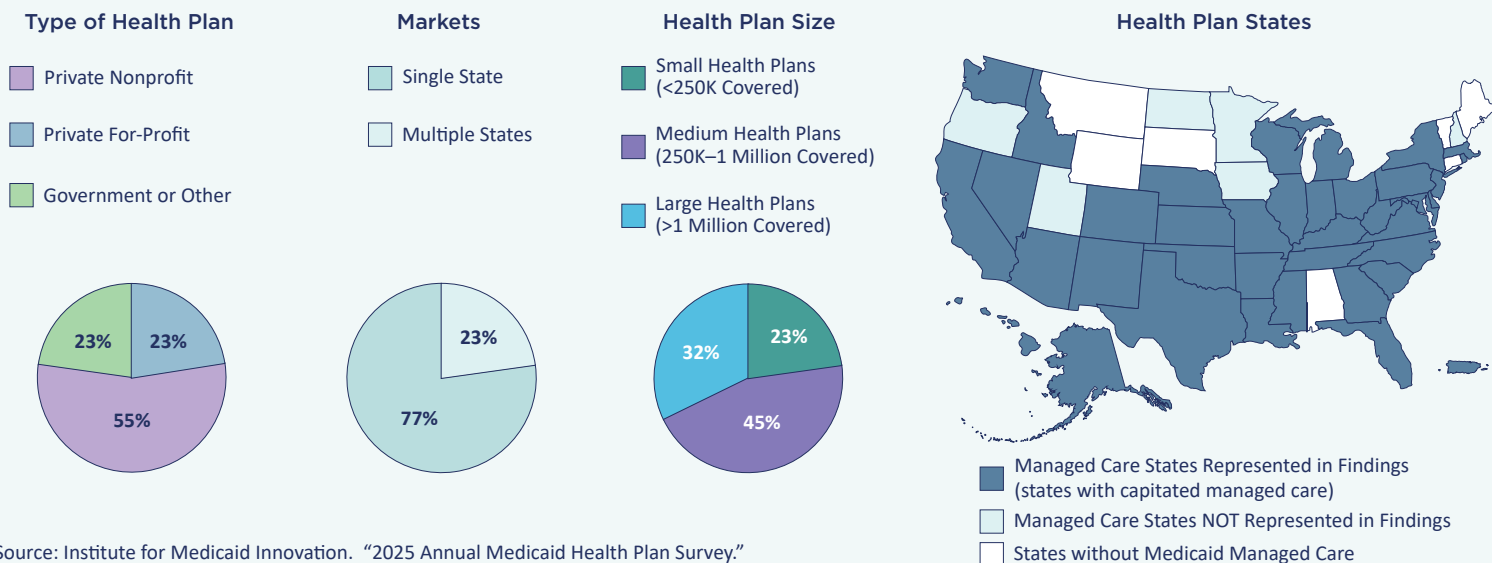




Annual Medicaid Managed Care Organization Survey Social Determinants of Health

Demographics

In its eighth year, the 2025 survey findings represent health plan data from almost every state with Medicaid managed care. The annual survey collected information at the parent company and corporate levels and is intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care. The survey respondents are representative of the national demographics of all Medicaid health plans.



Source: Institute for Medicaid Innovation. “2025 Annual Medicaid Health Plan Survey.”

Specific Populations for Which Medicaid Health Plans had Social Determinants of Health Programs

Pregnant and postpartum individuals	86%	Long-term services and supports population	59%
Adults with a substance use disorder	73%	Adults transitioning from institutions (e.g., nursing homes, assisted living facilities, rehabilitation)	55%
People experiencing homelessness or housing insecurity	73%	Aged, blind, and disabled	55%
Adults with disabilities (e.g., physical, intellectual, developmental)	68%	Children or adolescents with behavioral health diagnoses (mental health or substance use)	50%
Foster care youth or youth transitioning to adulthood	68%	Children with disabilities	50%
People with justice system involvement	68%	People living with HIV/AIDS	50%
Medicare and Medicaid enrollees (dual eligible)	64%	Expansion members	41%
People with limited English proficiency	64%	Our SDOH programs are open to all members	41%
Adults with serious mental illness	59%	Other	27%
Child welfare—or child protective services—involved families	59%	We do not have SDOH programs for specific populations	9%

Source: Institute for Medicaid Innovation. “2025 Annual Medicaid Health Plan Survey.”

Notes: **SDOH is social determinants of health.** **Other** includes members with challenges including food insecurity, workforce, transportation, maternity, and isolation, and individuals with cognitive disabilities, dementia, Alzheimer’s disease, and children with autism.













