qualified individual transitioning from a nursing facility, institution for mental diseases, or ICF/IID to a home and community-based setting to establish a basic household. Services may include: essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; transportation expenses to pay for trips associated with locating housing; set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water; and services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

C. Section 1115 Demonstrations

Description: 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 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. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, including but not limited to statewideness and comparability, to the extent and for the period necessary to carry out the demonstration project. 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 expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.³⁸ Pursuant to section 2107(e)(2) of the Act, section 1115 applies similarly to CHIP. Depending on the circumstances, states may seek section 1115 demonstration authority and also seek other authorities, as needed, or apply for a section 1115 demonstration without requesting flexibilities under other authorities.

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 likely have been absent the demonstration. Under a section 1115 demonstration, similar to any other claim for Medicaid and CHIP federal financial participation, states are required to provide the necessary state share, consistent with federal regulations and statute, in order to draw down federal financial participation in authorized spending. CMS currently approves section 1115(a)(2) expenditure authority for services or populations that could not be covered under other authorities, i.e., costs not otherwise matchable, only if the state identifies offsetting savings to ensure the demonstration remains budget neutral. In cases where expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid or CHIP state plan or other title XIX authority, such as a waiver under section 1915 of the Act, CMS considers these expenditures to be “hypothetical” expenditures that do not necessitate savings to offset the otherwise allowable coverage.³⁹ Section 1115

³⁸ 42 U.S.C. § 1315.

³⁹ Centers for Medicare & Medicaid Services. SMDL #18-009. August 22, 2018. Available at <https://www.medicare.gov/federal-policy-guidance/downloads/smdl18009.pdf>.

demonstrations are usually approved for an initial 5-year period, with a possible 3-year or 5-year renewal period after the first 5 years. Subject to the public notice and transparency requirements, CMS may approve an extension for a period up to 10 years of routine, non-complex section 1115 demonstration and expenditure authorities that have been proven successful based on monitoring and evaluation data.⁴⁰

Just as is the case for all section 1115 demonstrations, states that receive CMS approval for section 1115 demonstration authority to address SDOH are expected to conduct independent and robust evaluations of the demonstration. These evaluations generally draw on data collected for monitoring, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes. An interim evaluation is generally completed one year before the expiration of the demonstration, and under 42 CFR 431.424(d) must be included as part of the state’s proposal to extend the demonstration. A summative evaluation is generally due 18 months after the demonstration period ends. States are also expected to submit an evaluation design, for CMS approval. CMS typically includes in special terms and conditions (STCs) for approved demonstrations a requirement that the state submit a monitoring protocol for CMS review and approval that describes the state’s plan to monitor the demonstration in accordance with CMS expectations.

Who Is Eligible: States have significant flexibility in how they define target populations for demonstration services/activities, and states can determine their own state’s needs. For instance, states can target populations by age and/or defined risk factors for services. States can target section 1115 demonstration services to particular geographic areas and/or populations meeting defined characteristics. However, CMS currently will not approve a demonstration providing coverage of services consistent with those authorized under section 1915(c), (i), or (k) benefits unless the state agrees to adhere to programmatic requirements of individual assessments of need with respect to those services.

How Section 1115 Demonstrations Can Address SDOH: Through section 1115 authority, states have the opportunity to test innovative approaches for addressing SDOH, subject to CMS approval, in ways that consider local challenges and response capabilities. States could, for instance, elect to pilot services that address SDOH for a specific target population or in a limited geographic area. Furthermore, states could choose to test services and supports that could address SDOH through expenditure authority. For example, states could test the effectiveness of providing: one-time community transition services for individuals experiencing or at risk of experiencing homelessness transitioning into supportive housing to increase housing stability, lower health care costs, and improve health outcomes for individuals who are experiencing homelessness or are at high risk for homelessness; or recurring chore or cleaning services to reduce asthma triggers in the home for individuals with poor asthma control. States can also test alternative payment methodologies that are designed to address SDOH. When assessing whether to approve a section 1115 demonstration, CMS would examine whether the demonstration is likely to assist in promoting the objectives of Medicaid or CHIP. In that assessment, CMS will

⁴⁰ Centers for Medicare & Medicaid Services. “Section 1115 Demonstration Process Improvements.” CMCS Informational Bulletin. November 6, 2017. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf>.

consider whether the demonstration is likely to furnish medical assistance in a manner that improves the sustainability of the safety net, such as if provisions influence health outcomes, improving beneficiaries' physical and mental health, which may in turn cause them to consume fewer health care resources while they are enrolled in Medicaid. This may potentially reduce the need for future Medicaid enrollment or result in lower costs for states over the long-term, thereby sustaining the state's Medicaid program.

Evaluation designs for section 1115 demonstrations to address SDOH should consider the extent to which the provision of services addressing SDOH results in improved integration of all services, increased care coordination effectiveness, improved health outcomes, and reductions in unnecessary or inefficient use of health care. States will be expected to comply with CMS requirements for monitoring and evaluation, as applicable, and as specified in the state's STCs.

State Examples: Washington State's approved [section 1115 demonstration](#), entitled "Medicaid Transformation Project," authorizes the provision of Foundational Community Supports, which include both housing-related and supported-employment services. The intended goals of the demonstration are to integrate behavioral health into the larger health care system and to address housing and employment needs as SDOH. The aim is to improve health outcomes and reduce unnecessary utilization of high-cost health care services such as emergency department visits and inpatient bed stays. In addition, the state has developed and implemented training for LTSS social workers/case managers through their Tailored Supports for Older Adults (TSOA) and Medicaid Alternative Care (MAC) initiative. The state developed training materials to train Senior Information and Assistance/Aging and Disability Resource Center, state, and Area Agency on Aging staff on the new benefit levels, eligibility, authorization and qualification of providers.

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 healthcare 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 age 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 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.

D. Section 1945 Health Homes

Description: 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 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; referral to community

and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.⁴¹ 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 reliance on long-term care facilities, and improved experience of care for Medicaid beneficiaries with chronic conditions.

