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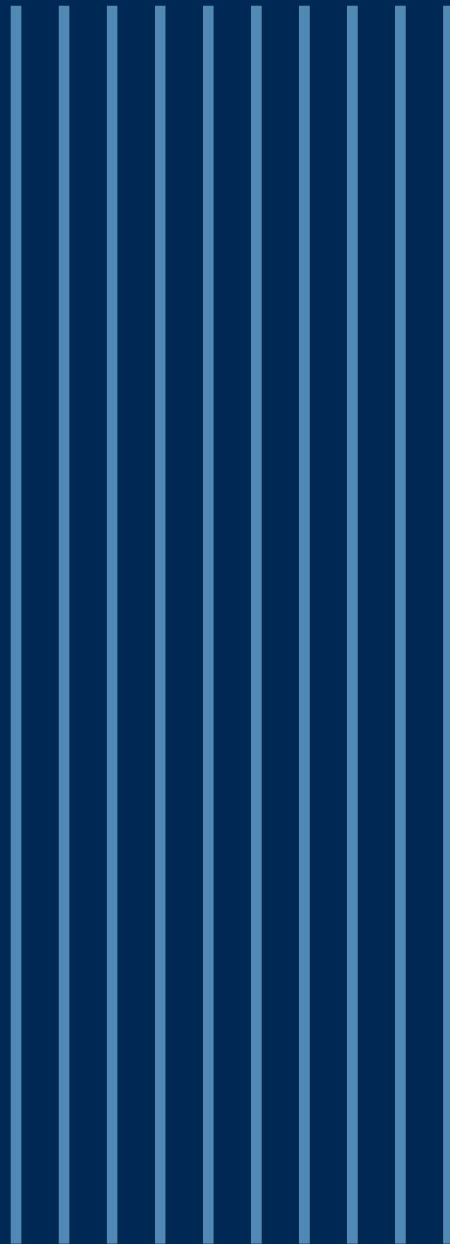
Leveraging Medicaid to support housing and nutrition in Ohio



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1 Introduction

Medicaid, a partnership between federal and state governments, was created in 1965 to provide health care services for people with low incomes who meet additional eligibility criteria. While the environments in which people live, work and play are foundational to good health, housing and nutrition supports historically have not been reimbursable Medicaid services for most Medicaid enrollees.

That changed in 2023. In recognition of the health impacts and costs of poor quality housing and nutrition, the Centers for Medicare and Medicaid Services (CMS) is offering **additional opportunities** to state Medicaid programs to pay for a discrete set of housing and nutrition services.

Purpose

The purpose of this report is to provide state and local partners across Ohio with:

- **Part 2.** An overview of the Ohio Medicaid program and a description of the federal Medicaid health-related social needs (HRSN) framework
- **Part 3.** An understanding of the reach of potentially Medicaid-reimbursable housing and nutrition programs operating in Ohio
- **Part 4.** Information about the approaches available to cover clinically appropriate, evidence-based housing and nutrition services through the Medicaid program
- **Part 5.** Opportunities and challenges associated with financing housing and nutrition services through the Medicaid program from state and national partners
- **Part 6.** Action steps that policymakers, health sector leaders, community-based organizations and philanthropic funders can take to support the financing of HRSN services through Medicaid

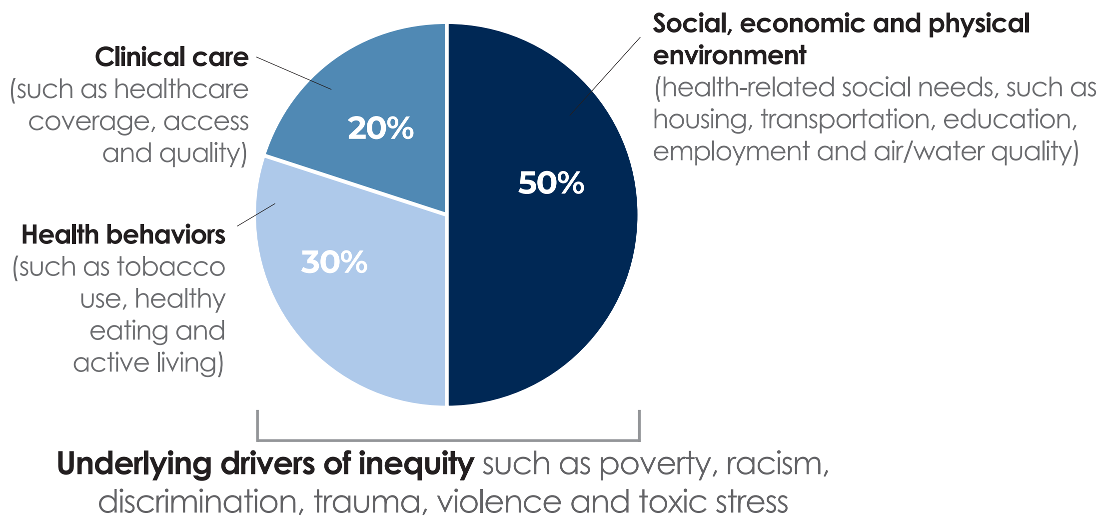
To achieve these goals, HPIO conducted a landscape analysis of the programs offering potentially Medicaid-reimbursable housing and nutrition services currently operating in Ohio (Part 3) and a series of 10 key informant interviews with state and national experts. Key informants from other states provided insights about how their state implemented a Medicaid financing approach for HRSN services (Part 4), and all key informants described the potential opportunities, challenges and impacts of Medicaid reimbursement options for HRSN services (Part 5).

Health-related social needs (HRSN)

HRSN are the social, economic and physical environment conditions that either enable or hinder opportunities for good health. These needs, sometimes referred to as the social drivers of health, include safe and affordable housing, healthy food access, reliable transportation, high-quality education, secure employment and clean water and air.

As displayed in figure 1.1, these factors are major contributors to health outcomes. Unmet HRSN also contribute to gaps in healthcare coverage and access, higher medical costs, barriers to healthy choices and the perpetuation of gaps in outcomes for communities with the most significant health challenges.

Figure 1.1. **Modifiable factors that influence health**

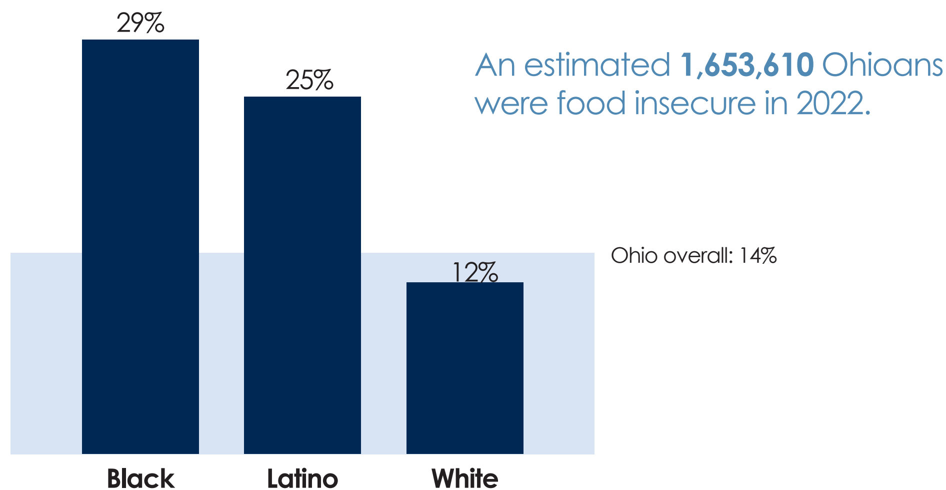


Source: Booske, Bridget C. et. al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.

Many Ohioans have unmet HRSN. For example, 14.1% of Ohioans are food insecure, meaning they lack consistent access to enough food for every person in the household to live an active, healthy life (as displayed in figure 1.2).