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Trends in Social Determinants of Health Screening Tools used by Medicaid Health Plans	2018	2019	2020	2021	2023	2024	2025
Internally developed tool that is not based on one of the tools listed	-	47%	53%	52%	42%	48%	45%
Adaptation of one or more of the tools listed	-	27%	47%	33%	38%	39%	27%
Protocol for Responding to and Assessing Patient Assets, Risks and Experiences	36%	27%	37%	19%	21%	35%	45%
Centers for Medicare & Medicaid Services Accountable Health Communities Health-Related Social Needs Screening Tool	29%	20%	16%	14%	17%	30%	23%
Tools embedded in provider electronic health record	-	13%	26%	24%	33%	22%	23%
State-mandated tool*	-	20%	16%	14%	21%	13%	18%
American Community Survey data	15%	13%	11%	0%	8%	13%	18%
Vulnerability Index—Service Prioritization Decision Assistance Tool	22%	20%	21%	14%	8%	13%	18%
Social Needs Screening Toolkit, HealthLeads USA	0%	7%	0%	0%	4%	13%	5%
Arizona Self-Sufficiency Matrix	0%	0%	0%	0%	4%	4%	5%
Self-Sufficiency Outcomes Matrix, OneCare Vermont, Center for Health Care Strategies version	0%	0%	0%	0%	0%	4%	0%
Social Determinants Screening Tool, AccessHealth Spartanburg, Center for Health Care Strategies version	0%	7%	0%	0%	0%	4%	5%
We do not use social determinants of health screening tools	14%	13%	0%	5%	4%	0%	0%
The EveryOne Project: Advancing Health Equity in Every Community Toolkit by American Academy of Family Physicians	0%	0%	0%	0%	0%	0%	0%
Other	50%	27%	16%	24%	21%	17%	18%

Source: Institute for Medicaid Innovation. “2025 Annual Medicaid Health Plan Survey.”

Notes: **Dash (-)** indicates that the answer option was not included in the survey. Note: Prior to 2023, Annual Medicaid Health Plan Survey questions requested information on prior year activities. In 2023, the survey began requesting information on the current year. **Other** includes National Committee for Quality Assurance Certified Health Appraisal. *State-mandated tools include Hawaii state-mandated social determinants of health screening tool, state indicated specific social determinants of health to track/screen which have been integrated into the Managed Care Organization Electronic Medical Record, Texas Health and Human Services Non-Medical Drivers of Health Screen, North Carolina, and West Virginia.

How States Support Medicaid Health Plans' Social Determinants of Health Initiatives

	Submit and receive approval for a Medicaid waiver that included support of SDOH initiatives	64%
	Make policy or regulatory changes to support SDOH initiatives	59%
	Allow or improve data sharing	50%
	Provide financial support	45%
	Provide screening tools	41%
	Provide tools and support for data analysis	36%
	Provide support for cultural and linguistic competency	32%
	Payments for SDOH services in plan capitation	23%
	Provide administrative assistance (e.g., staff resources)	23%
	Engaging health plan members in informing efforts to address structural racism	18%
	States do not support SDOH initiatives	9%
	Other	9%

Source: Institute for Medicaid Innovation. "2025 Annual Medicaid Health Plan Survey."

Notes: **SDOH** is social determinants of health. **Other** includes partner on a learning collaborative (Advancing Health Equity) and participation in the Association for Community Affiliated Plans Health Equity Learning Collaborative.

