From Charity to Contract: *Reimbursing SDOH/UDOH Mitigation as a Critical Health Care Investment*

An Analysis by C. Robinson, July 2026

Overview

Social Determinants of Health (SDOH) and Upstream Drivers of Health (UDOH) should be treated as a strategic healthcare investment rather than a grant-funded social service. Drawing on peer-reviewed research, the paper demonstrates that targeted, evidence-based interventions such as behavioral health integration, housing stabilization, nutrition support, and community health workers can significantly reduce downstream healthcare costs for high-risk groups.

While the widely cited claim that every $1.00 invested yields $6.00 in savings is not universal, the evidence supports returns ranging from $1.50 to more than $6.00 per dollar invested when interventions are carefully targeted, integrated into care delivery, and measured for outcomes.

The paper recommends shifting the financing of SDOH/UDOH mitigation from temporary grants and philanthropy to sustainable reimbursement models led by Medicaid, with support from Medicare and commercial payers. It proposes using the Collaborative Care Model (CoCM) as a framework for integrating behavioral health and social care while reimbursing Community-Based Organizations (CBOs), community health workers, and peer support providers for resolving social needs that directly impact health outcomes. By creating standardized payment pathways, strengthening partnerships with community organizations, and measuring financial, clinical, and social outcomes, healthcare systems can improve patient health, reduce avoidable utilization, and build a more sustainable, value-based model of care.

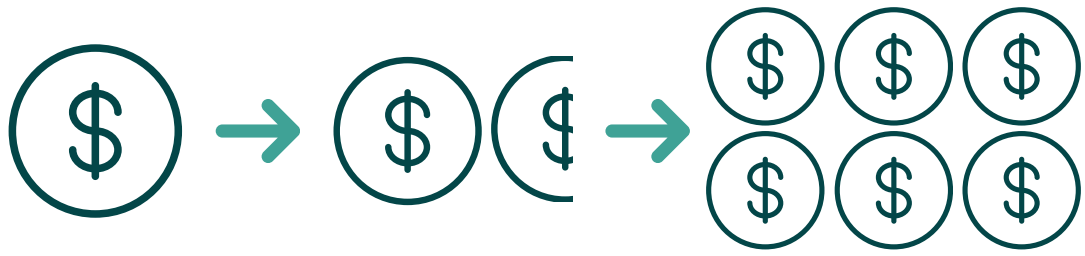
Minimum Medicaid Benefit Design

- Identify
- Navigate
- Mitigate
- Integrate
- Prove

Measurement Model

- Financial
- Clinical
- Social Need
- Equity
- CBO Sustainability

Average reduction in future healthcare spending through targeted SDOH/UDOH mitigation services (per $1.00 invested)



www.robinsonventures.com

Robinson Ventures, LLC

From Charity to Contract:

Reimbursing SDOH/UDOH Mitigation as a Critical Health Care Investment

How targeted upstream investment, community-based delivery, Medicaid payment design, and the Collaborative Care Model can convert social care from grant-funded activity into measurable health care value.

Core thesis: The $1 -> $6 thesis is a defensible design goal for targeted, evidence-based upstream interventions to be delivered to high-need populations under accountable reimbursement models. The near 6X multiple's evidence is strongest in selected housing and collaborative-care contexts, and the broader evidence supports a positive but variable return range.

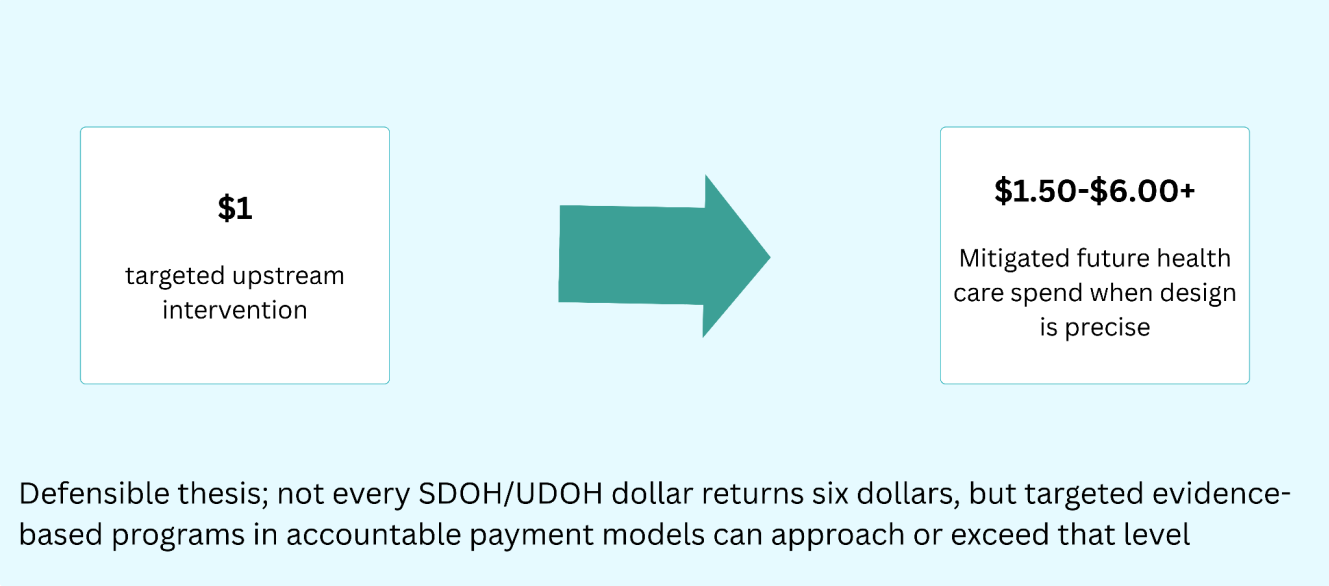


Figure 1. A practical framing for the ROI thesis: defend a range, design for precision, and reimburse for resolution.

Overview: Yes, with precision delivery of mitigation services

The most accurate answer is **directionally yes, but not always.** The peer-reviewed literature proves that each dollar spent on every social determinant or upstream-driver intervention reliably avoids up to or more than six dollars of future medical spending. Evidence-based interventions delivered to high-need populations can deliver meaningful returns of up to 6X or greater. The Collaborative Care Model produced a clear 6X finding; $522 in first-year intervention cost was associated with $3,363 lower four-year health care costs, or roughly $6.44 in avoided spending per intervention dollar [8]. Housing-focused reviews report positive ROI up to 480%, implying a gross benefit of near $5.80 per dollar when interpreted as net return, plus the original dollar invested [4]. Broader public-health interventions have shown even larger median returns, though these are wider health and social-care returns rather than payer-only medical claims [3].