Figure 1.2. **Food insecurity in Ohio, by race, 2022**

Percent of Ohioans without access to enough food for an active, healthy life due to limited financial resources



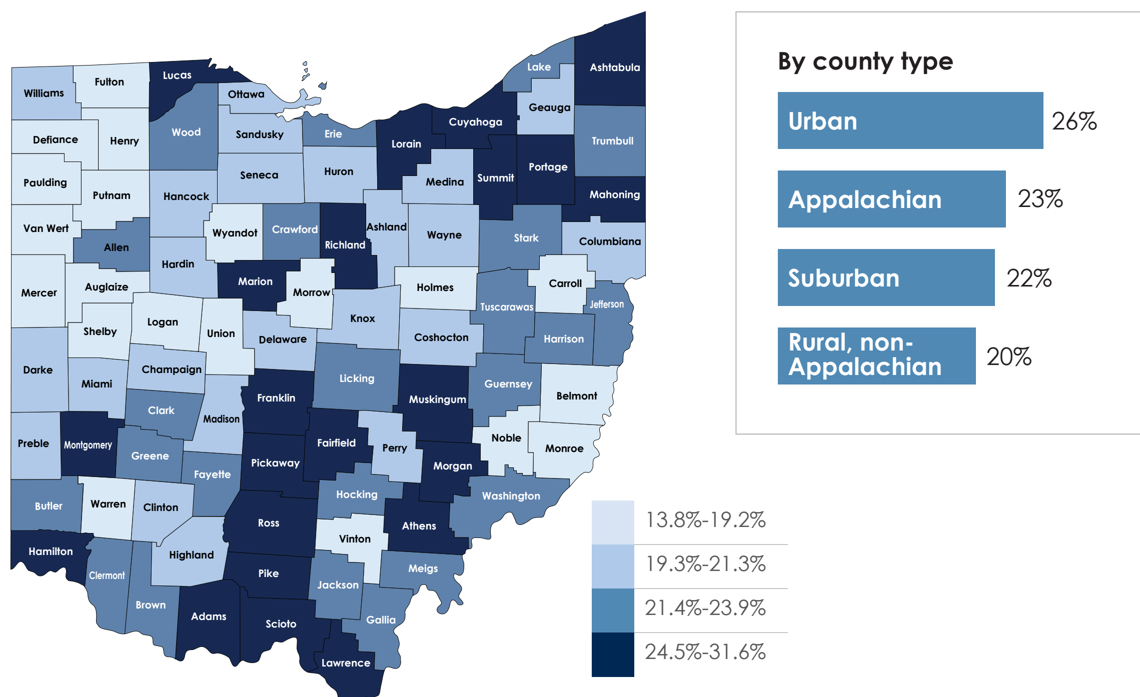
An estimated **1,653,610** Ohioans were food insecure in 2022.

Note: There may be overlap between the Black and Latino categories because "Black" refers to individuals whose identified race is Black or African American, including both Hispanic and non-Hispanic Black individuals. "White" refers to white, non-Hispanic individuals.
Source: Feeding America, Map the Meal Gap

Safe and stable housing is also foundational to good health. Housing influences access to jobs, healthy food, quality healthcare and educational opportunities and reduces stress.[1] Yet housing access is a challenge experienced across Ohio.

In 2022, Ohio only had 40 affordable and available rental homes per 100 extremely low-income renter households.[2] And once housing is secured, it is often unaffordable. Approximately 25% of Ohio renters and homeowners are housing cost burdened, spending 30% or more of their income on housing costs. As displayed in figure 1.3, people in urban counties are most likely to be impacted by housing cost burden, followed by Appalachian counties.

Figure 1.3. **Housing cost burden, 2022**
Percent of county population spending 30% or more of income on mortgage or rent



Source: HPIO analysis of American Community Survey, 2018-2022 5-Year Estimates

Inequities in health-related social needs

Every Ohioan should have the opportunity to live a long and healthy life, free from environments and experiences that expose them to harm. However, due to conditions and barriers to health in homes, schools, workplaces and communities, there are groups of Ohioans who disproportionately have unmet HRSN. This includes, for example, Ohioans of color, with disabilities, with low incomes, with low educational attainment, who are LGBTQ+, who are immigrants or refugees, who are older adults, and/or who live in rural or Appalachian regions of the state.[3] As a result, these groups tend to experience worse health outcomes.

2 Ohio Medicaid and the health-related social needs framework

Health-related social needs (HRSN), such as unstable housing, food insecurity and unreliable transportation can limit health potential. For this reason, state Medicaid programs are taking unprecedented steps to reimburse for HRSN-related services to improve health outcomes, reduce disparities and inequities and curb healthcare spending growth.

In recent years, the federal government, through the Centers for Medicare and Medicaid Services (CMS), has begun to offer state Medicaid programs increased flexibility to cover a subset of HRSN services; this flexibility is limited to certain housing and nutrition services, as well as case management related to these two types of services. Because Medicaid is jointly financed by the state and federal government, some of these opportunities could bring more federal funding to Ohio and address unmet needs.

Part 2 includes a brief overview of the Ohio Medicaid program, and a description of the housing and nutrition services that are potentially reimbursable through Medicaid.

Overview of Ohio Medicaid

The Medicaid program is a partnership between the federal and state government that pays for healthcare services for approximately 3.1 million Ohioans with low incomes, as displayed in figure 2.1. This includes more than 1.2 million children.[4] The Ohio Department of Medicaid (ODM) is the state agency charged with managing the Medicaid program in Ohio.

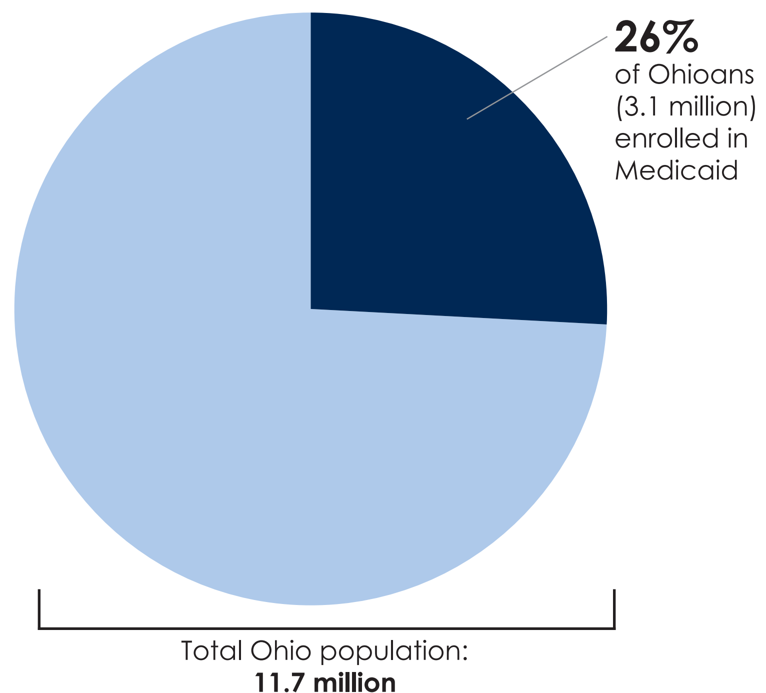
How is Medicaid funded?

Medicaid is funded jointly by the federal and state governments through a payment arrangement called the **Federal Medical Assistance Percentage (FMAP)** with the federal government financing a significant portion of all Medicaid-related service expenditures.[5] In state fiscal year (SFY) 2023, Ohio spent about $36 billion on Medicaid, with 73% coming from the federal government and 27% coming from the state's general revenue fund (GRF) and non-GRF state funding.[6]

Who is eligible for Medicaid coverage?

