health policy institute of ohio

Approaches to covering health-related social needs services through Medicaid

For consideration in Ohio by the HPIO Health-Related Social Needs Workgroup
September 16, 2024

The Health-Related Social Needs (HRSN) Workgroup is considering four approaches available to states to cover HRSN services through Medicaid:

1. **Changes to the Medicaid Managed Care Provider Agreement**
   a. Value-added services
   b. Community reinvestment
   c. In lieu of services and settings
2. **Waivers**
   a. Home- and community-based services waivers
   b. 1115 waivers
3. **State Plan Amendments**
4. **Children's Health Insurance Program (CHIP) Health Services Initiatives**

The information below is summarized from the HPIO report: "Leveraging Medicaid to Support Housing and Nutrition in Ohio."

1 Managed Care Provider Agreement

There are several ways that the Managed Care Provider Agreement—the contract between the Managed Care Organizations (MCOs) and the Ohio Department of Medicaid (ODM)—can be used to prescribe coverage of HRSN services:

1a. Value-Added Services

MCOs can voluntarily agree to offer services that are not required by ODM. In Ohio, an MCO must notify ODM that they plan to offer a value-added service; no approval from CMS is required. The MCO must demonstrate to ODM that the value-added services are readily available and accessible to members who are eligible to receive them for at least six months. Value-added services are not included when determining per-member, per-month payments to the MCOs. Instead, these services are paid for through the MCOs administrative costs.

Ohio implementation: **All Ohio MCOs offer value-added services**, including services that address HRSN such as non-emergency medical transportation, housing and employment navigation and home-delivered meals. Still, there is considerable variation in the value-added services that are currently offered by Ohio MCOs.

As stated in the Ohio Managed Care Provider Agreement, value-added services should be determined by the needs of the population in the region(s) served by the MCO. MCOs must offer value-added services consistently to every county within a geographic region of the state, as defined by ODM (regions: Central/Southeast, Northeast and West). If an MCO serves more than one region, they can vary availability of value-added services by region.

1b. Community reinvestment

Through their Managed Care Provider Agreements, states can direct MCOs to invest a portion of their profit and reserves into local communities, and MCOs may choose to invest in community-based organizations that address HRSN, including housing and nutrition.

Ohio implementation: ODM requires MCOs to participate in community reinvestment. As noted in the Managed Care Provider Agreement. MCOs must contribute 3% of after-tax profits to community reinvestment. This percentage will increase 1% each year to a maximum of 5%. Community reinvestment activities must align with the MCO's population health strategies, and MCOs are encouraged to work collaboratively to maximize the collective impact of community reinvestment funding.

In April 2024, Ohio's seven MCOs collaboratively granted $6.9 million in community reinvestment funds to community-based organizations primarily based in Cuyahoga and Athens Counties.

1c. In lieu of services and settings

"In lieu of" services and settings (ILOS) are cost-effective, medically appropriate substitutes or additions to Medicaid State Plan benefits. States must get approval from CMS to offer ILOS, which typically occurs during CMS's review of the state's Managed Care Provider Agreement. The state then gives the MCOs the option to offer approved services. Approved ILOS are considered when establishing an MCO's capitation rate, but approved ILOS cannot exceed 5% of the capitation rate.

For a state to provide ILOS, it must submit the name and definition of each ILOS to CMS, specify the covered services they replace, define each ILOS target population and require providers to use a consistent process to determine if the ILOS is medically appropriate for the patient. Once a state is offering ILOS, the state must meet the reporting and evaluation requirements determined by CMS.

New CMS guidance: In January 2023, CMS **issued guidance** to states on using ILOS to address unmet HRSN. In April 2024, CMS updated the **Medicaid managed care final rule**, which added specificity to how states can used the ILOS authority to address HRSN.

Ohio implementation: States, including Ohio, have commonly used the ILOS authority to address behavioral health. Ohio has no approved ILOS for HRSN services.

2 Waivers

ODM can submit a request to have certain federal Medicaid requirements waived to test new or existing ways to deliver and pay for health care services, including housing, nutrition and other HRSN services. These services must be cost-effective or cost-neutral, depending on the type of waiver requested.