The practical thesis is clear: upstream social care returns are real, but have to be engineered. Good targeting, accountable payment, trusted delivery, and closed-loop measurement matter. Screening alone does not generate ROI, nor do referrals without community capacity. Short-term pilots rarely generate enterprise value; need resolution does.

That resolution is community infrastructure. Community-based organizations, health workers, peer specialists, mental health organizations, Certified Community Behavioral Health Clinics, food-is-medicine organizations, housing partners, transportation partners, and social care networks already do the work that makes the medical ROI possible. They are the last-mile delivery system for trust, adherence, behavioral health stabilization, benefit activation, and social need resolution [14-16].

The financing model lags the operating reality. Too much SDOH/UDOH mitigation remains trapped in grants, philanthropy, demonstration dollars, and short-term pilots. Medicare, Medicaid, and commercial payers should pay for reimbursable, measurable social care functions when those functions are clinically connected to avoidable utilization. Medicaid should lead because Medicaid programs bear a disproportionate share of the cost of unmanaged behavioral health, unstable housing, food insecurity, transportation barriers, disability accommodations, and poverty. Every state Medicaid program should establish a payment path for SDOH/UDOH mitigation services, including within or alongside CoCM when behavioral health conditions and social needs interact.

Recommendation: For targeted, evidence-based SDOH/UDOH interventions delivered to high-need populations through accountable reimbursement models, the peer-reviewed evidence supports avoided health spending frequently in the roughly $1.50 to $6.00+ per dollar spent range, with selected collaborative care and housing evidence approaching or exceeding the near-6X thesis.

How to read this paper

- Peer-reviewed research is used for ROI, clinical outcomes, cost outcomes, and community-delivery evidence.
- Official CMS sources are used for payment-policy facts, including Medicare BHI/CoCM, Medicaid HRSN authorities, in-lieu-of-services policy, and CCBHC prospective payment structures.
- Dollar multiples are directional because studies use different definitions of ROI, time horizons, populations, and cost perspectives. This paper distinguishes net ROI from gross avoided spending whenever possible.

1. The investment thesis: social risk is medical cost risk

Social determinants of health are the conditions in which people are born, grow, live, work, seek care, and recover. Upstream drivers of health are the practical forces that determine whether a person can act on a care plan: food, housing, transportation, utilities, income, safety, social connection, education, access, and behavioral health stability. In payer terms, unresolved social risk is an actuarial liability.

A 2024 *JAMA Network Open* analysis of insured adults found that individual-level health-related social needs were significantly associated with health care expenditures across Medicare, Medicaid, and private insurance populations [1]. The implication is straightforward: payers already pay for social risk when it shows up downstream as emergency department use, inpatient admissions, readmissions, preventable complications, crisis utilization, and institutional care. The strategic choice is whether to pay late, at traditional medical prices, or earlier, at community prices.

The white-paper argues that Health plans and state Medicaid agencies should pay for social care when it is targeted to a covered member, tied to clinical risk or behavioral health need, documented in a care plan, delivered by qualified community capacity, and measured against utilization, quality, and member outcomes.

Robinson Ventures-style operating principle: Where social risk predictably drives medical cost, upstream mitigation should be financed as a critical healthcare investment. The question is no longer whether the work matters, but whether the financing model is disciplined enough to pay for what does work.

2. The ROI evidence: a defensible range, not a universal constant

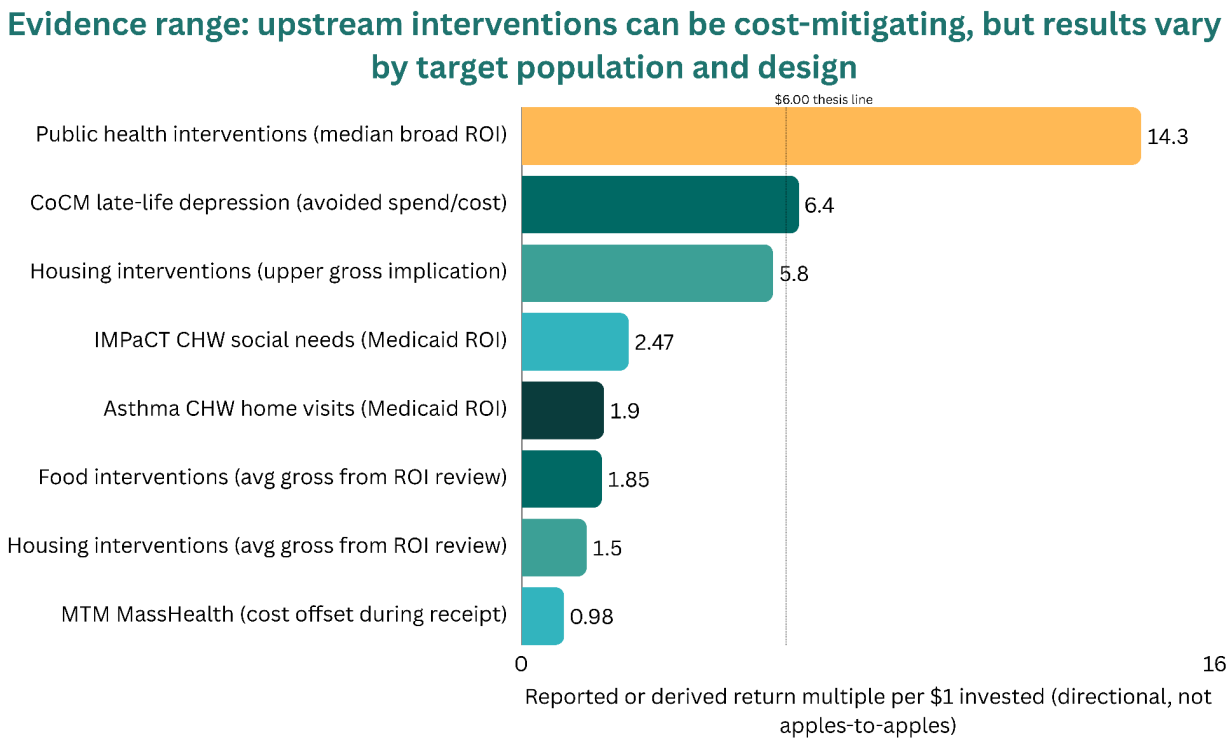


Figure 2. Selected peer-reviewed ROI and cost-mitigation evidence. Results are directional and not directly comparable because study perspectives, time horizons, populations, and ROI definitions differ.

The thesis that SDOH/UDOH mitigation can return 6X on every dollar spent is most defensible when framed as a range and as a design target. This is supported by selected studies, but not by the average result across all SDOH interventions. The strongest near-6X example comes from CoCM in late-life depression, where long-term follow-up of the IMPACT randomized trial found $3,363 in lower health care costs over four years compared with $522 in intervention cost [8]. The strongest 6X return example comes from a systematic review reporting housing intervention ROI as high as 480%; when ROI is interpreted as net return, that upper bound implies $4.80 net return plus the original $1 invested, or roughly $5.80 in gross value [4].