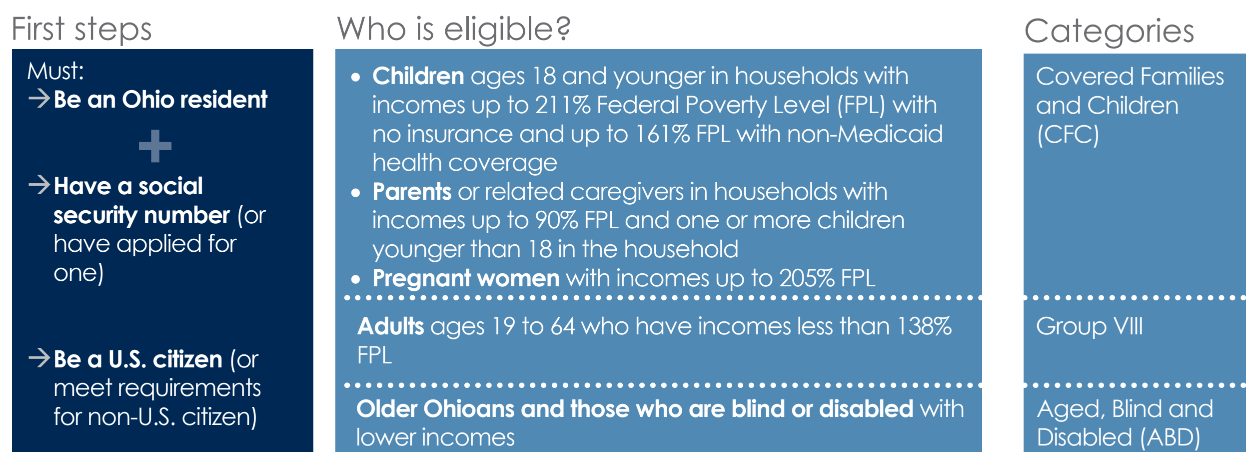
In addition to income, Ohio considers age, household characteristics and medical need in determining Medicaid eligibility and coverage (as shown in figure 2.2).[7] Most Ohioans enrolled in Medicaid fall within one of the following categories: Covered Families and Children (CFC), Group VIII, and Aged, Blind and Disabled (ABD).[8]

Figure 2.1. **Medicaid enrollment, May 2024.**



Sources: HPIO analysis of Ohio Department of Medicaid Demographic and Expenditure dashboard and U.S. Census Bureau, American Community Survey

Figure 2.2. **Overview of Medicaid eligibility**



Note: This graphic highlights the major categories of Medicaid eligibility in Ohio and is not comprehensive. See **Ohio Medicaid Basics 2023** for a more detailed explanation of all eligibility categories for Ohio Medicaid. People in need of Medicaid should apply at **benefits.ohio.gov**.

How does Ohio Medicaid pay for services?

In Ohio, most Medicaid coverage is provided through Medicaid Managed Care Organizations (MCOs). MCOs are privately-operated health insurance companies that contract with providers, such as physicians and hospitals, to deliver Medicaid-covered healthcare services to enrollees. MCOs operate under a **Managed Care Provider Agreement** with ODM, and ODM uses this contract with the MCOs to implement Medicaid policy decisions.

As of 2022, there are seven MCOs operating in Ohio[9]:

- AmeriHealth Caritas Ohio
- Anthem Blue Cross and Blue Shield
- Buckeye Community Health Plan
- CareSource Ohio
- Humana Health Plan of Ohio
- Molina Healthcare of Ohio
- UnitedHealthcare Community Plan of Ohio

Ohioans enrolled in Medicaid select their MCO. The MCOs pay for care in exchange for per-member, per-month payments from ODM that are set and adjusted annually.[10] Actuaries contracted by ODM calculate a capitation rate that is predicted to cover the cost of a defined package of benefits. A capitation rate has two main components:

- **Medical costs (projected benefit costs)** are the portion of the rate designed to cover the cost of providing medical benefits to enrollees.
- **Administrative costs (projected non-benefit costs)** are the portion of the rate that covers other MCO expenses, such as taxes, regulatory fees, risk margin, etc. (i.e., "the cost of doing business").

MCOs receive payments prospectively to cover the costs of serving their members and are "at risk" financially, meaning that the MCO must pay for expenses that exceed the amount received. Conversely, if expenses are lower than the payment, they keep the net revenue, realizing a profit.[11]

What services does Medicaid cover?

States are federally required to pay for a core set of services and can opt to cover additional services, as shown on page five of **Ohio Medicaid Basics 2023**.[12] Some services require a determination of medical necessity, prior authorization or a co-payment, and can also be limited in duration and scope. MCOs may also offer other services in addition to the traditional Medicaid benefits. For example, MCOs in Ohio voluntarily offer **value-added services**, such as wellness incentive programs and non-

emergency medical transportation, as additional benefits to their members (more information about value-added services available in Part 4).

ODM also partners with other state agencies to provide augmented services through various Medicaid waivers. For example, the Ohio Department of Aging administers the **PASSPORT Waiver** and the Ohio Department of Developmental Disabilities administers the **Individual Options, Level One and Self-Empowered Life Funding waivers** (more information about waivers available in Part 4).

HPIO's policy brief **Ohio Medicaid Basics 2023** contains more information about Medicaid eligibility, covered services, financing, spending and recent policy and programmatic changes.

Federal guidance to Medicaid programs on HRSN

In recognition of the health impacts and costs of the social drivers of health, CMS has **issued guidance** to state Medicaid programs on coverage options for HRSN services. This guidance includes:

- An **informational bulletin** on the rationale for covering HRSN services through Medicaid, which describes new opportunities to use **1115 demonstration waivers** and **in lieu of services and settings (ILOS)** to meet those objectives (more information in Part 4)
- A **table** describing the 15 housing and nutrition services that CMS will consider "allowable" for coverage under the Medicaid program (displayed in figure 2.3)

The guidance does not specify other HRSN services that could be approved for coverage, such as transportation. Case management is included as an allowable service under the HRSN framework as a means to connect people enrolled in Medicaid to housing and nutrition services.

As part of this guidance, CMS has determined that this set of housing and nutrition services is clinically appropriate and evidence based. The services must also be tailored to meet the needs of the Medicaid population. For example, CMS guidance states that, in order for home-delivered meals to be covered by Medicaid, they must be tailored to specific health risks, individualized to nutrition-sensitive health conditions (e.g., diabetes) and/or have demonstrated improvement in health outcomes.[13]

Medicaid coverage of these housing and nutrition services cannot replace funding from other federal or state agencies and must be integrated with existing social services in the state.[14]

Figure 2.3. **Potentially Medicaid-reimbursable housing and nutrition services**

Nutrition services	Service examples/additional detail, if applicable
1. **Case management** services for access to food and nutrition support	• Outreach and education • Linkages to other state and federal benefit programs, benefit program application assistance, benefit program application fees
2. **Nutrition counseling and instruction**	• Guidance on selecting healthy food • Healthy meal preparation
3. **Home-delivered meals or pantry stocking**,** including services tailored to children and pregnant individuals	Medically tailored meals to individuals at high risk of poor health outcomes, for example, pregnant individuals at risk of or diagnosed with diabetes
4. **Nutrition prescriptions****	• Fruit and vegetable prescriptions • Protein boxes • Food pharmacies • Healthy food vouchers
5. **Grocery provisions****	Grocery delivery service to high-risk individuals to avoid unnecessary acute care admission or institutionalization

Figure 2.3. **Potentially Medicaid-reimbursable housing and nutrition services** (cont.)

Housing services	Service examples/additional detail, if applicable
6. **Housing transition and navigation services**, including case management, without room and board (e.g., rent or other property costs)	• Pre-tenancy navigation services and services to find and secure housing • One-time transition and moving costs, such as security deposits, application fees, utilities activation fees and payment in arrears, etc. • Case management, including linkages to state and federal and state benefit programs, benefit program application assistance and fees, eviction prevention, tenant rights education
7. **First month's rent** as a transitional service	Securing housing with the first month's rent after release or discharge from an institutional setting
8. **Short-term pre-procedure and/or post-hospitalization housing*** with clinical services and supports	Housing costs for a rehabilitation facility after hospitalization for a clinically appropriate amount of time
9. **Caregiver respite****	Temporary placement of a Medicaid enrollee who otherwise lives at home into an institutional setting (e.g., nursing home) so that the enrollee's at-home caretaker can have a break from caretaking
10. **Up to six months of post-transition housing*** for people transitioning out of institutional or group care (such as for a substance use disorder), people experiencing or at risk of homelessness and youth transitioning out of the child welfare system	Post-transition housing may include integrated, clinically oriented recuperative or rehabilitative services and supports, and be limited to a clinically appropriate amount of time
11. **Up to six months of utility assistance*** for medically complex individuals	
12. **Day habilitation programs** to provide skills needed to live successfully in the community	Vocational habilitation programs, which provide learning and work experiences for people with developmental disabilities
13. **Sobering centers** with less than a 24 hour stay	Sobering centers are alternative locations for individuals who are publicly intoxicated, whether from alcohol or other drugs, who would typically be taken to the emergency department or jail.[15]
14. **Home remediations** that are medically necessary	• Air filtration, air conditioning and/or ventilation improvements • Refrigeration for medications • Carpet replacement • Mold and pest removal • Housing safety inspections
15. **Home/environmental accessibility modifications**	• Wheelchair accessibility ramps • Handrails and grab bars

*This service is considered "room and board" by CMS. Services that include room and board are generally only available through the 1115 waiver authority and are time-limited to a period of six months. Housing services that include room and board are limited to use by populations experiencing housing or care transitions, such as individuals who are homeless or are transitioning from an institution into the community

**This service may be considered "room and board" by CMS, depending on the design of the service. Nutrition supports are only considered room and board if the service provides three meals per day, and these supports can be authorized for additional six-month periods based on the need of the enrollee.