States implementing the section 1945 health home benefit receive enhanced federal matching funds for new health home programs or by adding health home services for new chronic conditions or expanding health home services to new geographic areas for an initial period (90 percent federal match for health home services during the first 8 fiscal quarters that the approved health home SPA is in effect). States can request an additional two quarters of enhanced federal match under SUD-focused health home SPAs approved on or after October 1, 2018. After the period of enhanced federal match ends, services are matched at the state’s usual service rate.

Who Is Eligible: 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, notwithstanding the statewideness and comparability requirements in section 1902(a)(1) and (a)(10)(B) of the Act. CMS has explained in guidance that states can specify which chronic conditions their health homes will target, but are not permitted to limit the benefit to specific age groups. While all individuals served must meet the minimum statutory criteria, states may elect to target the population to individuals with higher numbers or severity of chronic or mental health conditions. The population must include all categorically needy individuals who meet the state’s criteria (including those eligible based on receipt of services under a section 1915(c) home and community-based services waiver), and at state option may include individuals in any medically needy group or section 1115 demonstration population.^{42,43}

To qualify for health home services, Medicaid beneficiaries must: (1) have two or more chronic conditions; (2) have at least one chronic condition and be at risk of developing another; or (3) have at least one serious and persistent mental health condition. Chronic conditions are specified in the statute to include, but not be limited to: mental health conditions, SUD, asthma, diabetes, heart disease, and being overweight (i.e., Body Mass Index over 25). States may propose to target one or more conditions from the list, or, with approval from CMS, may target other conditions, such as HIV/AIDS.

How Section 1945 Health Homes Can Address SDOH: Among other things, health homes are responsible for connecting beneficiaries to other social services and supports. 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, the results of which could then help the health home to refer an individual to community and social support services. Health home

⁴¹ For a definition of health home services, see <https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf>.

⁴² <https://www.medicaid.gov/sites/default/files/2020-02/health-homes-faq-12-18-17.pdf>

⁴³ <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD10024.pdf>

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 provides assistance 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. California utilizes a housing navigator that develops relationships with housing agencies and permanent housing providers, including supportive housing providers, in order to refer and link Medicaid-eligible participants with community-based housing resources.

E. Managed Care Programs

Description: States may use a number of existing federal state plan and waiver authorities, including sections 1115(a), 1932, and 1915(b) of the Act, to authorize a risk-based managed care delivery system. These managed care authorities can be used by states to implement a managed care delivery system for state plan and waiver benefits. Under risk-based managed care arrangements, states provide some or all 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, or PMPM), regardless of whether the enrollee uses services.

Who Is Eligible: Individuals who receive services under Medicaid managed care contracts who meet any state-defined medical necessity criteria for the services covered under the contract.

How Managed Care Can Address SDOH: There are a variety of mechanisms described in the Medicaid managed care statutes 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 be expended for the benefit of 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 section 1915(b)(3) authority and have managed care plans provide this service to individuals with chronic conditions, as long as the meals do not constitute a full dietary regimen and the individuals receiving the service have an assessed need for home-delivered meals documented in their person-centered service plan. 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 circumstances⁴⁴ 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.
- *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. It is important to note that managed care plan contract payments that incorporate incentive payments may not exceed 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement.

In the 2016 managed care rule (81 FR 27530), CMS specified that incentive payments made to the managed care plan in accordance with § 438.6(b)(2) should not be included in the denominator of the medical loss ratio (MLR) as such payments are in addition to the capitation payments received under the contract. However, these MLR standards can support states and managed care plans in their efforts to design and implement comprehensive strategies to address SDOH by ensuring amounts can be appropriately identified and classified within each managed care plan’s MLR.

Under §§ 438.5(e) and 438.7(b)(3), related to non-benefit costs, and §§ 438.5(f) and 438.7(b)(4), related to adjustments, states can develop specific assumptions and methodologies in capitation rate development related to profit margins and efficiency adjustments that are based on generally accepted actuarial principles and practices. An important principle of actuarial soundness is to ensure that rates paid to plans are appropriate, reasonable, and attainable. States may consider strategies to incentivize plan performance, such as by providing incentive payments to plans that achieve certain results, including lower costs and improved health outcomes. Such strategies could provide plans with an incentive to achieve improvement as a result of investments in SDOH. States could also consider other policy pathways for encouraging plans to invest in SDOH efforts. For example, some states

⁴⁴ 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.medicare.gov/medicaid/managed-care/guidance/state-directed-payments/index.html>.

have established caps on plans' profit margins and required 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 necessarily be incorporated in the final capitation rates as well as the numerator of a plan's MLR.⁴⁵
- *Managed Care Plan Contracting Strategies (42 CFR § 438.208(b)).* States may develop and implement specific managed care plan procurement and contracting strategies to incentivize care coordination across medical and nonmedical contexts, including to address SDOH. For example, states may require managed care plans, through their plan contracts, to assess enrollee needs related to SDOH using a standardized assessment instrument,⁴⁶ refer enrollees to community-based supports and services as needed based on assessment results, track referrals to social services, include social or community health workers (CHWs) in care coordination teams, and other care coordination initiatives that promote holistic, person-centered care across medical and nonmedical contexts. CHWs are typically trained practitioners who provide certain follow-up medical and remedial care, as well as screening and preventive services. They can be a valuable link between enrollees and needed health care services. States may also require managed care plans to contract with community-based organizations with expertise in addressing SDOH for coordination of care purposes. Additionally, if managed care plans implement SDOH activities that meet the requirements in 45 CFR § 158.150(b) and are not excluded under 45 CFR § 158.150(c), managed care plans may include the costs associated with these activities in the numerator of the MLR as activities that improve health care quality under 42 CFR § 438.8(e)(3). States also may, as part of its procurement or pre-procurement strategies, encourage potential managed care plans to share promising practices and initiatives for addressing SDOH to encourage broader plan adoption of such practices and initiatives.

Other examples of how states can leverage managed care to address SDOH include enrolling⁴⁷ beneficiaries into a managed care plan with expertise and capacity to manage the

⁴⁵ 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.