The broader literature supports positive returns but shows variation. A 2024 *Health Affairs Scholar* review found an average ROI of 85% for food interventions and 50% for housing interventions, with positive ROI in most included studies but negative results in a few studies [2]. A community health worker intervention for high-risk Medicaid patients generated a $2.47 return per dollar within one fiscal year [5]. A randomized trial of community health worker home visits for Medicaid-enrolled children with asthma produced a 1.90 ROI [6]. A 2026 evaluation of Massachusetts Medicaid medically tailored meals found fewer hospitalizations and emergency department visits, with cost reductions offsetting 98% of program costs on average and net savings in selected high-risk groups [13].

The evidence does not support indiscriminate spending, it supports targeted investment. It also supports a reimbursement model that pays for interventions with the highest probability of replacing avoidable medical spend: behavioral health integration, housing stabilization, nutrition support, community health work, peer support, transportation activation, asthma home interventions, and closed-loop social care navigation.

Robinson Ventures, LLC

Evidence table: what supports the thesis

Intervention / Evidence Stream	Evidence Base	Financial Result	Thesis Implication
Collaborative care for late-life depression	Randomized trial follow-up; IMPACT model in older adults with depression.	$522 intervention cost; $3,363 lower health care costs over four years; about $6.44 avoided spend per dollar [8].	Strong near-6x support, especially for behavioral health integration and CoCM.
Health-focused housing interventions	Systematic review of housing interventions tied to health outcomes.	Positive ROI from 30% to 480%; upper bound implies roughly $5.80 gross benefit per dollar if ROI is net return [4].	Supports near-6x potential in well-targeted housing strategies.
Food and housing SDOH interventions	Systematic review of ROI studies in food and housing insecurity.	Average ROI: food 85%, housing 50%; wide range, with a few negative results [2].	Supports positive average ROI, but not a blanket $6 claim.
IMPaCT community health worker model	Evidence-based CHW program addressing unmet social needs among Medicaid patients.	38% lower inpatient admissions; $2.47 return per dollar within one fiscal year [5].	Supports reimbursing CBO/CHW delivery capacity.
Medicaid pediatric asthma CHW home visits	Randomized trial of CHW home visits for children with uncontrolled asthma.	Savings of $1,340.92 for $707.04 additional cost; ROI of 1.90 [6].	Shows targeted home/community interventions can avoid acute care.
Medically tailored meals	Cohort and simulation evidence plus 2026 Medicaid demonstration evaluation.	Simulation estimate of 1.6 million fewer hospitalizations and $13.6 billion annual net savings; MassHealth evaluation offset 98% of costs overall [12,13].	Supports nutrition as reimbursable medical-cost mitigation for selected members.
Public health interventions	Systematic review of public-health intervention ROI.	Median ROI of 14.3 to 1 across the broader health and social-care economy [3].	Supports upstream investment economics beyond payer-only claims.

Analytic caution: A 6X return on $1.00 invested claim should not be presented as absolute. It should be presented as an achievable result in a targeted portfolio. The payer value case is strongest when the intervention replaces known high-cost utilization, the population is high-risk, the time horizon is long enough, and the CBO delivery partner is reimbursed for actual resolution.

3. CBOs are already delivering the mitigation infrastructure

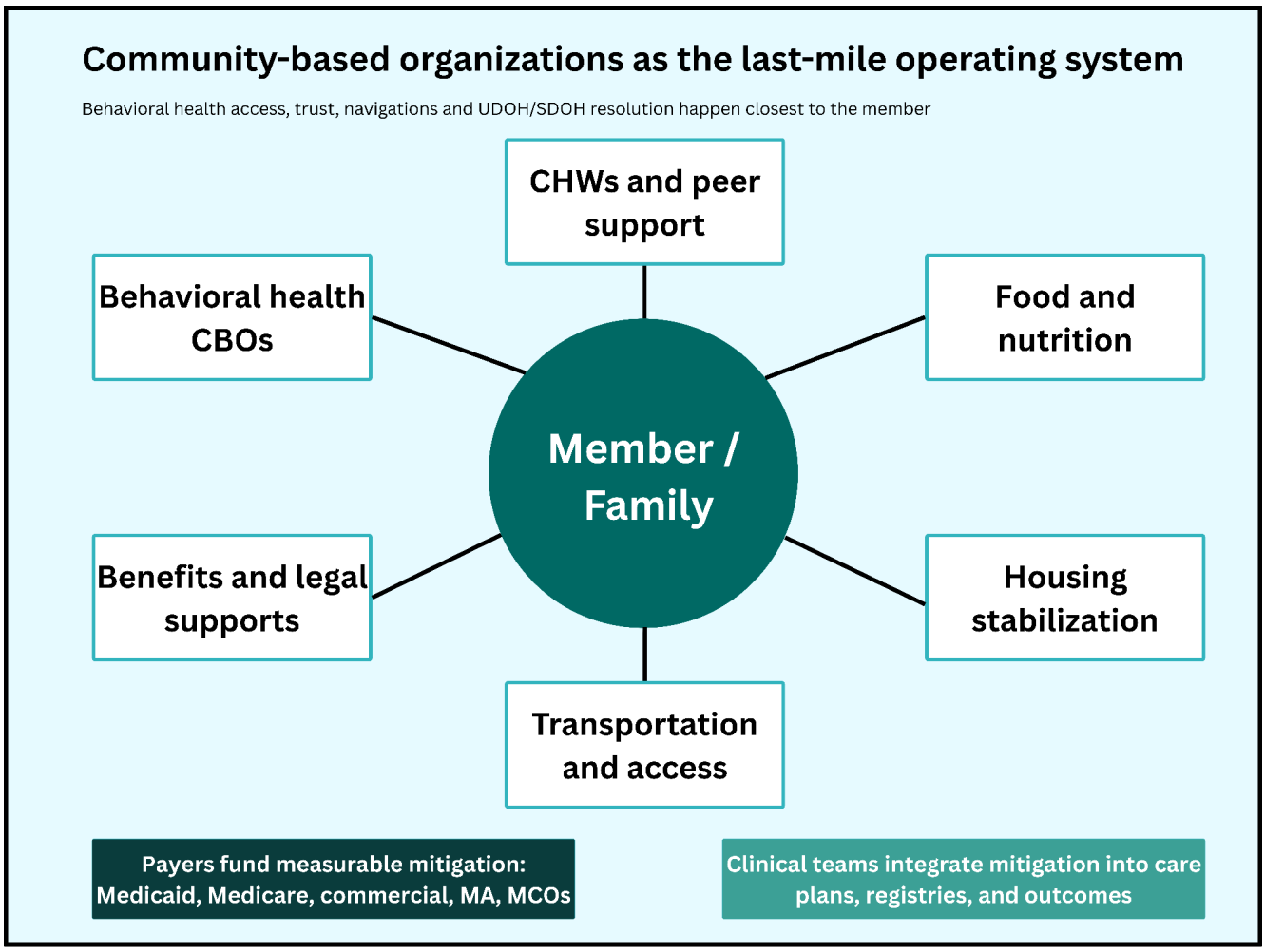


Figure 3. CBOs provide the trusted last-mile operating system for SDOH/UDOH mitigation, especially around behavioral health and social need resolution.