Sources: **Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)**, Centers of Medicare and Medicaid Services (CMS), November 2023 and **New Federal Guidance on Services Addressing 'Health-Related Social Needs' Under Medicaid**, Manatt, December 2023

3 Landscape analysis: Housing and nutrition services in Ohio

HPIO conducted a landscape analysis to identify programs delivering potentially Medicaid-reimbursable housing and nutrition services (as displayed in figure 2.3 above) currently offered throughout Ohio.[16] To compile the inventory of housing and nutrition programs, HPIO consulted a variety of sources, including:

- Program descriptions available from the Area Agencies on Aging and Community Action Agencies across the state
- A program inventory provided by the Ohio Association of Foodbanks
- Websites of other housing and nutrition service provider organizations
- Information received from subject matter experts

HPIO then counted the number of housing and nutrition programs identified in the landscape analysis by certain categories. This section includes key findings from that analysis.

The methodology used to complete this analysis is **available here.**

What types of potentially Medicaid-reimbursable housing and nutrition services exist in Ohio?

HPIO's analysis identified a total of 245 programs that are delivering potentially Medicaid-reimbursable housing and nutrition services, including 137 housing programs and 120 nutrition programs. Case management was the most common housing service (46 programs) and home-delivered meals and pantry stocking were the most common nutrition services (45 programs) identified in the landscape analysis.

Figure 3.1 highlights the number of identified housing and nutrition programs providing a potentially Medicaid-reimbursable service, categorized by the type of service the program provides.

There may be more programs across the state delivering potentially Medicaid-reimbursable housing and nutrition services than was captured by the landscape analysis. The **methodology document** describes the limitations of the analysis.

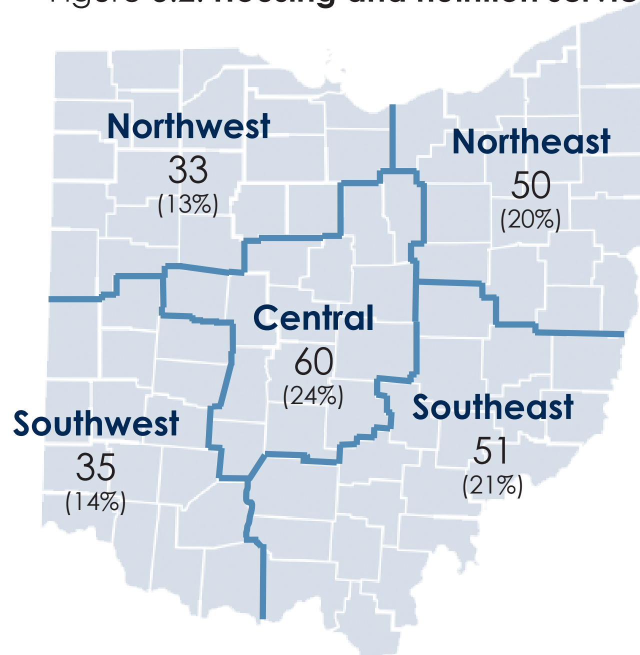
Figure 3.1. **Housing and nutrition programs, by potentially Medicaid-reimbursable service type, Ohio**

	Number of programs providing this service in Ohio
Nutrition	
Home-delivered meals/ pantry stocking	45
Nutrition prescriptions	20
Grocery provisions	19
Case management services for food/nutrition	18
Nutrition counseling and instruction	18
Housing	
Case management services for housing	46
Home accessibility modifications	24
Home remediations	16
Rental assistance	14
Day habilitation program	10
Housing transition and navigation services	10
Caregiver respite	9
Utility assistance	4
One-time transition/ moving costs	2
Sobering center	2
First month's rent, as a transitional service	0

Notes: These service types are defined by CMS. Figure 2.3 describes the service categories in more detail.
Source: HPIO analysis as of August 30, 2024

Providers across Ohio are delivering potentially Medicaid-reimbursable housing and nutrition services. HPIO's analysis identified the highest number of services serving Central Ohio (60 programs) and the lowest number serving Northwest Ohio (33 programs). Figure 3.2 highlights the number of programs per region.

Figure 3.2. **Housing and nutrition services, by region, Ohio**



Note: One nutrition program serves both Northeast and Central Ohio. The program is reflected in the counts for each region and has been accounted for in the percent calculations.
Source: HPIO analysis as of Aug. 30, 2024

Regional spotlight: Southeast Ohio

Twenty-one percent (21%) of identified housing and nutrition programs providing potentially Medicaid-reimbursable services are located in Southeast Ohio, a region with longstanding challenges with poverty and food insecurity.[17] There are many organizations in Southeast Ohio that are working to meet the housing and nutrition needs of their communities through potentially Medicaid-reimbursable services, such as:

- Community Action Agencies, including those in **Hocking - Athens - Perry (HAPCAP), Ironton-Lawrence, Washington-Morgan** and **Ross** Counties
- **SE Ohio Food Bank** (a program of HAPCAP **in partnership with Hopewell Health Center**)
- **The Appalachian Accessible Food Network**, including **Rural Action** and **Community Food Initiatives**
- Area Agencies on Aging, including **District 7** and **Buckeye Hills**
- Metropolitan Housing Authorities, including the **Athens Metropolitan Housing Authority**
- Behavioral health providers, such as **Integrated Services for Behavioral Health** and **Cedar Ridge Behavioral Health Solutions**
- Local health departments **in the Southeast region**

Who is providing these services and to whom?

HPIO's analysis identified 12 types of providers operating programs that provide potentially reimbursable housing and nutrition services in Ohio. These programs are frequently provided by Community Action Agencies, Area Agencies on Aging and independent non-profit housing and nutrition service providers. Figure 3.3 provides information on the number of providers identified in each provider type.

Figure 3.3. **Number of programs providing potentially Medicaid-reimbursable housing and nutrition services, by provider and service type, Ohio**

Provider type	All service providers	Housing services	Nutrition services
Community Action Agencies	76	56	20
Area Agencies on Aging	40	14	26
Independent non-profit housing or nutrition service providers	35	17	18
Foodbanks	25	None identified	25
Healthcare providers, including FQHCs	25	10	15
Local governments	11	11	None identified
Pathways Community HUBs	12	12	12
Religious organizations	6	6	None identified
Community coalitions	5	5	None identified
State agencies	4	4	None identified
Local health departments	2	None identified	2
Other (including universities, advocacy organizations, philanthropic funders and national nonprofits)	4	2	2

Note: The Pathways Community HUBs provide case management for housing and nutrition services (as well as other services). There are 12 HUBs in Ohio.
Source: HPIO analysis as of Aug. 30, 2024