⁴⁶ See, for example, the Accountable Health Communities Health-Related Social Needs Screening Tool (<https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>).

⁴⁷ States must have an enrollment system for its managed care programs that complies with the requirements of 42 CFR 438.54. States can use a passive enrollment process and/or a default enrollment process that would include

care of enrollees with complex SDOH needs (such as people who have a history of chronic homelessness), requiring managed care plans to focus on addressing SDOH in performance improvement plans, or requiring managed care plans to report on quality measures related to SDOH.

- *Quality Measurement and Improvement.*⁴⁸ States can leverage managed care quality requirements in 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 quality assessment and performance improvement (QAPI) programs in order to carry out 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.
- 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.⁴⁹

Managed care plans may also voluntarily choose to cover “in lieu of services” to address SDOH for their members:

- *In Lieu of Services.* Managed care plans may cover, for enrollees, services or settings that are in lieu of services or settings covered under the state plan in accordance with 42 CFR § 438.3(e)(2), which requires:

criteria around the plan’s expertise and capacity to manage the care of enrollees with complex SDOH needs so long as the other criteria outlined in 42 CFR 438.54 were also met.

⁴⁸ The managed care quality strategy, QAPI, and EQR requirements are addressed in 42 CFR §§ 438.310 through 438.370. While these quality requirements are specific to managed care, states are encouraged to leverage similar activities within their Medicaid fee-for-service programs to ensure that all Medicaid beneficiaries receive quality services and have positive health outcomes, regardless of delivery system.

⁴⁹ <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>

- The state determines that the 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;
- The enrollee is not required to use the alternative service or setting;
- The approved in lieu of service is authorized and identified in the managed care plan contract and offered to enrollees at the option of the managed care plan; and
- The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered state plan services, unless a statute or regulation explicitly requires otherwise.

Under the 2016 final rule (81 FR 27526), CMS also clarified that all services under § 438.3(e), including approved in lieu of services – such as in-home prenatal visits for at-risk pregnant beneficiaries as an alternative to a traditional office visit – can be considered as incurred claims in the numerator for purposes of the MLR.⁵⁰

- *Value-Added Services.* Under 42 CFR § 438.3(e), a managed care plan may voluntarily cover, for enrollees, services that are in addition to those covered under the state plan, although the cost of these services is not and may not be 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 may not be included in the capitation rate. Under the 2016 final rule (81 FR 27526), value-added services can be considered as incurred claims in the numerator for the purposes of the MLR calculation if the services are activities that improve health care quality under 45 CFR § 158.150 and are not excluded under 45 CFR § 158.150(c).

Under value-added and in lieu of services, there are opportunities for states and managed care plans to provide coverage for services that support SDOH, as long as federal Medicaid managed care regulatory requirements are met. For example, a managed care plan may voluntarily provide, as a value-added service, supportive housing services for a beneficiary living with severe mental illness who would otherwise cycle between hospital stays and homelessness, although the cost of these services may not be included in the capitation rate.

State Examples: 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.

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

⁵⁰ 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.

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.⁵¹

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 13 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.

F. Program of All-Inclusive Care for the Elderly (PACE)⁵²

Description: Authorized under sections 1894 and 1934 of the Act and codified in regulation at 42 CFR part 460, the Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to certain frail elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. Payment to PACE organizations is capitated, and provides PACE organizations with a single monthly payment in exchange for delivering all the services a participant needs rather than providing compensation only for those services covered under Medicare and Medicaid.

PACE benefits also include all other services determined necessary by the participant's interdisciplinary team to improve and maintain a participant's health. PACE organizations provide services in an adult day health center as well as through in-home and referral services in accordance with the participant's needs.

Who Is Eligible: Medicaid beneficiaries can generally join PACE if they meet certain conditions:

- Age 55 or older;
- Live in the service area of a PACE organization;
- Require a nursing facility level of care; and

⁵¹ External Quality Review Table 15. Progress on Childhood Asthma Performance Improvement Projects (PIPs), as Reported in External Quality Review (EQR) Technical Reports, 2018–2019 Reporting Cycle (n = 9 states, 23 PIPs) available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2018-2019-chart-pack.zip> (zip file).

⁵² For more information on PACE, see <https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html>.

- Be able to live safely in the community.

How PACE Can Address SDOH: An interdisciplinary team assesses each participant's needs, develops care plans, and delivers coordinated care and services. The interdisciplinary team meets to ensure that the comprehensive medical and social needs of each participant are met. Teams typically meet daily to discuss the status of participants. At a minimum, the team is composed of:

- Dietician;
- Driver;
- Home care coordinator;
- Registered nurse;
- Occupational therapist;
- PACE center manager;
- Personal care attendant;
- Physical therapist;
- Primary care provider;
- Recreational therapist or activity coordinator; and
- Masters-level social worker.

The PACE organization must furnish comprehensive medical, health, and social services that integrate acute and long-term care. PACE's comprehensive benefit package includes (but is not limited to) all Medicare and Medicaid covered services.⁵³ Among other benefits, this includes: meals and nutritional counseling,⁵⁴ social work services, and transportation.⁵⁵

State Example: Upham's Corner Elder Service Plan, a PACE organization based in Dorchester, MA, partnered with the Mayor of Boston in an initiative to target chronically homeless seniors who have been without a home for a year or more and had some level of disability. This year, the PACE organization enrolled eight seniors who were matched with housing and approved for support services -- all in one day. The PACE team works closely with housing managers to address issues as they arise so participants do not face the loss of housing.

⁵³ See 42 C.F.R. § 460.92. See <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c06.pdf> for more information.

⁵⁴ Under 42 C.F.R. § 460.78, the PACE organization must ensure, through the assessment and care planning process, that each participant receives nourishing, palatable, well-balanced meals that meet the participant's daily nutritional/medical and special dietary needs. The PACE organization must provide nutrition support to meet the daily nutritional needs of a participant, if indicated by his or her medical condition or diagnosis. Nutrition support includes tube feedings, total parenteral nutrition, or peripheral parenteral nutrition if indicated by the participant's medical condition or diagnosis.

