



Social Determinants of Health Referrals in Medicaid and the Role of Medicaid Managed Care Contracts

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State Medicaid agencies and Medicaid managed care organizations (MCOs) are developing and implementing strategies to address and support social determinants of health for children in an effort to improve health outcomes. Social determinants of health are non-clinical factors, such as education and housing, that play a role in a child's health, well-being and development, and that can have lifelong, as well as intergenerational effects.^{1,2,3}

Screening processes that ask families about social determinants of health are a first step in identifying unmet social needs such as food or housing insecurity. [Twenty-five state Medicaid agencies](#) now require MCOs to screen for social determinants of health in their Medicaid managed care contracts.⁴ For example, [Oregon and North Carolina](#) have implemented specific screening strategies in their Medicaid managed care programs to identify children who are in need of social support through the use of administrative data and standardized screening tools. State Medicaid managed care contracts can also be structured to facilitate referrals to community organizations and resources to help address families' identified social needs.

Many barriers and challenges exist in providing effective community-based referrals for social service needs including stigma (especially for accessing income-based eligibility services such as food resources), lack of transportation to access services, lack of knowledge about eligibility, and challenges navigating complex application and enrollment processes.⁵ According to the National Survey of Children's Health, only 17.1% of children receive care in a well-functioning system, which includes measures related to accessing social services.⁶ A strong referral network can allow for care coordinators, providers, health plans and state health programs such as Title V, to connect children and their families who have identified needs to supportive services.

Importance of Addressing Social Determinants of Health

Social determinants of health are responsible for 80 percent of health outcomes.⁷ A focus on social determinants of health improves health outcomes, and reduces the cost of care and unnecessary hospital utilization.^{8,9} A strong network of appropriate and qualified providers and services is essential to helping ensure children and their families receive services that address their social needs.

A strong network of human service systems and organizations that collectively address social needs can improve health outcomes by addressing contributors to poor health that are often overlooked. A longitudinal study conducted from 1998 to 2014 examined 360 US metropolitan communities and found a strong correlation between the number of organizations engaged in population health activities within the community and the scope of public health programs offered (e.g., housing, water and air quality).¹⁰ Communities that offered a large range of public health supports and also had a large number of contributing organizations experienced a nearly 20 percent reduction in mortality rates both for infants and adults.¹¹ For social determinant of health referrals to be effective, it is critical that communities have a comprehensive system of social services that address a wide range of social needs.

Social Determinants of Health Referrals for Children and Youth with Special Health Care Needs

Children and youth with special health care needs (CYSHCN) are defined as children who “have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.”¹² Nearly 20 percent of US children ages birth to 18 years (14.6 million children) have either chronic or complex health care needs that require physical and behavioral health care services and supports beyond what children normally require.¹³ Among CYSHCN, children with medical complexity are the smallest yet most rapidly growing population, comprising approximately 0.4 percent of US children.¹⁴

CYSHCN are particularly vulnerable to the impact of social determinants of health as, CYSHCN have higher social needs than the non-CYSHCN population.¹⁵ According to the National Survey of Children’s Health, CYSHCN are twice as likely than non-CYSHCN to experience two or more adverse childhood experiences,¹⁶ may have more difficulties accessing a quality education due to their higher clinical needs, and experience financial burdens due to the high cost of raising a CYSHCN.^{17,18} Social determinants of health such as lack of education and financial challenges have been shown to negatively affect health outcomes.^{19, 20, 21, 22, 23, 24}

Medicaid and the Children’s Health Insurance Program (CHIP) play an important role in providing care for CYSHCN, as they serve almost half of the population (47 percent).²⁵ Medicaid managed care is a predominant health care delivery system with nearly all states (47 states and Washington, DC) using some type of Medicaid managed care (MMC) system to serve some or all CYSHCN enrolled in Medicaid.²⁶ Medicaid managed care organizations have experience providing referrals to enrollees for services and are in a prime position to facilitate referrals to community-based organizations to address social determinants of health of CYSHCN. Currently, within the United States, 28 states specify within their Medicaid managed care contracts that community referrals should be made when needed.²⁷

States and MCOs are using a variety of strategies to increase and improve community referrals including: developing partnerships between Medicaid and Title V to implement referral policies, designating dedicated and trained staff to make referrals and follow-ups, and establishing and promoting registries of community-based providers and services.

State Examples

The following states have developed unique approaches to connecting Medicaid enrollees with community resources targeting social determinants of health.