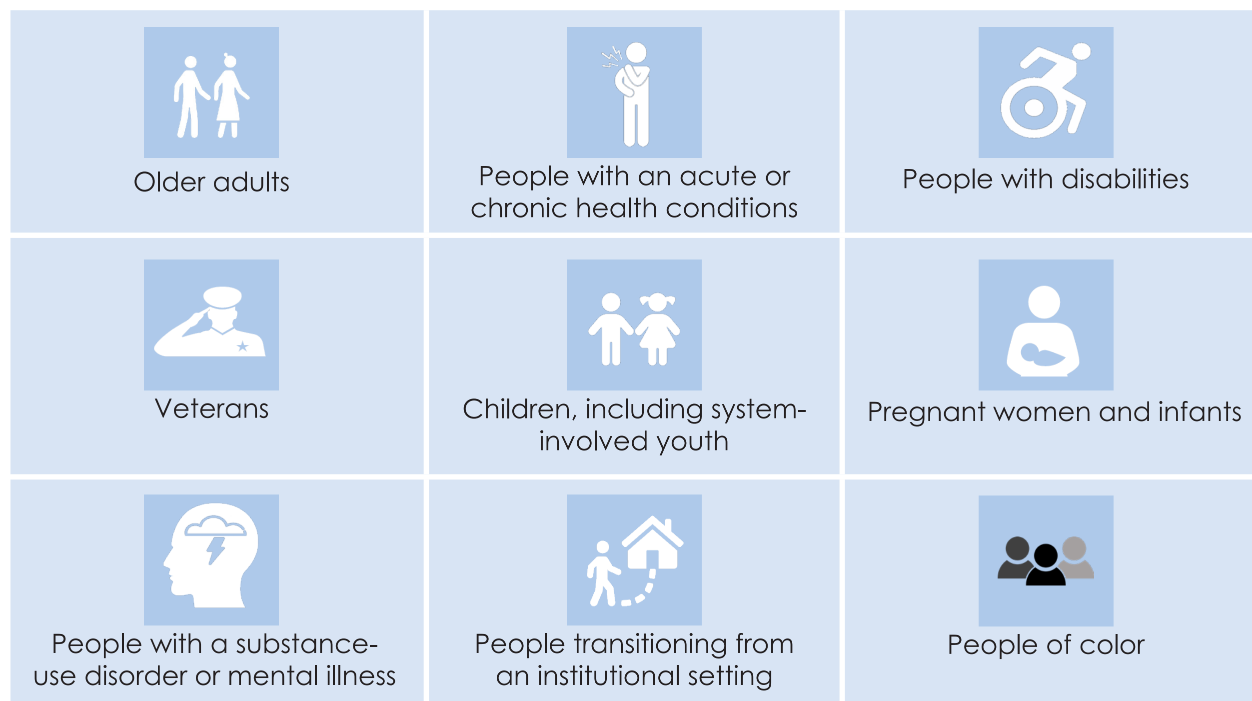
Provider spotlight: Foodbanks

Foodbanks across Ohio offer many of the potentially Medicaid-reimbursable nutrition services. Examples of the identified nutrition programs offered by foodbanks that deliver potentially reimbursable nutrition services include:

- **Healthy Communities** at the SE Ohio Food Bank: The SE Ohio Foodbank, which is operated by HAPCAP, utilizes community health workers to connect community members with other needed resources, like healthcare and healthy food access and housing.
- **Keeping Infants Nourished and Developing (KIND) Program** at the Freestore Foodbank and Cincinnati Children's Hospital: Clinic staff across 10 clinics screen patients for food insecurity, and provide baby formula to food insecure families, as well as connect them with nutritionists and social workers to help with long-term needs.
- **Lima Memorial Dialysis Clinic Distribution** at the West Ohio Foodbank: A partnership between the foodbank and the Lima Memorial Dialysis Clinic that provides on-site medically tailored grocery distribution for patients with kidney and renal failure to assist with their treatment.
- **Mid-Ohio Farmacy** at the Mid-Ohio Food Collective: A partnership between the foodbank and local healthcare providers that links patients to weekly access to fresh produce through local food pantries.
- **Therapeutic Food Clinics** at the Greater Cleveland Foodbank: Full-service food pantries located at health care provider locations, typically paired with food prescriptions with the aim of improving patient health outcomes.

All of these programs and potentially reimbursable services are designed to meet the needs of Ohioans with low incomes who are food insecure and/or experiencing homelessness or housing instability. In addition, many of the programs delivering the services are tailored to groups of Ohioans who are experiencing significant health challenges. Figure 3.4 lists the priority populations (i.e., populations for whom service providers tailor their programs) identified in the landscape analysis. People with an acute or chronic health condition and older adults were the most common priority populations identified.

Figure 3.4. **Priority populations served by housing nutrition programs**



How are HRSN services currently funded?

The programs providing potentially reimbursable HRSN services identified through the landscape analysis blend a variety of types of funding, such as philanthropy (including grants and individual giving) and local, state and federal dollars. This includes some Medicaid funding that is currently available (as described in Part 4). For example, Lifecare Alliance is providing home-delivered meals to older adults and adults with disabilities in Central Ohio, which is reimbursable through the Medicaid **PASSPORT Waiver** and/or **Ohio Homecare Wavier**.

Still, there are additional opportunities available at the federal level to reimburse providers for housing and nutrition services through Medicaid (described in Part 4), and HRSN services are not Medicaid benefits in Ohio. Because of this, most providers, especially community-based organizations, do not bill Medicaid. A variety of other barriers also exist to leveraging these additional approaches, including the time and cost to apply for approval from CMS and the political will/priorities of Ohio policymakers.

Some HRSN service providers have established creative partnerships with MCOs to finance their services, such as the Pathways Community HUBs (discussed below).

Provider spotlight: Pathways Community HUBs

As described in Part 2, certain types of case management services may be eligible for Medicaid reimbursement. In Ohio, the Pathways Community HUB model utilizes community health workers to connect clients with a variety of resources and services, including housing and food. While few of the other potentially Medicaid-reimbursable HRSN services included in the landscape analysis are supported by Medicaid funding, the care coordination services provided by HUBs are reimbursed by the MCOs. However, the HUB model is funded through the administrative portion of the MCOs capitation rate (see page 7 for more information), which are a limited set of funds.

HUBs bill MCOs when a client has been successfully referred to a service (i.e., the "Pathway" has been closed). Each Pathway has a unique billing code. That reimbursement is sent to the HUB-participating care coordination agency that employs the community health worker. There are **12 HUBs** operating in Ohio.

More information about the HUB model and reimbursement is available from the **Pathways Community HUB Institute**.

What does the research say about HRSN programs in Ohio?

There is strong evidence to support the provision of housing and nutrition services in the prevention and treatment of health conditions.[18] Many of the HRSN services identified in the landscape analysis are leveraging evidence-informed strategies in their modalities. Some programs are demonstrating positive outcomes through evaluations of their program. For example:

- **Healthy Beginnings at Home (HBAH) research pilot** was a randomized control trial which found that HBAH decreased Medicaid spending and NICU utilization among intervention participants. The pilot also demonstrated improved infant health outcomes but stipulated that a larger sample size is needed to affirm results.
- The **Mid-Ohio Farmacy program** from Mid-Ohio Food Collective completed **a pilot study** of the program in 2015. The study demonstrated improvements in fruit and vegetable intake and reduced A1C levels among participants with diabetes. Mid-Ohio Food Collective and the Ohio Association of Foodbanks are engaged in additional evaluation activities with the intention of expanding the program to more areas of the state.

- **Rural Action's Produce Prescriptions Program** received positive feedback from clients and has demonstrated a positive effect on participant food access and knowledge and food habits. For example, 45% of participants reported increased access to fruits and vegetables, and 29% reported increased fruit and vegetable intake, among other outcomes, because of the assistance received from the program.
- STAR House, a drop-in center for youth (ages 14-24) who are experiencing homelessness, has completed or participated **in several evaluations of their program** or youth drop-in centers overall. Emerging research on drop-in centers has found that they lead to improved housing stability, reduced substance use, increased self-efficacy and improved mental and physical health outcomes. STAR House, in particular, has also demonstrated improved nutrition outcomes.

4 Approaches to covering health-related social needs services through Medicaid

This part describes four types of approaches available to states to cover health-related social needs (HRSN) services through Medicaid:

- **Changes to the Medicaid Managed Care Provider Agreement**, including value-added services, community reinvestment, and in lieu of services and settings
- **Waivers**, including home- and community-based services waivers and 1115 waivers
- **State Plan Amendments**
- **Children's Health Insurance Program (CHIP) Health Services Initiative**

Some of these opportunities have existed for some time (e.g., value-added services, home- and community-based services waivers), while others are new flexibilities that CMS recently made available. Starting in 2022, CMS began releasing **guidance** on how states could use additional approaches, like 1115 waivers and in lieu of services and settings, to address HRSN.

While several other states have tapped into these opportunities and are paying for certain housing and nutrition services using Medicaid funds, Ohio has taken a different approach, requiring Medicaid Managed Care plans to reinvest in the communities they serve through grants and partnerships. Partners across the state are interested in exploring the full array of options to finance a set of housing and nutrition services through the Medicaid program.