⁵⁵ Pursuant to 42 C.F.R. §§ 460.76 and 460.106, transportation must be provided as indicated in a participant's plan of care.

Other Opportunities under Medicaid and CHIP to Address SDOH⁵⁶

1. *Integrated Care Models*

Description: Integrated care models are care delivery and payment models that reward coordinated, high quality care.⁵⁷ Integrated care models can include patient-centered medical homes (PCMHs), accountable care organizations (ACOs), or other models that emphasize person-centered, continuous, coordinated, and comprehensive care. These models typically include partnerships with community-based organizations, social service agencies, counties, and public health agencies.

How Integrated Care Models Can Address SDOH: Integrated care models can support a variety of innovative approaches to addressing individuals with complex SDOH needs, such as interdisciplinary care teams and comprehensive care coordination services, while providing flexibility for states to develop payment mechanisms that support intensive care interventions such as tiered rate methodologies and shared savings models.

Although there is no specific current statutory authority for ACOs within the Medicaid program, CMS released two letters to state Medicaid directors in 2012, providing guidance regarding Medicaid integrated care models, including ACOs and ACO-like models for payment and service delivery reform.⁵⁸ CMS also released guidance in a Center for Medicare and CHIP Services Informational Bulletin in 2013, “*Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality*,” clarifying how care delivery models such as integrated care models can help states and Medicaid providers to meet the complex needs of the highest utilizers of acute care in Medicaid populations.⁵⁹ Furthermore, integrated care approaches have been shown to improve health outcomes for individuals with behavioral health conditions. The Medicaid Innovation Accelerator Program (IAP) provides materials and resources on physical and mental health integration [here](#).

States typically use a per member per month (PMPM) payment model, with or without quality or cost incentives, in PCMH models, while they use shared savings and/or shared risk models, with quality requirements and/or incentives, to create a financial incentive for providers to

⁵⁶ The information presented is not necessarily a complete list of all other opportunities to address SDOH under Medicaid and CHIP. For example, it does not include a discussion of current or future Center for Medicare and Medicaid Innovation (CMMI) Models that test models that incorporate strategies to address SDOH, as these are time-limited interventions and may not be available to states that are not currently participating. It also does not include a discussion of the ways in which states can partner with other state or local entities to implement coordinated strategies to address SDOH, as an extensive review of these strategies was beyond the scope of this letter. CMS is, however, available to provide technical assistance to states that would like assistance related to these or other topics.

⁵⁷ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-24-2013.pdf>

⁵⁸ Centers for Medicare & Medicaid Services. “Integrated Care Models.” July 10, 2012. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD-12-001.pdf>; Centers for Medicare & Medicaid Services. “Policy Considerations for Integrated Care Models.” July 10, 2012. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-12-002.pdf>.

⁵⁹ Centers for Medicare & Medicaid Services. “Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality.” July 24, 2013. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-24-2013.pdf>.

deliver value over volume in ACO models. In some models, ACOs can also receive a PMPM payment to provide services and accept full financial risk for the health of their assigned or attributed population. CMS allows states considerable flexibility in structuring payment mechanisms for PCMH, ACO, and ACO-like models and encourages states to move from volume-based FFS reimbursement to integrated care models with financial incentives to improve beneficiary health outcomes.

State Example: Under Rhode Island’s Medicaid Managed Care Organizations sub-contract with Accountable Entities (which are integrated provider organizations responsible for the total cost of care and healthcare quality and outcomes of an attributed population), Accountable Entities must demonstrate the capacity to address SDOH, and they must identify three key domains of social need for each population that will advance the state’s three identified priority areas: housing insecurity, food insecurity, and safety and domestic violence.⁶⁰

2. CHIP Health Services Initiatives (HSI)

Description: States have the option under title XXI to develop state-designed HSIs to improve the health of low-income children. HSIs are permitted under section 2105(a)(1)(D)(ii) of the Act and are defined in the regulations at 42 CFR § 457.10. Both direct services and public health initiatives are permitted under the statute and regulations. An HSI must directly improve the health of low-income children⁶¹ less than 19 years of age who are eligible for CHIP and/or Medicaid, but may serve children regardless of income. In addition, to the extent possible, the state should use its efforts through an HSI to enroll eligible but unenrolled children in Medicaid or CHIP.

States finance the non-federal portion of HSI expenditures, and the federal portion is funded through a state’s available CHIP allotment for a fiscal year, as determined under section 2104 of the Act. HSI expenditures (including administration of the HSI itself) are subject to a cap that also applies to administrative expenses. Under section 2105(c)(2)(A) of the Act, claims for HSIs and administrative expenses together cannot exceed 10 percent of the total amount of title XXI funds claimed by the state each quarter. Within the 10 percent limit, states must fund costs associated with administration of the CHIP state plan first; any funds left over may be used for an HSI, subject to the 10 percent cap. In addition, states must assure in the CHIP state plan that they will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds. States should be able to demonstrate that they have a process for coordinating with other federal agencies and other federal funds.

How CHIP Health Services Initiatives Can Address SDOH: Many of the SDOH described in this letter have been or could be addressed through CHIP HSIs. For example, states have used HSIs for lead abatement projects in the homes of Medicaid and CHIP eligible children, home visits and environmental modifications (e.g., high-efficiency particulate air filters) to reduce asthma triggers, emergency food relief for families, and youth violence prevention programs in schools and community-based organizations.

⁶⁰ RItE Care Core MCO Contract Sections 1.127 and 2.01.0

⁶¹ As defined in 42 CFR Section 457.10, a low-income child means a child whose household income is at or below 200 percent of the federal poverty line for the size of the family involved.

State Example: New York’s CHIP HSI ([SPA #23](#)) provides emergency food relief and nutrition services to food-insecure children receiving services through the Hunger Prevention Nutrition Assistance Program. The goal of the program is to increase access to safe and nutritious food and related resources, to develop and provide nutrition and health education programs, and to empower people to increase their independence from emergency food assistance programs.