Health care tends to discover SDOH/UDOH needs inside a clinical workflow. Communities experience it in daily life. That difference is why CBOs matter. They know where the member lives, which housing partners answer the phone, which food resources are culturally appropriate, which transportation options actually arrive, which behavioral health supports are trusted, and which public benefits can be activated quickly. The CBO advantage is not simply a mission. It is operating knowledge.

Peer-reviewed evidence consistently describes CBOs and community health workers as essential bridges between health systems, Medicaid managed care organizations, providers, and members. Research on North Carolina social care integration found that CBOs bring cultural knowledge, community trust, and service-delivery expertise, while also facing chronic underfunding and limited staff capacity [15]. A *Health Affairs Scholar* analysis of CBO comments on Medicaid redesigns found repeated concerns about funding sufficiency, timing, cash flow, governance, metrics, and the need for partnership standards [14]. Research on community health workers emphasizes their role as trusted allies who connect Medicaid members to providers, managed care plans, and CBOs for food, housing, transportation, employment, and other social needs [16].

This is the central operating disconnect: the clinical system often receives the financial upside from fewer ED visits, fewer admissions, better behavioral health control, and lower total cost of care, while CBOs carry the operational burden of solving the need. A grant-funded CBO can prove a concept. It cannot reliably scale a health-plan strategy. To build a durable ROI engine, payers must move CBOs from charitable subcontractors to reimbursed network partners.

Strategic claim: CBOs are not vendors of goodwill. They are health infrastructure. If the health care system wants the return, it must pay for the delivery system that creates the return.

What CBOs already do that healthcare should reimburse

- Behavioral health stabilization through community mental health centers, CCBHCs, peer services, mobile crisis partners, recovery supports, and culturally responsive counseling access.
- Social care navigation, eligibility support, and benefit activation for Medicaid, SNAP, housing supports, transportation, utilities, disability resources, and reentry supports.
- Food-is-medicine services such as medically tailored meals, produce prescriptions, pantry partnerships, dietitian-informed nutrition support, and food access logistics.
- Housing transition and tenancy-sustaining supports, including landlord engagement, document support, move-in coordination, eviction prevention, and housing search assistance.
- Community health worker outreach, motivational support, care-plan reinforcement, appointment preparation, home visiting, and adherence support.
- Closed-loop referral work: confirming the member was reached, service was delivered, barrier was resolved, and the clinical/payer team received documentation.

4. Behavioral health is the natural operating system for SDOH/UDOH mitigation

SDOH/UDOH mitigation is often discussed as a social service strategy. In practice, it frequently becomes a behavioral health strategy. Depression undermines cancer care and diabetes control. Anxiety disrupts follow-up. Substance use disorder destabilizes housing and employment. Trauma complicates trust. Food insecurity, housing instability, utilities insecurity, and transportation barriers worsen mental health and undermine treatment engagement. Therefore, behavioral health integration should be treated as a core chassis for upstream investment.

The Collaborative Care Model is especially important because it is both clinically proven and operationally structured. The original IMPACT randomized trial showed that collaborative care for older adults with depression produced substantially higher response than usual care: at 12 months, 45% of intervention patients had at least a 50% reduction in depressive symptoms compared with 19% of usual-care patients [9]. Long-term cost follow-up produced the near-6X economic signal discussed earlier [8]. A systematic review found collaborative care to be a promising, potentially cost-effective approach for major depression in primary care, while also noting variability in economic evaluation quality [10].

Medicare now explicitly covers Behavioral Health Integration and Psychiatric CoCM services. CMS describes CoCM as a team-based approach involving a treating/billing practitioner, a behavioral health care manager, and a psychiatric consultant, with care management support and psychiatric consultation added to usual care [17]. CMS guidance also recognizes CoCM/BHI for mental, behavioral health, and psychiatric conditions, including substance use disorders, and allows behavioral health care managers and psychiatric consultants to be under contract with the billing practitioner rather than physically located in the same practice [17,18].

