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Medicaid, Sexually Transmitted Infections, and Social Determinants of Health

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Introduction

Medicaid covers 93 million Americans,[1] pays for 42% of births,[2] and covers a disproportionate share of sexually transmitted infection (STI)-related medical visits, when insurance is used to pay for care.[3] Traditionally, Medicaid was largely restricted to covering clinical services, but lately states have implemented a range of approaches to address social determinants of health, or SDOH.[4] Amidst soaring rates of reported bacterial STIs in the U.S., a considerable body of evidence indicates that SDOH such as housing status, socioeconomic status, and education level significantly impact STI acquisition risk and access to STI services.

This commentary offers a roadmap for STI programs and providers to engage with the Medicaid program to address the SDOH that contribute to the STI epidemic. It summarizes the evidence on STIs and SDOH, explains how states are addressing SDOH in their Medicaid programs, and discusses opportunities for STI programs and providers. These insights were informed by the literature, state Medicaid policies, and interviews with national experts and state Medicaid programs, all discussed at further length in a separate report [cite to url of full report, which will go live the day this is published][5].

Social determinants of health that influence STI risk or access to services

Studies have found relationships between a range of SDOH and STIs.[6,7] The social factors discussed below, in particular, are associated with higher STI risk or reduced access to STI services (see Figure 1 for overview).

Economic status—Lower socioeconomic status, high unemployment rates, and low income are associated with increased risk for STIs and higher STI rates.[7,8] Poverty and employment patterns can also influence migration and sexual networks.[7] Economic

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vulnerability may also lead to engaging in sex trade as a source of income, increasing STI risk.[9]

Housing instability—Multiple studies have identified associations between unstable housing and STI risk. Researchers have found that unstable housing was associated with increased risk of STIs and HIV among street-involved youth[10] and with more partners and more unprotected sex among African-American STI clinic patients.[11] For example, a study of low-income women in Baltimore found an association between homelessness, frequent residential mobility, and recent self-reported STI diagnosis.[12] Risks of STI diagnosis are elevated for LGBTQ+ youth, who experience higher rates of homelessness and are more likely to engage in sex in exchange for money, housing, and basic needs.[13]

There are several potential pathways for these associations. In addition to exacerbating economic vulnerability, housing instability can disrupt social networks, leading to increased vulnerabilities in sexual relationships.[14,15] Residential mobility can also disrupt access to healthcare services, resulting in reduced testing and treatment for STIs, ongoing transmission within sexual networks, and potentially increased community prevalence.[15,16]

Healthcare Access and insurance—Access to quality healthcare varies significantly across racial and ethnic populations and tends to be worse in higher STI risk areas.[17] For example, a recent analysis of STI rates by county found a significant association between a lack of Medicaid expansion and higher STI rates.[18] While multiple correlated factors including race and poverty may mediate this relationship, poor access to care may promote continuing transmission and prevalence of disease in the population by increasing the proportion of the population with untreated STIs.[19]

Educational Access and Quality—Low educational attainment is associated with risk factors such as earlier sexual debut and fear of negotiating condom use.[9,20] Increasing access to quality education and comprehensive sexual health education can reduce rates of sexual risk behaviors that lead to STI acquisition.[21,22]

Neighborhood and Built Environment—High-risk, low-income settings in large metropolitan areas have higher incidences of HIV, syphilis, herpes simplex virus, chlamydia, and hepatitis B, because inequitable neighborhood resource allocation is associated with high-risk sexual behaviors and decreased access to healthcare.[23] Adolescents in these settings experience higher rates of early sexual initiation, multiple sex partners, STIs, unintended pregnancies, and sexual assault, and lower rates of contraceptive use.[24,25,26]

Incarceration—As of 2020, about 2.3 million people were incarcerated in prisons or jails across the United States.[27] Rates of STIs are heightened among people who are incarcerated,[28] due in part to disruption of stable partnerships[29] and community-level sex ratio imbalances.[7] Upon release, formerly incarcerated individuals experience heightened HIV/STI risk because of engagement in high-risk sexual activity and increased substance abuse.[30]

It is important to note that these and other SDOH are often closely interrelated. For example, economic status influences access to health insurance, and incarceration may both reflect and perpetuate economic need. Understanding the interplay of multiple SDOH is crucial for addressing their impact on STI risk and access to care.