3. Administrative Procedures

Description: Federal matching funds under Medicaid are available for costs incurred by the state for administrative activities that directly support efforts to identify and enroll potentially eligible individuals into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan, when those activities are performed either directly by the state Medicaid agency or through contract or interagency agreement by another entity.

How Administrative Procedures Can Address SDOH:

- *Collaboration with Community-Based Programs*

Medicaid and CHIP can be an integral part of a collaboration with other community-based programs, including state and local housing agencies, social service organizations, programs funded by the Administration for Community Living,⁶² programs funded by the Administration for Children and Families,⁶³ public health agencies, faith-based organizations, and other community-based entities that support an individual’s ability to live and receive needed care in their chosen community setting. The effectiveness of these activities is based on collaboration across the many entities that serve low-income individuals with SDOH needs. State Medicaid agencies employing individuals to perform partnership building, such as with [No Wrong Door System](#) (NWD)⁶⁴ lead agencies in the aging and disability networks, and collaboration activities may claim the 50 percent administrative claiming rate for these activities if the costs can be recognizable as allowable Medicaid administrative costs and only to the extent that the state has documented that the costs directly benefit the Medicaid program and are claimed consistent with federal cost allocation principles. For example, to address the housing needs of beneficiaries, a state could claim administrative match for activities, such as:

⁶² These programs include Area Agencies on Aging, Centers for Independent Living, and Aging and Disability Resource Centers, funded under the Older Americans Act and the Rehabilitation Act. See, *Strategic Framework for Action*, https://acl.gov/sites/default/files/programs/2020-06/ACL_Strategic_Framework_for_Action_v1_%20June%202020_final_508_v2.pdf.

⁶³ For example, the Community-Based Child Abuse Prevention (CBCAP) program (authorized by title II of the Child Abuse Prevention and Treatment Act (as amended by Public Law 115-271)) awards funding annually to every state, the District of Columbia, and Puerto Rico to support community-based efforts to implement effective family support and child maltreatment activities. More information on CBCAP can be found at www.friendsnrc.org.

⁶⁴ The State Medicaid Agency is part of the state’s Aging & Disability Resource Center/No Wrong Door (ADRC/NWD) System. Person centered counselors, a key part of a state’s ADRC/NWD System, facilitate assessment and service plan develop using a process that takes into account the individual’s full array of resources, service needs, and service availability See also NWD System Medicaid Claiming Guidance and Tools. See <https://nwd.acl.gov/sustaining-a-nwd-system.html>.

- Developing formal and informal agreements and working relationships with state and local housing and community development agencies to help beneficiaries access existing and new housing resources;
- Participating and contributing to the planning processes of state and local housing and community development agencies by collecting (e.g., through beneficiary surveys or claims data) and providing demographic, housing needs, and other relevant data for Medicaid eligible populations; and
- Coordinating with available housing locator systems or listings, and developing and/or coordinating data tracking systems to include information on the availability of affordable and accessible housing.

Administrative activities are focused on coordination between various agencies to increase access to community-based resources, in contrast to activities focused on helping beneficiaries connect to community resources such as housing or employment opportunities.

- *Data Integration and Information Sharing*

Integrated information systems and data sharing capabilities at the state level are critical to supporting the evolving role of states in assuring appropriate, accessible, and cost-effective care for individuals with complex social needs. Medicaid offers a variety of pathways to support the design and development of statewide data and analytic infrastructure to address SDOH. Leveraging Medicaid resources to support data integration and data sharing can assist state health systems to identify individuals with SDOH needs and link them to appropriate medical and social support services.

Enhanced federal Medicaid matching funds (at 90 percent) are available for state expenditures to design, develop, install, or enhance Mechanized Claims Processing and Informational Retrieval Systems and (at 75 percent) to operate such systems, under section 1903(a)(3)(A)(i) and (B) of the Act and 42 C.F.R. part 433, subpart C.

States are reminded that 42 CFR §§ 433.112(b)(16) and 433.116(c) require, as a condition of receiving enhanced federal matching funds under 1903(a)(3)(A)(i) and (B) of the Act, that the Medicaid mechanized claims processing and information retrieval system be interoperable with human services programs, health information exchanges, and public health agencies, as applicable.

In considering the technical infrastructure needed to administer programs focused on addressing SDOH among Medicaid beneficiaries, states should leverage any existing state and federal investments in care coordination hubs, such as Area Agencies on Aging,⁶⁵ which coordinate and offer services that can help older adults remain in their homes, or Aging and Disability Resource Centers,⁶⁶ which provide objective information, advice, counseling, and assistance to help older adults, people with disabilities, and their family members, regardless of income, with accessing LTSS. These entities are already well established across the country and have existing relationships with a broad range of local community-based resources that can help to address SDOH among Medicaid beneficiaries. Medicaid investments in connections and interoperability

⁶⁵ <https://acl.gov/programs/aging-and-disability-networks/area-agencies-aging>

⁶⁶ <https://acl.gov/programs/aging-and-disability-networks/aging-and-disability-resource-centers>

with such systems can be supported with enhanced federal financial participation, subject to all applicable federal requirements, including compliance with the cost allocation principles in 45 C.F.R. part 75, subpart E. In developing these connections, states are reminded of previous guidance explaining that states could comply with certain conditions of receiving enhanced federal matching funds under section 1903(a)(3)(A)(i) and (B) of the Act by implementing Open Application Program Interfaces (APIs) in the Medicaid enterprise.⁶⁷ Additionally, pursuant to 42 CFR 433.112(b)(12), as a condition of receiving enhanced federal matching funds under section 1903(a)(3)(A)(i) and (B) of the Act, states must ensure alignment of their mechanized claims processing and information retrieval system with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health Information Technology in accordance with 45 CFR part 170, subpart B. CMS also encourages states to review the Interoperability Standards Advisory (ISA) published by the Office of the National Coordinator, which includes standards for representing food insecurity, housing insecurity, transportation insecurity, and other social data.⁶⁸ Similarly, states are encouraged to review and participate in the ongoing work of the U.S. Department of Health and Human Services (HHS) supported Gravity Project⁶⁹ which convenes developers and users of SDOH data in efforts to find consensus for future national standards.