Strategy: Partnership between Medicaid and Title V to Implement Referral Policies

Florida's Title V CYSHCN program is part of the Florida Department of Health's Office of Children's Medical Services (CMS) Managed Care Plan, a program for children with special health care needs who are Medicaid beneficiaries. The program's services are provided by WellCare Health Plans, Inc., a Medicaid MCO.²⁸ Children are eligible if they qualify for Medicaid and are under the age of 21 or qualify for CHIP and are under age 19, and have one or more identified special health care needs which requires both preventative and ongoing care.²⁹ The CMS Plan offers benefits that support the child's social determinants of health factors including financial assistance, nutrition counseling, home-delivered meals, and behavioral health services for caregivers.³⁰ Additionally, children enrolled in the CMS Plan have access to the Community Connections Health Line, which provides referrals to community-based resources for children and their families, including:^{31, 32}

- Financial Assistance (e.g., utilities, rent)
- Housing services
- Transportation
- Food assistance
- Affordable childcare
- Job/education assistance
- Family Supplies (e.g., diapers, formula, cribs)

Additionally, the Florida Medicaid agency requires that all MCOs have procedures in place that allow them to identify "available community support services and facilitate enrollee referrals to those entities for enrollees with identified community support needs."³³ The MCOs are also required to document the referrals to the community programs and resources in the enrollees medical/case record, and have procedures in place to follow up on "the enrollee's receipt of services from the community program."³⁴

Strategy: Dedicated and Trained Staff to Make Referrals and Follow-up

New Mexico's Human Services Department, which administers the state Medicaid program, has extensive requirements in their MMC contracts for MCOs to address referrals for social determinants of health. MCOs that are contracting with the state Medicaid agency must employ a full-time housing specialist.³⁵ The housing specialist works directly with "members to assess housing needs and identify appropriate resources to help them attain and maintain housing."³⁶ In addition to assisting the members, the housing specialist also "serves as an internal resource to provide training and technical assistance to the contractor's care coordinators."³⁷ Additionally, as part of the Integrated Primary Care and Community Support model (I-PaCS), which is a model of care that integrates community health workers into primary care settings, all MCOs are encouraged to incorporate the use of community health workers (CHW) into their community referral strategies.³⁸ The state Medicaid agency allows for variability in how MCOs contract with CHWs.

Strategy: Registry of Community-based Providers and Services

Delaware's Medicaid program has structured their Medicaid managed care contracts to ensure that the state's Medicaid MCOs connect its members who would benefit from social services to providers.³⁹ The MCOs are required to maintain and update a registry of resources available for Medicaid members. In addition to including contact information for each program, the registry is "searchable by type of activity, location, whether the program is a Covered Service, and any additional eligibility criteria that a member must meet to participate in the program."⁴⁰ MCOs are required to review and update the registry every six months. MCOs must also have full-time resource coordination employees on staff. These employees are non-clinical staff who are supervised by an RN, or any other clinically qualified supervisor.⁴¹ The MCOs also provide appointment linkage assistance to their members for non-clinical appointments that address social needs. Members can access this service by calling the service information line. The MCOs employ staff who can facilitate appointment connections including housing coordinators and field-based Member Advocates.

Conclusion

Social determinants of health referrals are a critical element of the overall system of care for CYSHCN that offers opportunities for state innovation. As exemplified by Florida, New Mexico, and Delaware, Medicaid managed care contracting is one common strategy that state Medicaid agencies are using to implement or expand systematic social determinant of health referral networks and ensure that high-need populations, including CYSHCN, receive the social service supports. Including social needs referrals language in MCO contracts can create accountability for ensuring Medicaid enrollees are being linked to resources or programs that address social needs and create mechanisms for tracking that referral. MCO staff are required to interact and coordinate care directly with enrollees and therefore can be a strong point of connection between enrollees and community resources to support their social needs.

Building strong community partnerships is essential for referral networks. Medicaid agencies and providers partnering with state Title V CYSHCN programs could offer a particularly important connection to community resources and family supports specific to CYSHCN and their families. State Title V CYSHCN programs often have strong connections and relationships with families of CYSHCN and family-focused organizations and community resources, which play a key role in developing family-centered referral networks. State Medicaid agencies that are interested in expanding social service referral networks for CYSHCN may want to partner with Title V directly for referral purposes or requiring that their MCOs do so through language in managed care contracts.^{42, 43}

As social determinants of health referral networks and processes become more robust, Medicaid programs can become more successful in linking their enrollees to needed social services with the overall goal of improving health care.

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