Medicaid and SDOH: The Landscape

State Medicaid programs and managed care plans have significant power and flexibility to address a range of SDOH (also referred to by some programs as Health-Related Social Needs, or HRSN)[31s]:

General state flexibilities: States have considerable flexibility to design their Medicaid programs to link people to housing, transportation, employment, nutrition services, case management, and other community-based services.[31s,32s] States can also opt to provide Medicaid health homes that coordinate medical and social services for people with or at risk of multiple chronic conditions.[32s] Maine's Medicaid program, for example, has a health home for beneficiaries with opioid use disorder that incorporates screenings for housing needs and referrals to services to address social needs.[33s]

Meeting unmet social needs often requires partnerships with non-clinical support services. For example, Minnesota's Medicaid program funds community-based housing providers to offer support to vulnerable Medicaid beneficiaries. Similarly, Wisconsin funds community organizations and local health departments to identify families who may be eligible for Medicaid-funded housing services.

Medicaid Managed Care Flexibilities and Requirements—Thirty-nine states and DC contract with Managed Care Organizations (MCOs), and nationally, two-thirds of all Medicaid beneficiaries are covered by MCOs.[34s] MCOs have considerable flexibility to monitor and address their enrollees' SDOH needs. One key approach is "In-Lieu-Of Services (ILOS)," which let MCOs substitute services, including SDOH services, for other services covered under the state plan.[35s] California, for example, encourages Medicaid MCOs to provide housing transition services and other housing-related needs as ILOSs[33s] Medicaid MCOs can also pay for non-medical services, including those addressing SDOH, as "value-added" services.[32s] These can include SDOH services such as case management or transportation services, post-discharge meals, education services, and transitional housing.[33s]

In addition, states can require MCOs to:

- Implement SDOH screenings, by the plan or providers.
- Refer beneficiaries to social service providers.
- Partner with community-based organizations.
- Incentivize providers to create referral processes for social services.
- Incorporate SDOH in their quality programs.
- Use social factor codes, called Z codes, on claims.

- Train their staff about SDOH, or dedicate staff members to SDOH coordination.[36]

States can also account for SDOH when setting MCO capitation rates.[36s] Massachusetts, for example, has a capitation rate adjustment that accounts for neighborhood stress scores by zip code, including data on homelessness, serious mental illness, and substance use disorder.[33s]

Alternative Payment Models—A variety of optional payment models allow states to pay for care in ways that can include addressing social determinants of health. These include integrated care models, such as Medicaid Accountable Care Organizations, that typically partner with community-based organizations, social service agencies, and public health agencies.[31s,35s]

Section 1115 waivers—Section 1115 waivers allow states to implement experimental, pilot, or demonstration projects related to eligibility, benefits and cost-sharing, or payment and delivery systems.[31s] States have used Section 1115 waivers in a variety of ways to address SDOH. For example, North Carolina's Healthy Opportunities Pilot provides enhanced case management and SDOH-related services related to housing, food, transportation, and interpersonal safety.[37s] Oregon's waiver provides financial incentives to managed care plans to measure and address health-related social needs.[38s] California's waiver includes housing services for Medicaid beneficiaries who are homeless or at risk of homelessness and are recuperating from hospitalization.[39s]

Considerations for STI Programs and Providers

Based on the landscape of state and MCO efforts, our conversations with Medicaid officials, and the existing evidence on the relationship between STIs and SDOH, we offer the following ideas for STI programs and providers. To varying degrees, all of these steps working with state Medicaid programs and managed care plans; STD programs should identify existing health department/Medicaid relationships that can be expanded and leveraged, or initiate new discussions with the appropriate Medicaid officials.

Collection of SDOH data—SDOH tracking could serve both individual and public health goals in the context of STI services.

If providers of STI services begin to formally identify unmet social needs among their patients, they can better understand the factors impacting individual risk and choices, identify whether and how these needs change over time, and make appropriate referrals.