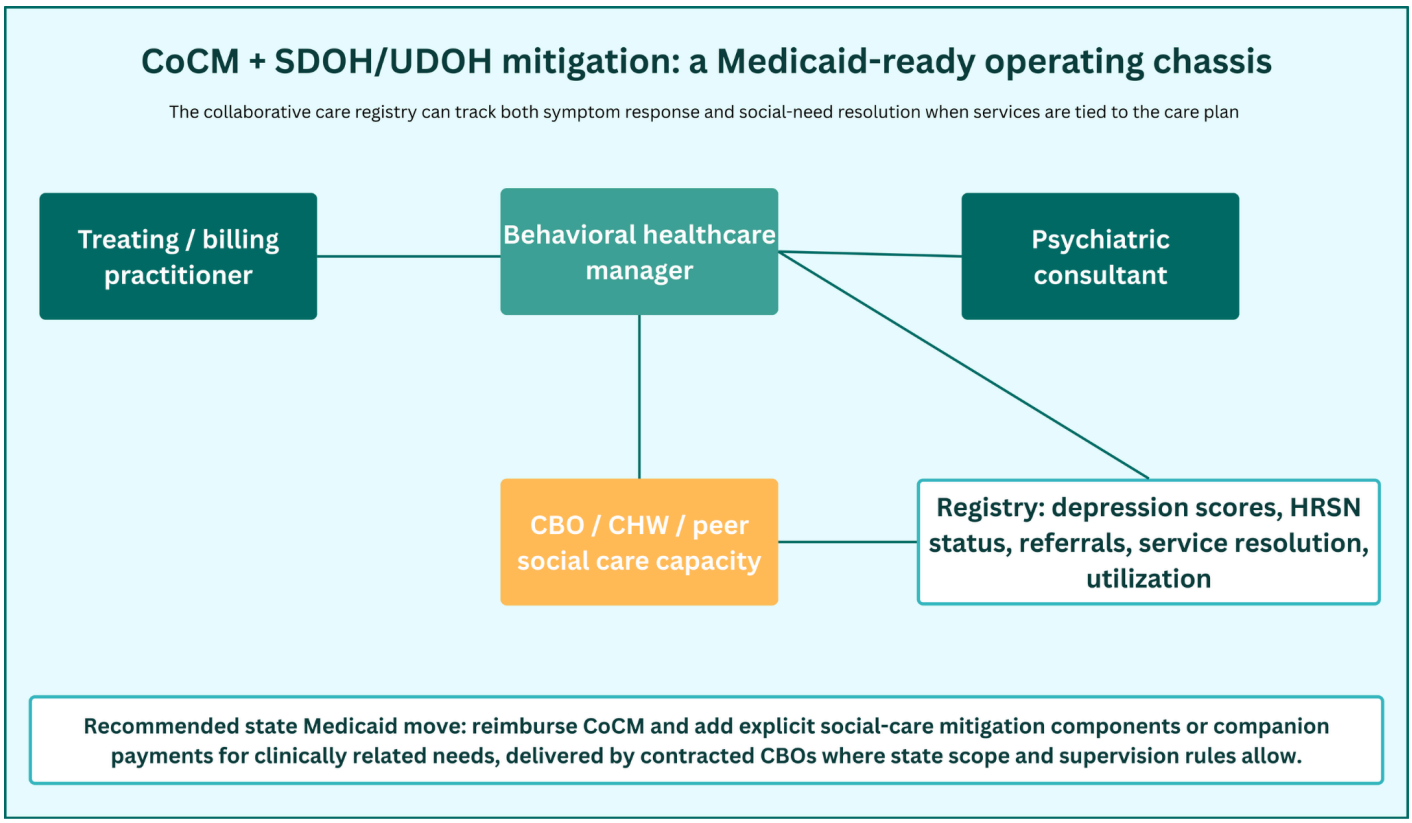


Figure 4. CoCM can become the operating chassis for social care when Medicaid pays for clinically related SDOH/UDOH mitigation and allows CBO capacity to participate in the care architecture where permitted.

CoCM sub-thesis:Every state Medicaid program should reimburse CoCM or an equivalent integrated behavioral health model, and should allow clinically related SDOH/UDOH mitigation to be delivered within or alongside that model. The care plan should be able to document not only symptom severity and medication response, but also food, housing, transportation, utility, safety, and social support barriers that are materially interfering with behavioral health or medical outcomes.

What CoCM-linked social care should include

- Validated behavioral health measurement plus standardized HRSN/SDOH screening.
- A shared care plan that connects social need resolution to behavioral health and medical goals.
- A registry that tracks symptom scores, social need status, referrals, service delivery, and resolution.
- CBO, CHW, peer, or social care navigator participation under state scope, contracting, supervision, and documentation requirements.
- Payment for the work of engagement, navigation, service activation, and closed-loop confirmation - not only the act of generating a referral.

5. The financing model must move from grants to reimbursement

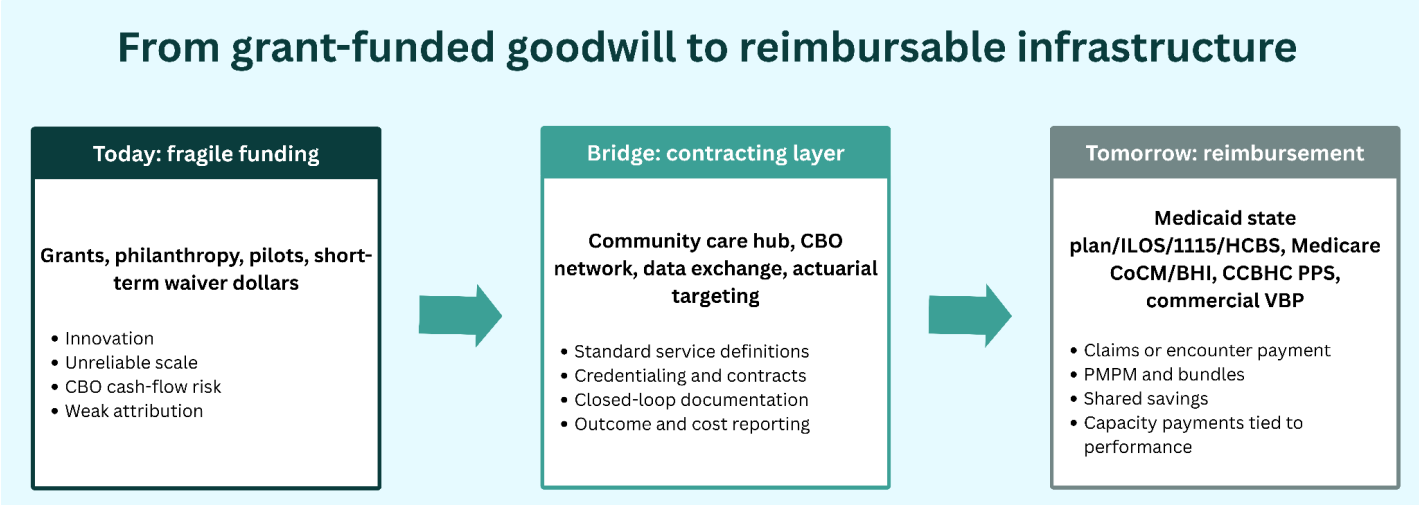


Figure 5. The strategic movement required: from fragile grant funding to durable payer reimbursement through a contracting and data layer.

Grant funding is useful for innovation, readiness, training, data infrastructure, and early proof of concept. It is not a durable reimbursement model. Philanthropy can seed a partnership, but it should not be the permanent financing source for services that reduce medical spending. If an intervention is sufficiently tied to avoidable utilization, improved outcomes, or quality performance, it should graduate to payer reimbursement.

The current mismatch creates three predictable failures. First, health care screens for needs and finds them, but the community resource base is not funded to respond. Second, CBOs accept medical-system expectations without medical-system cash flow, leading to staff strain, administrative burden, and inequitable contracting dynamics. Third, payers undercount the value of social care because they do not systematically convert CBO work into claims, encounters, quality measures, or total-cost-of-care reporting.

The next model should be reimbursement-based and multi-payer. Medicare already has community health integration (CHI), primary illness navigation (PIN), and PIN- peer support codes (G-codes) that allow for the reimbursement of activities related to SDOH/UDOH mitigation. Medicare also has BHI and CoCM codes that create a reimbursable behavioral health integration lane [17,18]. Medicaid can use state plan authority, section 1915 HCBS authorities, managed care in-lieu-of-services and settings, section 1115 demonstrations, CHIP health services initiatives, and CCBHC prospective payment methodologies to finance HRSN-adjacent services and behavioral health infrastructure [19-21]. Commercial payers can use value-based contracts, shared savings, bundled payments, employer health strategies, and network adequacy investments to finance similar functions.

Payment design principle: A payer should not pay indefinitely for unstructured charity. A payer should pay for defined services, delivered by qualified partners, tied to eligible populations, documented in care plans, reported through claims or encounters, and measured against utilization, quality, and member experience.