States should keep in mind that appropriate and effective investments in state health information technology (health IT) can be an important component of a state’s SDOH activities and strategy, and can be particularly helpful with regard to facilitating data integration and information sharing between the state and providers.

- *Outreach and Enrollment*

One way to efficiently connect individuals who are eligible for Medicaid or CHIP to other benefits that can address SDOH, such as the Supplemental Nutrition Assistance Program (SNAP), is by implementing multi-benefit applications. These applications may provide a streamlined opportunity to connect a beneficiary to multiple state benefits, thereby enhancing access to these benefits and increasing awareness of other benefit programs. Multi-benefit applications, in accordance with 42 CFR § 435.907, may be used as an alternative Medicaid application so long as the application collects sufficient information to make a modified adjusted gross income (MAGI)-based determination and applicants are not required to answer questions not needed to make a determination for health coverage if they are not applying for any other benefit programs.⁷⁰

States can also use various enrollment strategies⁷¹ to make it easier for eligible individuals to enroll in Medicaid and CHIP coverage, including presumptive eligibility, “Express Lane” eligibility, continuous eligibility for children, and facilitating access to covered Medicaid

⁶⁷ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16010.pdf>

⁶⁸ <https://www.healthit.gov/isa/social-psychological-and-behavioral-data>

⁶⁹ <https://www.hl7.org/gravity/>

⁷⁰ Guidance regarding Medicaid application development is located at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/state-alt-app-guidance-6-18-2013.pdf>.

⁷¹ For additional information on these and other enrollment strategies, see <https://www.medicaid.gov/medicaid/enrollment-strategies/index.html>.

services for eligible individuals prior to and after the period of time spent in a correctional facility:

- Presumptive eligibility is a strategy that states employ to facilitate enrollment of individuals who are likely eligible for Medicaid or CHIP to access services without having to wait for their full application to be processed. States may authorize "qualified entities" – health care providers, community-based organizations, hospitals and schools, among others – to screen for Medicaid and CHIP eligibility and immediately enroll eligible individuals.
- States may rely on eligibility information from "Express Lane" agency programs to streamline and simplify enrollment and renewal in Medicaid and CHIP. Express Lane agencies may include SNAP, School Lunch programs, Temporary Assistance for Needy Families (TANF), Head Start, and the Women, Infant, and Children's program (WIC), among others. States can also use state income tax data to determine Medicaid and CHIP eligibility for children.
- States may provide children with 12 months of continuous coverage through Medicaid and CHIP, even if the family's income changes during the year. Guaranteeing ongoing coverage ensures that children receive appropriate care, and helps doctors develop relationships with children and their families. This option eliminates cycling on and off of coverage during the year. This also reduces state time and money that would be spent on unnecessary paperwork and preventable care needs.
- The state Medicaid agency must accept applications from inmates to enroll in Medicaid or renew Medicaid enrollment during the time of their incarceration. If the individual meets all applicable Medicaid eligibility requirements, the state must enroll or renew the enrollment of the individual effective before, during, and after the period of time spent in the correctional facility. Once enrolled, however, the state may place the inmate in a suspended eligibility status during the period of incarceration, or it may suspend coverage.⁷²

4. Medicare Savings Programs (MSPs)

Description: Low-income Medicaid beneficiaries who are also enrolled in Medicare can qualify for Medicaid coverage of Medicare Part B premiums⁷³ through the state-administered Medicare Saving Programs (MSPs).

How Medicare Savings Programs Can Address SDOH: For many individuals who qualify, enrollment in a Medicare Savings Program expands their effective income by 10% or more – income that can be used to buy food, access transportation, and stabilize housing. As such, MSPs functionally address SDOH by giving beneficiaries more control over how they use their resources to address their needs. However, in many states, enrollment of eligible Medicare beneficiaries in MSPs is low.⁷⁴ As described in SMDL # 18-012,⁷⁵ states have opportunities to

⁷² <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf>

⁷³ <https://www.cms.gov/newsroom/fact-sheets/2020-medicare-parts-b-premiums-and-deductibles>

⁷⁴ <https://www.macpac.gov/publication/medicare-savings-programs-new-estimates-continue-to-show-many-eligible-individuals-not-enrolled/>

⁷⁵ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf>

streamline eligibility determination and enrollment into MSPs in ways that would reduce administrative burden and could improve the economic security of millions of Medicare beneficiaries.

5. Money Follows the Person Demonstration

Description: The Money Follows the Person demonstration, first authorized by Congress as part of the Deficit Reduction Act in 2005 and since extended several times, is a long-standing grant-funded initiative designed to shift Medicaid’s LTSS spending from institutional care to HCBS. Program goals include: increasing the use of HCBS and reducing the use of institutionally-based services; eliminating barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to let people receive LTSS in the settings of their choice; strengthening the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and putting procedures in place to provide quality assurance and improvement of HCBS.

How Can the Money Follows the Person Demonstration Address SDOH: Money Follows the Person provides critical tools to address gaps in the availability of community services for Medicaid-eligible individuals with disabilities and older adults. For example, Money Follows the Person grantees have built partnerships with housing agencies to increase the supply of housing options and resources, established community transition programs, and piloted the use of new services and supports (e.g., tenancy supports services, paying for one-time transition costs such as security deposits) to determine if they help to promote community living.

Closing

CMS remains committed to partnering with states to address beneficiaries’ SDOH through the appropriate use of the Medicaid and CHIP programs. When used in accordance with statutory and regulatory requirements, Medicaid and CHIP can be effective tools to lower health care costs, improve health outcomes, and increase the cost-effectiveness of health care services and interventions for Medicaid and CHIP beneficiaries. CMS encourages states to pursue innovative payment and delivery system approaches, along with strong quality oversight and evaluation strategies, to achieve these goals. If you have questions about this guidance, please contact Jennifer Bowdoin, Director of the Division of Community Systems Transformation in the Disabled and Elderly Health Programs Group at jennifer.bowdoin@cms.hhs.gov.