To the extent SDOH data is collected centrally, STI programs may be able to track the relationship between unmet social needs, STI risk, and utilization of STI services. This could potentially be accomplished by analyzing Medicaid claims data for STI testing and treatment, along with any SDOH data gathered and reported by providers. STI programs and providers could coordinate data sharing with community-based organizations, social service agencies, and health departments to better coordinate efforts to address SDOH-related needs.

Referrals to services—STI programs and providers can develop robust SDOH referral systems to meet patients' needs. Referrals require knowledge of the range of services available in the community, as well as staff to make referrals (such as case managers or social workers), and relationships with social service agencies or community-based organizations.

STI service providers may want to develop specific relationships with service providers that have the cultural competence to serve their patient populations, including youth, LGBTQ+ people, people of color, and others. Local or state STI programs (or broader departments of health) could develop a directory of SDOH services with information about eligibility for a range of public and private programs for providers and organizations without existing connections to service providers.

Eligibility for services—Some states target Medicaid SDOH services to specific populations based on demographics, health status, specific unmet social needs, or region. STI programs and providers can cross-walk eligibility with STI risk and STI services to maximize their benefit for their patient populations.

For example:

- Substance use disorder in the U.S. is intertwined with increased STI risk, and can itself be conceived of as a social determinant driving STI risk and impeding access to care.[40s] In addition to coverage of SUD treatment services, many state Medicaid programs have supportive benefits that focus on or include people with SUD, including, as of 2018, peer support services (38 states), comprehensive community supports (29 states), supported employment (13 states) and tenancy support services (4 states).[41s] STI programs and providers could reach out to initiatives that focus on or include people with substance use disorder - to integrate STI screening and treatment into the suite of services.
- Similarly, STI programs could work with Medicaid officials to ensure that STI screening and services are integrated into SDOH programs for pregnant or postpartum participants.
- In states with geographically limited initiatives, STI programs can identify high-volume STI providers in the targeted region to ensure that they know how to connect their patients to SDOH services.

Partnerships between Medicaid and community-based organizations—State Medicaid agencies and MCOs are increasingly partnering with non-clinical community-based organizations (CBOs) to address unmet SDOH for their enrollees. For example, California has a pending waiver proposal to use Medicaid funds for grants to increase the strength of the state's reproductive health system.[42s] In addition to increasing provider capacity, grants would be used to support partnerships with CBOs that can provide or make referrals for transportation, childcare and "similar needs."[42s] For STI programs and for their community partners that are not clinically focused, such partnerships could be a way to

leverage Medicaid support for key support services to address STIs and promote sexual health.

The intersection of Medicaid and the Correctional System—Recently, states have developed a variety of approaches to "suspend," rather than terminate, Medicaid coverage for incarcerated people to facilitate access to care upon reentry to the community.[43s] In some states, these approaches are combined with screening or coordination requirements, mandating that inmates be screened for health needs and/or Medicaid eligibility or that Medicaid MCOs coordinate inmates' transition to care. In addition, in January 2023 CMS approved the first state waiver, from California, to cover a set of services for inmates for a brief period before release from incarceration[44s]; similar waivers from other states are pending.

Though these efforts are not typically framed as part of a state's SDOH efforts, involvement with the correctional system has a significant impact on sexual health. STI program staff and providers can identify their state Medicaid program's policy on inmates and reentry, and seek opportunities to increase STI screening, education, and connection to services for this population.

Specific SDOH considerations for youth—Adolescents and young adults bear the brunt of the STI epidemic,[45s] and 60% of Medicaid or CHIP enrollees are under age 27.[46s] Children are also more likely to live in poverty than adults, making up only 22% of the population but one-third of all people living in poverty.[47s,48s] Given these heightened vulnerabilities, STI programs and providers could explore if their state Medicaid program or MCOs offer any SDOH support that could assist their minor or young adult patients and their families. These efforts could take into consideration unique needs for youth, such as heightened privacy concerns for youth living at home, and transportation needs.