A reimbursement architecture that can scale

Payer / Platform	Available or Emerging Path	Recommended Move
Medicare	CHI, PIN, PIN-PS, BHI and Psychiatric CoCM codes; Medicare Advantage flexibility; value-based primary care.	Use CoCM/BHI as a behavioral health integration chassis and contract with CBO/CHW/peer capacity where allowed

Medicaid	State plan services, 1915 HCBS, managed care ILOS, 1115 demonstrations, CHIP HSI, CCBHC optional state plan benefit and PPS.	Define a statewide SDOH/UDOH mitigation benefit or service set and require MCO contracts to reimburse need-resolution work.
Medicaid MCOs	Capitation, ILOS, value-based provider contracts, quality incentives, care management delegation.	Pay CBO networks through PMPM, bundled, encounter, capacity, and shared-savings arrangements tied to outcomes.
Commercial payers	Employer health, behavioral health integration, ACO/provider risk contracts, quality programs, bundles.	Buy social care as a total-cost-of-care and workforce productivity strategy, not as community relations.
CBO networks / community care hubs	Central contracting, credentialing, referral routing, service documentation, CBO capacity support.	Aggregate small CBO capacity into a contracting layer that payers can reimburse and audit without crushing local partners.

6. Medicaid sub-thesis: every state should pay for SDOH/UDOH mitigation services

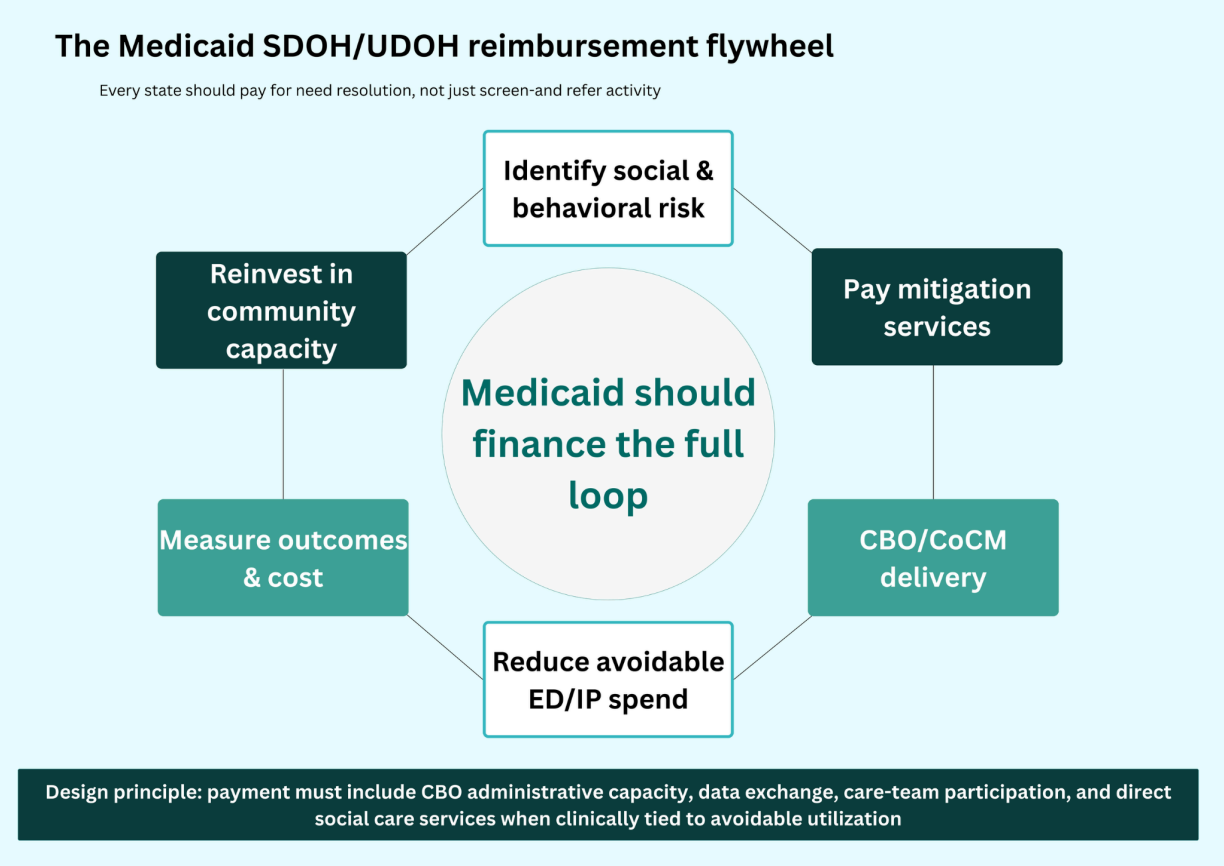


Figure 6. Medicaid should finance the complete mitigation loop: identify risk, pay for resolution, document delivery, measure results, and reinvest savings in community capacity.

Medicaid is the payer most exposed to the consequences of unresolved upstream need. It covers people for whom housing instability, food insecurity, transportation barriers, disability, economic insecurity, social isolation, and behavioral

health needs are often interdependent. If Medicaid pays only after instability becomes a crisis, it buys the most expensive version of care. If Medicaid pays earlier, it can buy prevention, stabilization, and recovery.

CMS identifies multiple ways states can address health-related social needs through Medicaid and CHIP, including state plan authorities, section 1915 HCBS waivers and state plan programs, managed care in-lieu-of-services and settings, section 1115 demonstrations, and CHIP health services initiatives [19]. CMS also recognizes that managed care in-lieu-of-services can be used for services that substitute for covered settings or services, including strategies related to housing instability and nutrition insecurity when regulatory requirements are met [20]. In behavioral health, Congress made CCBHCs a permanent optional Medicaid state plan benefit, and CMS has issued prospective payment guidance for states that elect the model [21].

The policy conclusion is clear: states do not need to wait for one perfect federal pathway. They should assemble a Medicaid payment stack that fits state law, budget neutrality, managed care contracting, and local CBO capacity. The outcome should be the same in every state: SDOH/UDOH mitigation is paid as a defined service when it is clinically connected, member-specific, documented, and measurable.

State Medicaid thesis: All state Medicaid programs should pay for SDOH/UDOH mitigation services. At minimum, every state should reimburse CoCM or a state-equivalent integrated behavioral health model; pay for CHW, peer, and social care navigation functions; cover selected direct mitigation services such as nutrition, housing transition/sustaining supports, transportation access, and home-based environmental supports; and fund the CBO infrastructure needed to document, bill, and measure results.