2a. Home-and community-based services waivers

States can seek **1915(c) home and community-based services (HCBS) waivers** to provide services to those who would require institutional care in the absence of HCBS. These waivers are designed to serve a specific population, such as older adults and adults with disabilities, and are used to provide services, including housing and nutrition services, that allow people to stay in their homes or in the community, as opposed to inpatient facilities. States can limit services to certain areas (e.g., counties) and/or limit the number of people who can access services, further narrowing the target population for these services.

The HCBS waiver must be cost-neutral for the federal government. States need CMS approval after providing a public comment period for the proposal. The initial waiver is approved for three years and can be renewed in five-year increments.

Ohio implementation: Ohio has **eight approved HCBS waivers**, including the **MyCare Ohio Waiver, Ohio Home Care Waiver (OHCW)** and **PASSPORT Waiver** that include housing, nutrition and/or other HRSN services.

2b. Section 1115 demonstration waiver

Section 1115 demonstration waivers allow states to implement or test experimental, pilot or demonstration projects that promote the objectives of Medicaid and can lead to cost-effectiveness. In Ohio, the General Assembly must be notified that ODM plans to submit an 1115 waiver to CMS, and any state funding required to implement the waiver must be secured through the state operating budget or other appropriation. States also need CMS approval of the waiver after providing a public commenting period for the proposal. The initial waiver is generally approved for five years and can be renewed in five-year increments.

States can focus on a specific population for their 1115 waiver proposal, with the ability to limit services to geographic areas and/or cap the number of eligible people to limit the state's costs.

Through an 1115 waiver, states can receive federal funding for capacity building and federal financial participation for costs that would otherwise not be matchable federally. This flexibility in financing allows states to cover services and populations not included in their Medicaid State Plan.

New CMS guidance: Starting in December 2022, CMS began **issuing guidance** to states on using 1115 waivers to address unmet HRSN. This guidance includes more information about the limits CMS has placed on covering HRSN services through an 1115 waiver. For example, six months of rental assistance can be offered through an 1115 waver, but only for people experiencing significant life transitions, like those transitioning out of institutional or congregate care and youth transitioning out of the child welfare system.

Ohio implementation: Ohio has not pursued an 1115 waiver within the HRSN framework. Ohio does have an approved 1115 waiver related to inpatient and residential treatment for a substance use disorder.

3 State Plan Amendments

A Medicaid State Plan—an agreement between the state and federal government describing how the state will administer its Medicaid program—can be amended when a state decides to change how its Medicaid program operates, and that change does not require a waiver and is permissible under federal law.

There are limits to the types of services that can be approved through a State Plan Amendment (SPA). Services in the Medicaid State Plan must be either federally mandated or optional benefits allowable by CMS, and does not include many HRSN services. However, case management services are an optional benefit allowable by CMS for inclusion in State Plans and are included in the HRSN framework.

The services covered in an SPA must be available to all qualified members statewide. There is no federal budget neutrality or cost limit for this authority.

Ohio implementation: Ohio has several approved state plan amendments, but none of them are designated for supporting HRSN.

Other state example: California has an **approved state plan amendment** that added community health worker services to their state Medicaid benefits as of July 2022.

4 Children's Health Insurance Program (CHIP) Health Service Initiatives

The Children's Health Insurance Program (CHIP) offers health coverage to eligible children through Medicaid. Children eligible for CHIP come from families whose incomes are too high to qualify for Medicaid but too low to afford private health insurance. States are allowed to allocate a limited portion of CHIP funding to health services initiatives (HSIs) aimed at improving the health of eligible children.

CHIP HSIs can be used to address HRSN, including lead abatement, home visits, environmental modifications, emergency food relief and school-and-community-based youth violence prevention. States can fund HSIs using the administrative cost of CHIP, but the cost of HSIs and other administrative expenses for administering CHIP cannot exceed 10% of the total state's CHIP plan. States receive the federal CHIP matching rate for covering services under their HSIs.

To implement an HSI, states must submit a CHIP State Plan Amendment that describes the populations to be served, the ways in which the HSI will improve children's health and an updated CHIP program budget. Once CMS approves the HSI, the state is required to submit annual reports that include HSI outcomes, population served, number of children served and other metrics.

Ohio implementation: Ohio has an approved CHIP HSI that is being used for lead abatement.