Sincerely,

A solid black rectangular box redacting the signature of Anne Marie Costello.

Anne Marie Costello
Acting Deputy Administrator and Director

Enclosure

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority		Who Is Eligible	Examples of How the Authority Can Address SDOH
Section 1905(a) State Plan Authority	Rehabilitative Services Benefit (section 1905(a)(13) and 42 CFR § 440.130(d))	Individuals who meet any state-defined medical necessity criteria for covered services.	Regain skills and functioning to address SDOH; peer supports to assist with linking to social supports and services.
	Rural Health Clinics (RHCs)/ Federally Qualified Health Centers (FQHCs) (section 1905(a)(2)(B), 1905(a)(2)(C), and 1905(l)(1) and (2))	Individuals who meet any state-defined medical necessity criteria. This is a mandatory benefit for the categorically needy.	Screen individuals to identify social needs, collect and analyze SDOH data to inform interventions, and co-locate social services, as long as these activities are delivered as part of a Medicaid-covered RHC/FQHC service.
	Case Management/ Targeted Case Management (sections 1905(a)(19) and 1915(g) and 42 CFR §§ 440.169 and 441.18)	Individuals who meet any state-defined medical necessity criteria. States can provide targeted case management services to specific populations and limit the services geographically.	Linking/coordinating /referring to medical, educational, social, and other services; comprehensive care planning.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority		Who Is Eligible	Examples of How the Authority Can Address SDOH
HCBS Options	Section 1915(c) HCBS Waiver	Individuals who meet the state’s institutional level of care (meaning the individual could be admitted to a nursing facility, hospital, ICF/IID); need for services must be based on an assessed need and identified in a state-approved service plan. States can target waivers to specific populations and limit waivers geographically.	Service coordination or case management, home accessibility adaptations, one-time community transition costs, housing and tenancy supports, habilitation services, non-medical transportation, home delivered meals, supported employment services, assistive technologies to facilitate communication, “other” types of services that may assist in diverting individuals from institutional placement and supporting community living for eligible individuals.
	Section 1915(i) HCBS State Plan	Individuals who are eligible for medical assistance under the state plan, meet state-defined needs-based criteria, and reside in the community. Needs-based criteria are factors used to determine an individual’s requirements for support that can only be ascertained for a given person through an individualized evaluation of need and may include but cannot only include state-defined risk factors, such as risk of or experiencing homelessness, risk of food insecurity for individuals with diabetes, or risk of social isolation for older adults with chronic conditions. Services must be offered state-wide, but states can target the services to specific populations.	See section 1915(c) waivers.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority		Who Is Eligible	Examples of How the Authority Can Address SDOH
	Section 1915(j) Optional Self-Directed Personal Assistance Services	Individuals eligible for state plan personal care services or for a section 1915(c) waiver program.	Expenditures for goods and services, supports, or supplies related to a need or goal identified in the individual’s state-approved person-centered service plan.
	Section 1915(k) Community First Choice State Plan	Individuals who meet the state’s institutional level of care (meaning the individual could be admitted to a nursing facility, hospital, ICF/IID). Services must be offered state-wide.	Expenditures for transition costs (such as first month’s rent and utilities, bedding, and basic kitchen supplies) necessary for an individual transitioning from an institutional setting to a home and community-based setting; and expenditures relating to a need that increases an individual’s independence or substitutes for human assistance, to the extent that Medicaid expenditures would otherwise be made for human assistance.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority	Who Is Eligible	Examples of How the Authority Can Address SDOH
<p>Section 1115 Demonstration</p>	<p>States have significant flexibility in how to define target populations for demonstration services/activities, which should be available based on individual assessments of need as defined by the state. States can target services geographically and/or to populations meeting defined characteristics.</p> <p>States can test incentives that provide a pathway to coverage for certain individuals who may not be eligible for Medicaid through the state plan by requiring participation in work or other community engagement as a requirement for Medicaid eligibility or for receipt of additional Medicaid benefits. This allows individuals to opt into Medicaid coverage or receive enhanced benefits.</p>	<p>Case management/care coordination; tenancy supports; one-time transition costs; non-medical transportation; home delivered meals; supported employment. States have flexibility to provide other state-defined direct services to address SDOH, subject to CMS approval.</p> <p>Employment can help to lift low-income individuals and families out of poverty and, in doing so, address a broad range of social needs that can impact health. As discussed in SMDL 18-002, CMS supports states’ efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability.¹ These measures may also enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services (including those that address SDOH) and populations they cover, thereby maintaining the long-term fiscal sustainability of a state’s Medicaid program.</p>

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority	Who Is Eligible	Examples of How the Authority Can Address SDOH
Section 1945 Health Home	Beneficiaries who: (1) have two or more chronic conditions; (2) have at least one chronic condition and are at risk of developing another; or (3) have at least one serious and persistent mental health condition. States can target eligibility for services based on a beneficiary’s chronic conditions, but are not permitted to limit the benefit to specific age groups. The population must include all categorically needy individuals who meet the state’s criteria (including those eligible based on receipt of services under a section 1915(c) home and community-based services waiver), and at state option may include individuals in any medically needy group or section 1115 demonstration population.	Comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; individual and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority	Who Is Eligible	Examples of How the Authority Can Address SDOH
<p>Managed Care Programs (Sections 1115(a), 1932(a), 1915(a), and 1915(b))</p>	<p>Individuals who meet any state-defined medical necessity criteria for the services covered under the contract.</p>	<p>Depending on the authority used, examples include case management/care coordination; tenancy supports; one-time transition costs; non-emergency medical transportation; home-delivered meals; supported employment; other direct services to address SDOH. For those services the state has existing Medicaid authority to cover (e.g. state plan), the state can incorporate those as contractual requirements on the plan and incorporate into the actuarially sound capitation rates. Otherwise, states can explore coverage as an in-lieu of service or plans may voluntarily provide as a value-added service, provided all regulatory requirements are met. States can also leverage managed care quality requirements, including Quality Strategies, quality assessment and performance improvement (QAPI) requirements, and external quality review to incentivize managed care plans to address SDOH.</p>