Managed Care Provider Agreement

In Ohio, most Medicaid coverage is provided through Managed Care Organizations (MCOs). The **Managed Care Provider Agreement** is the contract between the MCOs and the Ohio Department of Medicaid (ODM). The agreement includes the MCOs' scope of work and requirements for providing Medicaid services in Ohio and are updated semiannually. CMS reviews and approves the state's Managed Care Provider Agreement each time it is updated.[19]

There are a variety of ways that the Managed Care Provider Agreement can be used to prescribe coverage of HRSN services, including:

- Value-added services
- Community reinvestment
- In lieu of services and settings (ILOS)

Managed Care Provider Agreement: **Value-added services**

MCOs can voluntarily agree to offer services that are not required by ODM. These are referred to as value-added services. 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.[20]

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.

Key informant state example: Oklahoma SoonerSelect and Value-Added Services

SoonerSelect is the new Medicaid Managed Care program in Oklahoma, which went live in February 2024. The Oklahoma Health Care Authority selected the following MCOs to provide managed care services: Aetna Better Health of Oklahoma, Humana Healthy Horizons of Oklahoma and Oklahoma Complete Health. In addition to providing required services, each MCO voluntarily provides value-added benefits to enhance and improve the health outcomes of enrollees. The Oklahoma Health Care Authority encouraged each MCO to include value-added services in their proposals based on community needs.[21]

Some HRSN services are included in the **value-added services** offered by MCOs in Oklahoma. For example:

- Food insecurity screenings and, if screened positive, a monthly and annual allowance for healthy foods
- Medically tailored meals for enrollees with high-risk pregnancies
- Nutrition counseling for enrollees with chronic conditions
- An annual allowance for housing expenses, including rent, mortgage or utility payments and moving expenses
- Legal assistance to maintain stable housing, address employment and/or educational issues, and expunge criminal records

It is projected that about 800,000 Oklahomans enrolled in Medicaid will benefit from the value-added services. Since SoonerSelect was recently launched, data on impact is not yet available.

Managed Care Provider Agreement: **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.[22]

Ohio implementation: ODM requires MCOs to participate in community reinvestment through the **Ohio Managed Care Provider Agreement**. As noted in the Managed Care Provider Agreement:

- MCOs must contribute 3% of after-tax profits to community reinvestment and increase this percentage by 1% each year to a maximum of 5%.
- Community reinvestment activities must align with the MCO's population health strategies (MCOs must design an approach to improving health and addressing health disparities as part of the provider agreement).
- MCOs across Ohio are encouraged to work collaboratively to maximize the collective impact of community reinvestment funding.
- MCOs must submit a Community Reinvestment Plan and Evaluation to ODM, and after the first year, MCOs must evaluate their previous community reinvestment activities

As part of their population health strategies, MCOs establish health equity goals. MCOs must identify health disparities in their service areas, connect with community members to understand community needs and partner with community-based organizations to address those needs. Community reinvestment grants may be aligned with these health equity goals.

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.[23] These grants were targeted at addressing local needs and social drivers of health to improve health outcomes in those counties. These grants included funding toward housing and nutrition programs, including grants to:

- **Hocking - Athens - Perry County Community Action (HAPCAP)** ($1.4 million) toward several nutrition programs in Southeast Ohio including a school-based food pantry, food as medicine, outreach to seniors on SNAP (food stamps) and home delivery of healthy food to people with limited mobility.
- **Star House** ($150,000) for the expansion of a Columbus-based 24/7 drop-in center for youth ages 14-24 who are experiencing homelessness, as well as a replication of the program in Toledo. The program offers resources, including an on-site medical clinic and employment and education assistance, as well as several studio apartments for those ages 18-24.
- **Greater Cleveland Food Bank** ($60,000) to support their new Community Resource Center that provides legal, education, healthcare and housing support in addition to food aid.

Other state example: Arizona is one of six states (including Ohio) that require community reinvestment from its MCOs. MCOs in Arizona must spend a minimum of 6% of after-tax profits from each line of business on community reinvestment activities. The Arizona Health Care Cost Containment System (AHCCCS, the state Medicaid agency) requires MCOs to align their community reinvestment activities with the state's **Whole Person Care Initiative** priorities, which include housing, non-medical transportation services, employment and education supports, social support enhancements and recidivism reduction activities. AHCCS has **more information available**.

Managed Care Provider Agreement: **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.[24] The state then gives the MCOs the option to offer approved services.[25] Approved ILOS are considered when establishing an MCO's capitation rate (page 7 contains more information), but approved ILOS cannot exceed 5% of the capitation rate.[26] ILOS must meet federal requirements for managed care services under **42 CFR 438.3(e)(2)**.[27]

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.[28] Once a state is offering ILOS, the state must meet the reporting and evaluation requirements determined by CMS.

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 have commonly used the ILOS authority to address behavioral health.[29] In Ohio, since July 1, 2017, ODM has allowed MCOs to cover short-term stays (15

days per month) in an Institution for Mental Diseases (IMD) (an inpatient behavioral health treatment facility with more than 16 beds[30]) for adults ages 21 to 64.[31]

Other state example: Michigan is introducing four federally approved ILOS to address nutrition in 2025. These ILOS include:

- **Medically Tailored Home Delivered Meals:** A fresh or frozen home delivered meal that is ready to eat and medically tailored for a specific disease or condition
- **Healthy Home Delivered Meals:** A nutritionally balanced, home delivered meal consisting of a hot, cold, frozen or shelf-stable meal aimed at promoting improved nutrition for the service recipient
- **Healthy Food Packs:** An assortment of medically tailored or nutritionally appropriate foods provided to a Medicaid enrollee
- **Produce Prescriptions:** A voucher offered by a provider for the Medicaid enrollee to purchase any variety of fruits and vegetables or plants/seeds that produce fruits and vegetables from a participating food retailer

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[32], including housing, nutrition and other HRSN services. These services must be cost-effective or cost-neutral, depending on the type of waiver requested.

Waivers that can be used to cover housing and nutrition services include:

- Home- and community-based services (HCBS) waivers
- Section 1115 waivers

Waiver:
Home- and community-based services

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.[33] 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.[34] 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.[35]

The HCBS waiver must be cost-neutral for the federal government.[36] 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 following examples that include housing, nutrition and/or other HRSN services:

Waiver	Services
MyCare Ohio	ODM administers the waiver and contracts with MCOs to offer services for enrollees 18 and over who are dual-eligible in certain counties. **Example of services:** Adult day services; alternative meal services; home-delivered meals; home medical equipment and supplemental adaptive and assistive devices; home modification, maintenance and repair; nutritional consultation; community transition; independent living assistance and transportation. **Enrollment:** 39,166 enrolled in SFY2023[47]
Ohio Home Care Waiver (OHCW)	ODM administers the waiver and contracts with case management agencies for case management services. The waiver is for adults under 60 years who need nursing facility level of care. **Example of services:** Adult day services, home-delivered meals, home modification, out-of-home respite, transportation and supplemental adaptive and assistive device. **Enrollment:** 9,113 people enrolled in SFY2023[48]
PASSPORT Waiver	The Ohio Department of Aging administers the waiver for individuals ages 60 and older who need nursing facility level of care and requires that the individual be able to remain safely at home with physician consent. **Example of services:** Adult day services, alternative meal services, home-delivered meals, nutritional consultation, transportation (including non-medical transportation), home improvement (e.g., minor home repair, maintenance and modification), homemaker and personal care services and independent living assistance. **Enrollment:** 24,962 enrolled in SFY2023[49]

Sources: Medicaid.gov, Ohio Legislative Service Commission and Ohio Department of Medicaid

Other state example: **Connecticut** has an approved HCBS for Elders Waiver that provides services for enrollees who are ages 65 or older and who need nursing facility level of care. The services include home delivered meals, transportation, care management, respite care and environmental accessibility adaptations.[37]

Waiver:
Section 1115 demonstration

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[38], and any state funding required to implement the waiver must be secured through the state operating budget or other appropriation.[39] 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.[40]

States can focus on a specific population for their 1115 waiver proposal[41], with the ability to limit services to geographic areas and/or cap the number of eligible people to limit the state's costs.

Under section 1115, states can waive two typical Medicaid requirements[42]:

- **Statewide requirement:** Medicaid services must typically be available throughout the entire state
- **Comparability requirement:** Medicaid services must typically be provided in the same amount, duration and scope to all beneficiaries

Under an 1115 waiver, these requirements can be waived in order to focus services on specific populations or conditions.

1115 waivers must be budget-neutral for the federal government, but CMS offers flexibility for spending on HRSN. States can receive federal funding for capacity building and federal financial participation for costs that would otherwise not be matchable federally.[43] This flexibility in financing allows states to cover services and populations not included in their Medicaid State Plan.