Minimum Medicaid benefit design

Layer	Covered Service Functions	Payment Design Requirement
Identify	Standardized HRSN/SDOH screening, behavioral health screening, risk stratification, Z-code/problem-list documentation where appropriate.	Do not pay for screening as a means to an end; require linkage to care planning and mitigation capacity.
Navigate	CHW, peer, social care navigator, benefits enrollment, eligibility support, appointment support, motivational engagement.	Pay for time, outreach, trust-building, and benefit activation.
Mitigate	Medically tailored meals, nutrition plans, housing transition/sustaining, transportation, utility supports, asthma home remediation, safety supports where allowable.	Pay for the actual intervention when tied to clinical risk and expected cost avoidance.
Integrate	CoCM/BHI, CCBHC care coordination, primary care integration, psychiatric consultation, registry management.	Tie social care to behavioral health treatment-to-target workflows.
Prove	Closed-loop referral confirmation, encounter reporting, claims, outcomes, utilization, member experience, equity metrics.	Make CBO work visible in the same measurement system used for medical value.

Why Medicaid should include CoCM in the SDOH/UDOH model

The CoCM model creates a disciplined operating structure that SDOH/UDOH work often lacks: a defined team, a care plan, a registry, periodic psychiatric review, validated measures, and treatment-to-target accountability. Medicaid populations need that structure because behavioral health and social instability commonly reinforce each other. A person cannot reliably attend therapy without transportation, cannot stabilize depression while food insecure, cannot manage substance use disorder without housing supports, and cannot follow a diabetes plan while utilities are disconnected.

The Medicaid model should therefore do two things at once. First, pay for CoCM or equivalent integrated behavioral health services. Second, pay for clinically related social need mitigation as a companion service, add-on, bundle, or delegated care-management component. The state should not require CBOs to become medical practices, but it should create contracting pathways that allow CBOs, CHWs, peers, and community care hubs to participate in the care architecture and to receive payment for documented work.

7. Implementation blueprint: from thesis to operating model

The strongest ROI evidence points to a pragmatic implementation truth: upstream investment produces returns when the design is targeted, measurable, reimbursed, and delivered by the right organization. The following blueprint turns the white-paper thesis into an execution plan for state Medicaid agencies, Medicaid managed care plans, providers, CBO networks, and commercial payers.

Execution	Operational Requirement
Define the avoidable spend problem	Identify the utilization being replaced: ED, inpatient admissions, readmissions, crisis use, avoidable post-acute care, poor medication adherence, or uncontrolled chronic disease.
Target high-yield cohorts	Start with members where social need is linked to predictable cost: serious mental illness, SUD, depression, dual eligibility, pregnancy/postpartum risk, asthma, diabetes, CHF, high ED use, homelessness, justice reentry.
Select evidence-backed interventions	Match the need to an intervention: CoCM, CHW outreach, peer support, MTM, housing transition/sustaining, transportation activation, asthma home remediation, benefits navigation.
Build the CBO contracting layer	Use community care hubs or network contracts to credential CBOs, standardize service definitions, fund capacity, manage referrals, and support documentation.
Define reimbursement	Choose fee schedule, encounter, PMPM, bundle, milestone, capacity payment, quality bonus, shared savings, or hybrid. Avoid unpaid referral expectations.
Integrate into care workflows	Embed services in CoCM, primary care, CCBHC, MCO care management, discharge planning, and community outreach. Use registries and closed-loop referral data.
Measure and reinvest	Track social need resolution, clinical outcomes, ED/IP utilization, total cost, equity, member experience, and CBO financial sustainability. Reinvest savings in community capacity.

Measurement model

- Financial: ED visits, inpatient admissions, readmissions, avoidable admissions, crisis episodes, total cost of care, pharmacy adherence, post-acute spend, and medical loss ratio impact.
- Clinical: depression remission or response, substance use engagement, chronic disease control, asthma control, maternal outcomes, medication adherence, preventive visit completion.
- Social need: food stability, housing status, transportation reliability, utilities stability, benefits activation, safety planning, social isolation, employment or education supports where relevant.
- Equity: stratify results by race, ethnicity, language, disability, geography, rurality, age, and behavioral health diagnosis to ensure savings are not produced by access restriction.
- CBO sustainability: payment timeliness, administrative burden, workforce retention, referral quality, service completion, and capacity utilization.

Execution standard: The operating target is not more screening. The operating target is reimbursed resolution with enough data discipline to prove value and enough community trust to make the intervention work.

8. Risks, safeguards, and responsible use of the $6 thesis

The thesis that $1 spent on UDOH/SDOH mitigation can create a 6X ($6) ROI on future medical spend can be strategically useful, but only if it is used responsibly. Overstating the claim creates credibility risk with actuaries, state budget officers, health plan finance teams, providers, and CBO partners. The best formulation is not "every dollar saves six." The best formulation is "targeted, evidence-based social care can mitigate material future medical spend, and selected interventions show near-six or greater return under the right conditions."

Risk	Why it matters	Safeguard
Screen-and-refer without resources	Needs are identified but not solved; members experience a bridge to nowhere.	Pay for CBO capacity and service resolution, not just screening.
Poor targeting	Low-risk populations may not have enough avoidable spend for ROI.	Use claims, clinical, behavioral health, and social risk data to target cohorts.
Short time horizon	Housing, behavioral health, and chronic disease interventions may require more than one budget cycle.	Use multi-year evaluation and shared-savings logic.
CBO underpayment	Community partners subsidize the medical system and cannot scale.	Include administrative, data, training, and working-capital payments.
Attribution disputes	Payers may question whether savings came from the intervention.	Use comparison groups, stepped-wedge designs, matched cohorts, or randomized pilots where possible.
Medicalization of social life	Not every social need should become a medical claim.	Require clinical linkage, member consent, care-plan documentation, and community governance.

Suggested language for policy and business development: Targeted SDOH/UDOH mitigation services can reduce future health care spending, with peer-reviewed evidence supporting roughly $1.50 to $6.00+ in mitigated health spending per dollar invested in selected interventions and populations. The highest returns require accountable reimbursement, trusted community delivery, integration with behavioral health and primary care, and rigorous measurement.

Conclusion: it is not magic; it is a design target

The central belief behind this white paper is substantially right, provided it is sharpened. The evidence supports a powerful thesis: upstream investments can mitigate downstream health care spend, sometimes approaching or exceeding six dollars per dollar invested. But the return is not automatic. It emerges when states and payers choose high-risk cohorts, deploy interventions with evidence, reimburse the community organizations that actually resolve the need, and measure the result with the same discipline used for clinical quality and cost of care.

CBOs are already doing the work. Behavioral health organizations are already sitting at the intersection of social need, trust, crisis, recovery, and chronic disease. CoCM is already a reimbursable model that can carry integrated behavioral health into primary care and other settings. Medicaid already has pathways to pay for HRSN and behavioral health infrastructure. The missing piece is statewide commitment.

Every state Medicaid program should pay for SDOH/UDOH mitigation services, including in a CoCM model. Medicare and commercial payers should align. Grant funding should seed innovation, not subsidize permanent underpayment. The goal is a payer-community compact: when social risk drives medical costs, pay community partners to resolve the risk, document the work, share the value, and reinvest in the infrastructure that keeps people healthy.