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority	Who Is Eligible	Examples of How the Authority Can Address SDOH
<p>Program of All-Inclusive Care for the Elderly (PACE) (sections 1894 and 1934 and 42 CFR part 460)</p>	<p>Individuals who: are age 55 or older; live in the service area of a PACE organization; require a nursing facility level of care; and are able to live safely in the community.</p>	<p>Comprehensive care coordination and management, meals and nutritional counseling, social work services, transportation, and all other services determined necessary by the enrollee’s interdisciplinary team to improve and maintain an individual’s health.</p>

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH⁷⁶

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports ^{77,78}
Housing-Related Services and Supports				
<i>Home Accessibility Modifications</i>	Temporary or permanent changes to a home’s interior or exterior structure to improve individuals’ ability to remain in their homes and community, if they choose.	Depending on unique structural characteristics, temporary modifications could include the installation of a wheelchair ramp outside the home or grab bars in the shower. Permanent modifications could include enlarging a doorway to allow wheelchair passage.	Children with special health care needs, adults with disabilities, older adults	Section 1905(a)(7) home health benefit; section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1915(j) optional self-directed personal assistance services; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934; CHIP HSI.

⁷⁶ The services and supports listed in this table align with those discussed in the section on “Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH” and do not necessarily include all opportunities available under Medicaid and CHIP to address SDOH. See “Opportunities to Address SDOH under Medicaid and CHIP Authorities” for information on additional opportunities.

⁷⁷ See “Opportunities to Address SDOH under Medicaid and CHIP Authorities” and Appendix A for more information on the eligible populations and other information on what is allowable related to the services and supports under each applicable federal authority.

⁷⁸ Please note that all of the illustrative examples may not be coverable under all of the authorities listed in each row of this table.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH⁷⁶

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports^{77,78}
<i>One-Time Community Transition Costs</i>	Help to facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a community-based living arrangement in a private residence	Security deposits, utility activation fees, and essential household furnishings.	Children with special health care needs, adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1915(k) Community First Choice; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH⁷⁶

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports^{77,78}
<i>Housing and Tenancy Supports: Pre-tenancy Services</i>	Assist individuals to prepare for and transition to housing	Conducting an individualized screening and community integration assessment that identifies the individual’s preferences and any barriers to community residence; developing a community integration plan based on the community integration assessment; assisting with the housing search and application process, consistent with the community integration assessment and plan; ensuring that housing units are safe and ready for move-in; assisting in arranging for and supporting the details of move-in; and connecting the individual to community-based resources that provide assistance with activities such as securing required documents and fees needed to apply for housing and making any reasonable accommodation request(s) related to the individual’s disability to a housing provider.	Adults with disabilities, older adults	Section 1905(a)(19) case management benefit; section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH⁷⁶

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports^{77,78}
<i>Housing and Tenancy Supports: Tenancy Sustaining Services</i>	Tenancy sustaining supports are provided once an individual is housed to help the person achieve and maintain housing stability	Providing early identification and intervention for any behaviors that may jeopardize housing; education or training on the role, rights, and responsibilities of the tenant and landlord; connecting the individual to community resources to maintain housing stability; and individualized case management and care coordination (e.g., connecting the individual with needed Medicaid and non-Medicaid service providers and resources) in accordance with the person-centered care plan and the individual housing support plan.	Adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs; CHIP HSI; PACE under sections 1894 and 1934.
Non-Medical Transportation	Can enable individuals receiving home and community-based services to gain access to HCBS, activities, and resources	Transportation to grocery stores and places of employment.	Children with special health care needs, adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH⁷⁶

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports^{77,78}
Home-Delivered Meals	Help to address the nutritional needs of older adults and individuals with disabilities who need Medicaid-funded home and community-based services (HCBS)	No more than two meals per day provided to older adults in a state’s HCBS waiver program.	Adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH⁷⁶

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports^{77,78}
Educational Services	Help children with disabilities achieve their educational goals. Under the Individuals with Disabilities Education Act (IDEA), children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in the child’s individualized education plan (IEP) or, for infants and toddlers (children under age three), the individualized family service plan (IFSP).	Personal care services, physical or occupational therapy services provided to children by qualified providers in a school setting.	Children with special health care needs, young adults with disabilities	Various section 1905(a) state plan benefits (such as the rehabilitative services benefit in section 1905(a)(13)); section 1915(c) HCBS waiver (services may not duplicate those required under IDEA); section 1915(i) state plan (services may not duplicate those required under IDEA).

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH⁷⁶

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports^{77,78}
Supported Employment	Ongoing supports to individuals who, because of their disabilities, need intensive on-going support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting	Customized employment, job coaching to provide supports and services not specifically related to job skill training that enable the individual to successfully integrate into the job setting (e.g., instruction on how to ameliorate the impacts of a mental illness on the job), and personal care services to provide assistance at an individual’s place of employment.	Adolescents, working age adults with disabilities	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs.
Community Integration and Social Supports	Medicaid-funded HCBS provide opportunities for Medicaid beneficiaries to choose to receive services in their home or community rather than institutions	Instruction on how to utilize public transportation, companion services to accompany an individual with disabilities into places in the community.	Children with special health care needs, adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1915(k); section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH⁷⁶

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports^{77,78}
Case Management	Assists eligible individuals to gain access to needed medical, social, educational, and other services	Assessment and linkages to needed services provided to individuals who are homeless or at risk of homelessness.	Children with special health care needs, adults with disabilities, older adults	Section 1905(a)(19) state plan case management benefit; section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1915(k); section 1115 demonstration; section 1945 health home; managed care programs; PACE under sections 1894 and 1934; CHIP HSI.