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.[44]

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 (SUD).[45] The waiver gives ODM the ability to cover high-quality, clinically appropriate treatment for enrollees with SUD during short-term stays in residential and inpatient treatment settings.[46]

The KFF **Section 1115 Medicaid Waiver Watch provides more** information about approved HRSN 1115 waivers in other states.

Key informant state example: North Carolina Healthy Opportunities Pilots

North Carolina's approved Section 1115 waiver provides funding to community-based organizations and MCOs to provide eligible Medicaid enrollees with a variety of non-medical services to address food, housing, interpersonal violence and transportation needs through the **Healthy Opportunities Pilots (HOP)** program. The program predominately serves Medicaid enrollees in three rural regions of the state. HOP was launched in multiple phases, starting with the food and nutrition services in March 2022, housing and transportation in May 2022, toxic stress in June 2022 and interpersonal violence services in April 2023.[50]

- **Summary of services:** HOP reimburses providers for a broad set of services, including those related to food and nutrition, housing and utilities, transportation, interpersonal violence and toxic stress, for a broad range of Medicaid enrollees, including children and pregnant individuals with qualifying clinical conditions.
- **Funding:** North Carolina received $650 million over five years in federal Medicaid funds to support the pilots to connect patients to social services with the ability to use up to $100 million for capacity building.
- **Payment approach:** To pay local organizations for services rendered, North Carolina set up an invoicing model and developed a technology platform that converted the invoices into Medicaid claims. In addition, North Carolina set up a network-led model to help local organizations build capacity, provide training and technical assistance and improve overall business practices. The majority of services invoiced by local organizations are reimbursed by HOP within 30 days of submission.
- **Impact:** As of June 2024, HOP has provided over 455,000 services to more than 20,000 Medicaid enrollees and their families, which accounted for over $87 million in reimbursement to local service organizations. An initial assessment of the HOP found that, in 2022, food services made up 90% of services delivered, and 63% of people enrolled in HOP received at least one invoiced service.[51]

The North Carolina 1115 waiver predates CMS' HRSN guidance. The Healthy Opportunities Pilot was included in the context of North Carolina's 1115 waiver to establish managed care in their state.[52]

State Plan Amendments

A Medicaid State Plan is an agreement between the state and federal government describing how the state will administer its Medicaid program. The state must follow all federal laws, as well as specify which individuals and services will be covered. 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, the state can submit a State Plan Amendment (SPA) to CMS for review and approval.[53] Approved SPAs are publicly available on **Medicaid.gov**.

There are limits to the types of services that can be approved through an SPA. Services in the Medicaid State Plan must be either federally mandated or optional benefits allowable by CMS[54], 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. HPIO's **2023 Medicaid Basics contains** more information about the optional services that are covered in Ohio's State Plan.

The services covered in an SPA must be rehabilitative in nature and 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. However, 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. These services address a wide variety of health and social needs and include services such as health education, screening and assessment, navigation to services and individual support or advocacy to prevent health conditions or harm to enrollees.[55] The list of benefits includes medical services, such as delivery of medications, as well as HRSN, such as employment and transportation services.[56]

Home- and community-based services (HCBS) State Plan Amendment

In addition to providing HCBS services through a waiver, states can add these services to their Medicaid State Plan through a **1915(i) State Plan Amendment** (SPA). A 1915(i) SPA must specify the HCBS benefits included, and the specific population(s) targeted by the benefit.

Minnesota uses this approach to provide housing stabilization services to people with disabilities, including qualifying older adults and people with mental health conditions and substance use disorders. These services are intended to support an individual's transition into housing, increase long-term stability in housing in the community and avoid future periods of homelessness or institutionalization.

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.[57] States are allowed to allocate a limited portion of CHIP funding to health services initiatives (HSIs) aimed at improving the health of eligible children.[58]

CHIP HSIs can be used to address HRSN. In **guidance to states**, CMS has indicated some example HRSN services that states can provide using HSIs, 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.[59] States receive the federal CHIP matching rate for covering services under their HSIs.[60]

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.[61] 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. ODM is partnering with the Ohio Department of Health to administer the program. Under this program, CHIP HSI funds are used to install water filters in homes, lead abatement on surfaces and fixtures, as well as education and outreach support to low-income parents and pregnant women who have lead poisoning.[62] The initiative is for children under the age of 19 and pregnant women.

ODM's website provides more information about Ohio's CHIP State Plan, including information about the CHIP HSI.

Other state example: New York has a **CHIP HSI** that provides emergency food and nutrition services to children who are food insecure.

For additional information on several of these approaches (1115 waivers, HCBS authorities, ILOS, and CHIP HSI), see The Center for Health Law and Policy Innovation report "**Food is Medicine: A State Medicaid Policy Toolkit**."

Federal requirement: Social Determinants of Health Risk Assessment

As of January 2024, CMS requires hospitals and other inpatient healthcare settings to assess patients for HRSN, also known as social determinants of health. This requirement is included in the **2024 Physical Fee Schedule**, and includes five domains that must be assessed:

- Food insecurity
- Housing insecurity
- Interpersonal safety
- Transportation needs
- Utility difficulties

Data from these assessments must be reported to CMS by May 2025.

While there is no requirement that healthcare systems connect patients to HRSN services, the availability of this data can inform state and national strategies to best support HRSN services to meet the identified need.

5 Key informant findings: Opportunities and challenges related to Medicaid financing of health-related social needs services

To gather insights on the potential impacts of Medicaid reimbursement for housing and nutrition services in Ohio, HPIO conducted 10 key-informant interviews with 16 participants. Eight of the interviews were with Ohio-based organizations in the housing, nutrition and/or healthcare sectors:

- Coalition on Homelessness and Housing in Ohio (COHHIO)
- Corporation for Ohio Appalachian Development
- Hocking - Athens - Perry County Community Action (HAPCAP)
- Ohio Association of Community Action Agencies
- Ohio Association of Community Health Centers
- Ohio Association of Foodbanks
- Produce Perks Midwest
- UnitedHealthcare

The final two interviews were with organizations in other states that reimburse for health-related social needs (HRSN) services through Medicaid:

- FreshRx Oklahoma
- North Carolina Department of Health and Human Services

Key findings on the opportunities and challenges associated with Medicaid financing for housing and nutrition services are described below.

What opportunities are associated with developing pathways for reimbursement of certain types of HRSN services?

Opportunity to expand the financial resources available for HRSN services

Ohio key informants indicated that organizations providing housing and nutrition services are blending a variety of funding sources, including government grants, philanthropic support and private donations to provide HRSN services. Many of these funding sources are competitive, and the amounts awarded are not guaranteed in each funding cycle. Key informants were hopeful that Medicaid reimbursement could improve the stability and sustainability of their programs, in addition to their current sources of funding. Moreover, they see these opportunities as a possible means to expand programming and broaden their reach within the communities they serve.

> "So, one funder's priority might be women who are pregnant, and another funder might be really interested in the health of seniors. That leads to different delivery methods, different types of food, and all that. So, I'd say [we currently receive] primarily philanthropic and private dollars, piece meal and one-time limited funding."
>
> — Ohio key informant

Opportunity to fill the gap left by pandemic-era funding

Key informants highlighted that some social service and healthcare service providers, such as Community Action Agencies and Community Health Centers, received additional funding during the COVID-19 Public Health Emergency (PHE). Now that the PHE has ended and pandemic-era funding

is running out, some key informant service providers recognize that they will not be able to maintain current levels of services and staffing without additional funding.

Community members also had additional support available during the PHE, including expanded **SNAP**, **TANF** and **Medicaid** benefits. According to one key informant, as these expanded benefits end, providers expect to see an increase in the need for housing and nutrition services in the coming years, which will require more funding to provide.

> "Rental assistance has been done and they [community members] need help. We will see more people with evictions and homelessness in three years."
>
> ". . . so, there's a big question around how in the world we're going to support all these organizations through GRF [General Revenue Fund] funding as we're running out of TANF dollars… we do need to find another place to fund programs like this."
>
> "We received a lot of federal dollars [during the COVID-19 pandemic] that are absolutely going away and so there's a lot of strain on [service providers] that had to use those dollars to just keep their doors open..."
>
> — Ohio key Informants

Opportunity to expand care coordination of HRSN services
Key informants noted that Medicaid coverage could better reimburse and expand their ability to connect people to housing and nutrition supports using care coordination. This was mentioned most often among partners who employ or work closely with community health workers (CHWs). Key informants noted that funding for CHWs comes from various sources, including philanthropic funding and modest Medicaid reimbursement through the Pathways HUB model. Key informants believe that Medicaid reimbursement could expand the impact of CHWs and other care coordinators and, if direct billing is possible, streamline the payment process for their services.