Robinson Ventures, LLC

References

[1] Mohan, G., & Gaskin, D. J. (2024). Social Determinants of Health and US Health Care Expenditures by Insurer. JAMA Network Open, 7(10), e2440467. https://doi.org/10.1001/jamanetworkopen.2024.40467

[2] Nikpay, S., Zhang, Z., & Karaca-Mandic, P. (2024). Return on Investments in Social Determinants of Health Interventions: What is the evidence? Health Affairs Scholar, 2(9). https://doi.org/10.1093/haschl/qxae114

[3] Masters, R., Anwar, E., Collins, B., Cookson, R., & Capewell, S. (2017). Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health, 71(8), 827–834. https://doi.org/10.1136/jech-2016-208141

[4] Davison, G., Ferris, D., Pearson, A., & Shach, R. (2019). Investments with returns: a systematic literature review of health-focused housing interventions. Journal of Housing and the Built Environment. https://doi.org/10.1007/s10901-019-09715-6

[5] Kangovi, S., Mitra, N., Grande, D., Long, J. A., & Asch, D. A. (2020). Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. Health Affairs, 39(2), 207–213. https://doi.org/10.1377/hlthaff.2019.00981

[6] Campbell, J. D., Brooks, M., Hosokawa, P., Robinson, J., Song, L., & Krieger, J. (2015). Community Health Worker Home Visits for Medicaid-Enrolled Children With Asthma: Effects on Asthma Outcomes and Costs. American Journal of Public Health, 105(11), 2366–2372. https://doi.org/10.2105/ajph.2015.302685

[7] Hsu, J., Wilhelm, N., Lewis, L., & Herman, E. (2016). Economic Evidence for US Asthma Self-Management Education and Home-Based Interventions. The Journal of Allergy and Clinical Immunology. In Practice, 4(6), 1123–1134.e27. https://doi.org/10.1016/j.jaip.2016.05.012

[8] Unützer, J., Katon, W. J., Fan, M.-Y., Schoenbaum, M. C., Lin, E. H. B., Della, R. D, & Powers, D. (2008). Long-term Cost Effects of Collaborative Care for Late-life Depression. The American Journal of Managed Care, 14(2), 95. https://pmc.ncbi.nlm.nih.gov/articles/PMC3810022/

[9] Unützer, J., Katon, W., Callahan, C. M., Williams, Jr, J. W., Hunkeler, E., Harpole, L., Hoffing, M., Della Penna, R. D., Noël, P. H., Lin, E. H. B., Areán, P. A., Hegel, M. T., Tang, L., Belin, T. R., Oishi, S., Langston, C., & for the IMPACT Investigators. (2002). Collaborative Care Management of Late-Life Depression in the Primary Care Setting. JAMA, 288(22), 2836. https://doi.org/10.1001/jama.288.22.2836

[10] van Steenbergen-Weijenburg, K. M., van der Feltz-Cornelis, C. M., Horn, E. K., van Marwijk, H. W. J., Beekman, A. T. F., Rutten, F. F. H., & Hakkaart-van Roijen, L. (2010). Cost-effectiveness of collaborative care for the treatment of major depressive disorder in primary care. A systematic review. BMC Health Services Research, 10, 19. https://doi.org/10.1186/1472-6963-10-19

[11] Berkowitz, S. A., Terranova, J., Randall, L., Cranston, K., Waters, D. B., & Hsu, J. (2019). Association Between Receipt of a Medically Tailored Meal Program and Health Care Use. JAMA Internal Medicine, 179(6), 786. https://doi.org/10.1001/jamainternmed.2019.0198

[12] Hager, K., Cudhea, F. P., Wong, J. B., Berkowitz, S. A., Downer, S., Lauren, B. N., & Mozaffarian, D. (2022). Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US. JAMA Network Open, 5(10), e2236898. https://doi.org/10.1001/jamanetworkopen.2022.36898

[13] Hager, K., Alcusky, M., Zhang, F. F., Sing, G., Ash, A., Mick, E., Terranova, J., DiBacco, E., Buckler, S., Rich, A., Bowman, J., Folta, S., Prendergast, K., Frank, J., Ball, C., Chiang, J. S., & Mozaffarian, D. (2026). Medically tailored meals receipt and healthcare utilization and costs in Massachusetts' Medicaid demonstration. Nature Medicine. https://doi.org/10.1038/s41591-026-04407-5

[14] Tsering, D., Stauffer, C. M., Gittzus, J. A., Byhoff, E., & Taylor, L. A. (2023). "More than Just Checking the Box" Community Based Organizations on their Role in Medicaid Redesigns. Health Affairs Scholar, 1(5). https://doi.org/10.1093/haschl/qxad060

[15] Nohria R., Yu, J., Tu, K., Feng, G., Mcneil, S., Johnson, F., Lyn, M., & Scherr, K. (2023). Community-based organizations' perspectives on piloting health and social care integration in North Carolina. BMC Public Health, 23(1). https://doi.org/10.1186/s12889-023-16722-4

[16] Austin, S., & Qu, H. (2024). Community Health Workers Bridging the Gap: Connecting Medicaid Members with Providers, Managed Care, and Community-Based Organizations. Risk Management and Healthcare Policy, Volume 17, 2949–2958. https://doi.org/10.2147/rmhp.s482855

[17] Centers for Medicare & Medicaid Services. (2026, January). Behavioral health integration services (MLN Booklet). U.S. Department of Health and Human Services. https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf

[18] Centers for Medicare & Medicaid Services. (2023, December 5). Frequently asked questions about billing Medicare for Behavioral Health Integration services. U.S. Department of Health and Human Services. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/behavioral-health-integration-faqs.pdf

[19] Centers for Medicare & Medicaid Services. (n.d.). Health-related social needs. Medicaid.gov. Retrieved July 6, 2026, from https://www.medicaid.gov/medicaid/section-1115-demonstrations/health-related-social-needs

[20] Centers for Medicare & Medicaid Services. (n.d.). In lieu of services and settings. Medicaid.gov. Retrieved July 6, 2026, from https://www.medicaid.gov/medicaid/managed-care/guidance/lieu-of-services-and-settings

[21] Centers for Medicare & Medicaid Services. (n.d.). CCBHC Prospective Payment System (PPS) & Quality Bonus Payments (QBPs). Medicaid.gov. Retrieved July 6, 2026, from https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration/prospective-payment-system-pps-quality-bonus-payments-qbps

Prepared for strategic discussion. This paper is not legal, actuarial, or reimbursement advice. State Medicaid programs and payers should validate service definitions, provider qualifications, billing codes, budget neutrality, managed care contract requirements, and federal/state authorities before implementation.