Conclusion

The growing attention to SDOH in the Medicaid program creates many opportunities for STI programs and providers to better understand and serve their Medicaid-enrolled patients. It could be useful for STI providers to engage in these efforts to leverage SDOH supports for their patients, and STI programs could maximize these Medicaid SDOH features to improving sexual health.

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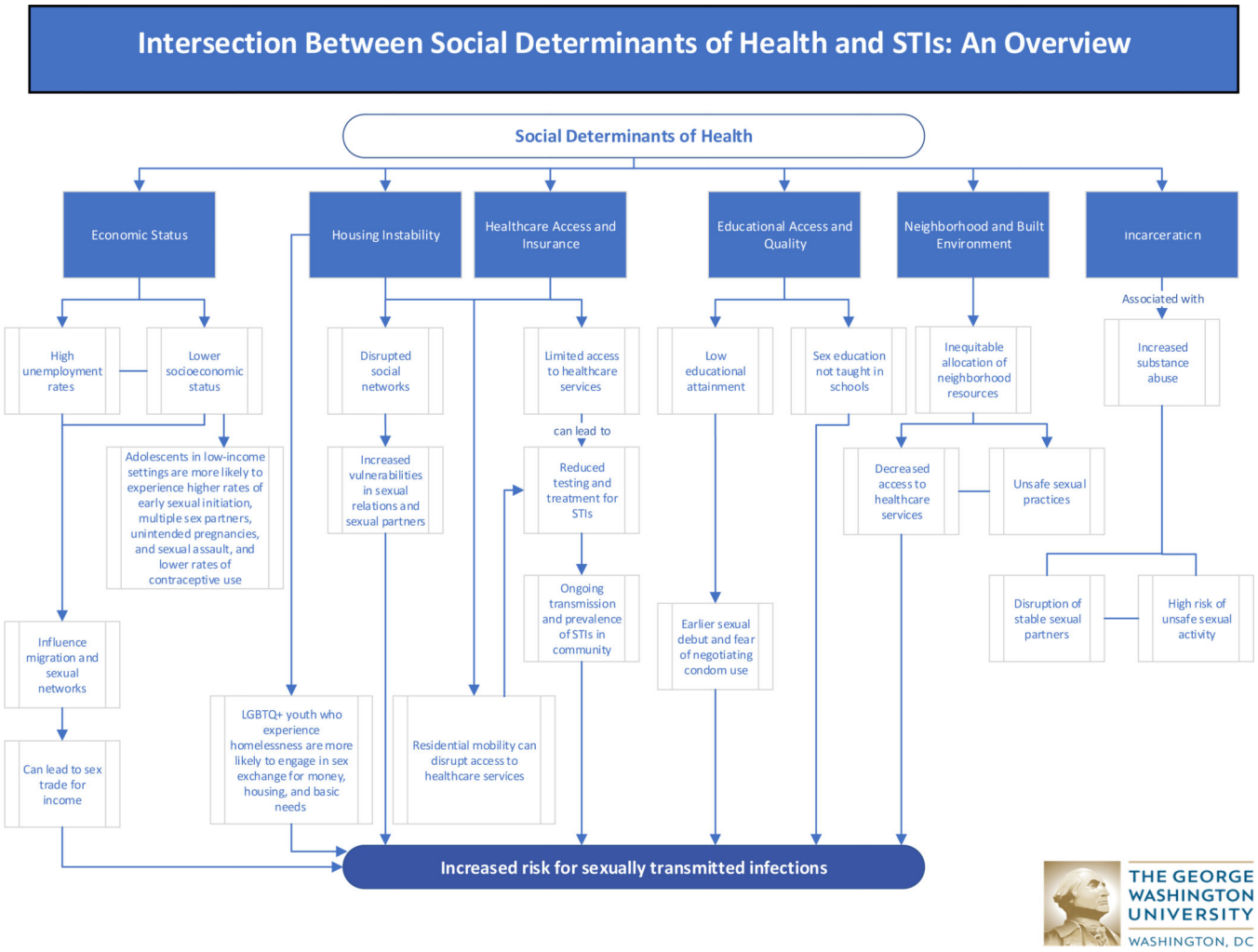

Figure 1.