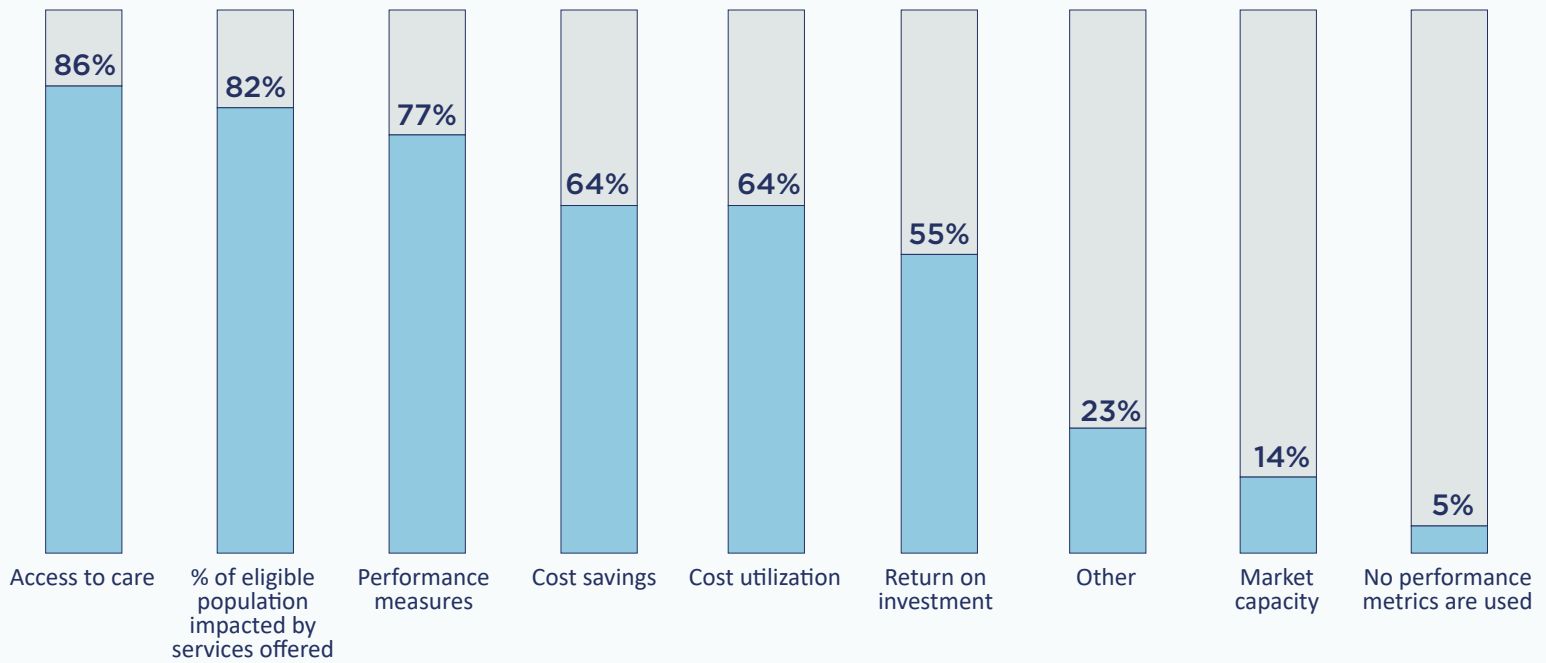
Additional Social Determinants of Health Services and Supports Medicaid Health Plans Offer Above State Requirements

73%	Food insecurity
64%	Transportation problems
59%	Housing instability
55%	Employment
50%	Education
45%	Family and community support
41%	Access to disability supports
41%	Access to mental health services
41%	Access to substance use services
41%	Physical activity
36%	Utility help needs
32%	Financial strain
23%	Other
5%	None

Source: Institute for Medicaid Innovation. "2025 Annual Medicaid Health Plan Survey."

Note: **Other** includes community health workers, benefits enrollment navigation, grant programs, and community resource centers.

Metrics Used by Medicaid Health Plans to Assess and Evaluate Social Determinants of Health Initiatives



Source: Institute for Medicaid Innovation. "2025 Annual Medicaid Health Plan Survey."

Notes: **Other** includes metrics tailored to member-centered outcomes, state reporting on social determinants of health, internal data measuring on social determinants of health drivers based on admission, readmission, engagement with community-based organizations, quality of life, member satisfaction, and changes in health outcomes.

How State Medicaid Agencies Could Further Assist Medicaid Health Plans in Addressing Social Determinants of Health Needs

91%	Standardize 834 enrollment file to include social needs information*		73%	Improve data sharing between health plans and provider groups	
86%	Improve data sharing between government agencies (e.g., child welfare system, criminal justice system) and health plans		73%	Increase resources to support facilitation of partnerships	
86%	Improve data sharing between health plans and community-based organizations		64%	Increase financial resources for community-based organizations	
82%	Improve data sharing between state and health plans		59%	Increase technical assistance resources	
82%	Increase financial resources from state to health plans		59%	Purchase tools and resources that require a license and provide access to all health plans	
77%	Increase resources to support capitated payments models, pay-for-performance, and risk programs with providers		14%	Other	
73%	Facilitate contracting with community-based organizations		0%	States cannot provide any further assistance	

Source: Institute for Medicaid Innovation. "2025 Annual Medicaid Health Plan Survey."

Notes: **Other** includes improving the use of ICD-10 Z codes for providers. *An 834 enrollment file is a standardized electronic file format used in health insurance to communicate enrollment and eligibility information between a health plan sponsor (i.e., an employer or a government agency) and a health insurance payer (e.g., a health plan or insurer).