> "… we can't bill for case management. We can't bill for community health workers. We can't bill for peer support. . . So, anything that's happening in those spaces, [providers] are having to creatively finance through private foundations and other sources of funding."
>
> — Ohio key Informant

Opportunity to improve health and economic outcomes
Key informants expressed their opinion that, with increased funding for the housing and nutrition services their association members and peer organizations offer, they can reduce housing and food insecurity and improve health outcomes.

> "[A community member] talked about the impact of food insecurity on the health of her and her family. You know, they lost a job. They lost their other resources. They became unstable. They became homeless, they experienced food insecurity. And [community member] described that through that couple of year period, their health problems got much, much worse, much more complex, more difficult to manage. We, as emergency food assistance providers, are critical to supporting the health of individuals who experience food insecurity."
>
> — Ohio key informant

Additionally, key informants expressed that improving access to food and housing has direct impacts on the Ohio economy. Key informants also believed that, by reducing toxic stress related to concerns about food and housing, Ohioans are more likely to secure and maintain employment. One key informant also found that Medicaid funding for HRSN can serve as an economic driver for community-based organizations and businesses providing housing and food services.

> "Having more customers for produce at their local stand or a grocery store [because community members are taking part in a nutrition program] means a lot to the work of the food economy."
> — Ohio key informant

Opportunities to reimburse for housing and nutrition are promising
While each approach has positives and negatives, key informants were optimistic about many of the housing and nutrition funding flexibilities available from the Centers for Medicare and Medicaid Services (CMS).

For example, key informants mentioned that the 1115 waiver option would most significantly increase the funding available for housing and nutrition services and would expand the types of services that could be covered by Medicaid. Key informants also believed that the in lieu of services (ILOS) option could be more quickly implemented to fund existing services. Some key informants preferred a unified statewide strategy for reimbursing HRSN services that would be possible under an 1115 waiver, while others saw value in individual MCOs covering unique services through ILOS and the competition that would create among the MCOs. Several key informants noted that the Ohio Department of Medicaid has not indicated interest in applying for an 1115 waiver on HRSN.

Community reinvestment was also positively mentioned by several key informants, noting ways this funding is currently used to support housing and nutrition services. Key informants found that community reinvestment could be better tailored to address specific HRSN and emphasized the importance of funding local organizations who have deep knowledge of the needs of their communities.

> "Healthcare is an entitlement environment where there is lots of legal resources, there's lots of money, there's lots of capacity and I think that the 1115 options are very clear about providing those infrastructure dollars to community-based organizations to help level that playing field, which is such a significant pro of the 1115."
>
> "I feel like the in lieu of services [option] is the easier pathway to start with while working on the Medicaid waiver."
>
> "Yes, for sure, we definitely have agencies who are recipients of community reinvestment funding, but even external to that, we know one 'agency', that I happened to know better than some of the others, is working separately with some of the managed care [organizations].
> — Ohio key informants

What <u>challenges</u> are associated with developing pathways for reimbursement of certain types of HRSN services?

Challenges related to the lack of capacity and infrastructure needed to bill Medicaid
The resources, expertise and technology infrastructure required to engage with the Medicaid system were frequently mentioned challenges by key informants. Several discussed the complexities of the reimbursement process, which can lead to delays and difficulties in receiving payments. Workforce challenges, coupled with lack of funding, can exacerbate the challenge of building this organizational capacity. Key informants also mentioned that it can take up to 90 days to receive Medicaid reimbursement for services, which is difficult for many community-based organizations to withstand. One key informant also noted that some local partners may be better positioned to bill Medicaid than others, and partnerships between local organizations could alleviate some of this burden.

> "That is the question, what infrastructure needs to be built? Not can they do it [bill Medicaid for services]. Because why would we [nutrition service providers] have the infrastructure to do it?"
> — Ohio key informants

> "The smaller ones [community-based organizations], it's not of benefit to them to get that billing infrastructure in place. It's too expensive and time consuming. They just can't afford it."
>
> "We would love to figure out a way… for health centers to be able to have a contract with a managed care plan or with Medicaid itself where they are getting a per member per month reimbursement or some of the things that we're talking about. Because I think they know their patients best and they also know their communities best, and they're going to be the very best stewards of the most efficiently putting that money to work."
>
> — Ohio key informants

Key informants in other states also noted that billing infrastructure has been a challenge. Technical issues and data-sharing constraints were barriers that needed to be overcome in order for community-based organizations and the Medicaid program to work together.

> "The other challenge is there were invoicing challenges because these are brand new policies: brand new for everyone and brand-new systems. And so that brought challenges for organizations on how to utilize the systems or if a change happened in the system that we did not foresee."
>
> — Key informant (other state)

Challenges related to the ability to expand HRSN programs to scale

For a housing or nutrition service to become a Medicaid benefit under most CMS authorities, it must be able to be offered to all eligible Medicaid enrollees.[63] Key informants expressed concern about their ability to scale their services so that they could be eligible for Medicaid reimbursement or to handle the number of referrals that may come to their organization once their services are included as Medicaid benefits. Another challenge mentioned by one key informant is that it can be difficult to expand a service in the way Medicaid might need without the consistent funding that could be available through Medicaid.

> "The concern is how are you going to serve all the [Medicaid] members?... We've got to offer it to everyone who would be eligible. That's probably one of the biggest challenges… scaling. We have to raise all this money and be big enough to then contract [with Medicaid] and have a [funding] pathway, but we need the funding pathway [in order] to grow."
>
> "A lot of these organizations that are providing services and need infrastructure support… Medicaid organizations do not traditionally provide funds to build capacity and to do the accounting on the back end. It's usually reimbursement based. These organizations do not have the [capacity-building] funding available but can provide the services if they are provided with the infrastructure upfront to be able to stand up capacity."
>
> — Key informants (other state)

Challenges related to individual-level vs. household-level services

Healthcare services are offered to individual patients, and the Medicaid system is designed to bill for services provided to individual patients. However, key informants described how many housing and nutrition programs are designed to serve families in need. When an individual is screened as food insecure, it is likely that their family is also affected, and they will share the resources made available to them. Key informants noted that this challenge should not be used as a reason not to fund HRSN services through the Medicaid program.

> "Household is tricky because it is critically important, right? That is the reality of how food works for families. It is a household level… and that's a little uncomfortable for the healthcare system because healthcare system is used to, if you're the patient, you get this prescription drug, and if your kid is on a different plan, then we bill a different system for that drug."
>
> — Ohio key informant

Challenges related to the availability of affordable housing or nutritious food in Ohio communities
Care coordination and navigation services are a central component of the HRSN services potentially covered by Medicaid. However, key informants noted that while these services are helpful, they are limited by the resources available in communities. Medicaid funding cannot be used to address some of the root causes of HRSN, such as the existence of food desserts and the lack of safe, affordable housing.

> "There's real limits to [care coordination services] when there are no options… these are problems we can't case manage our way out of… We even see this in the food space with some of the home-delivered meal stuff is definitely very valuable. We definitely have a lot of people who are very geographically isolated and could benefit from the expansion of those kinds of services."
>
> "So with the home and community-based services, you have to have the services available. That's equally a challenge, along with the availability of [housing] units."
>
> — Ohio key informants

Challenges related to navigating available services
Several key informants expressed concern about the complexity of the Medicaid program for those who are enrolled, and how people are not always informed of the benefits they already have. This is particularly true given the recent large-scale changes to the Medicaid program as part of the **Next Generation of Ohio Medicaid Managed Care** approach. Key informants expressed concern that, if additional HRSN services became covered services under Medicaid, communicating about that change to Medicaid recipients and people at all levels of the provider organizations would be a challenge.

> "Most members continue to not know the benefits and services that are currently available to them. Very rarely, except for people who are super savvy, do people really know that they can get driven to a grocery store, that they can get taken to the pantry. So, I think more visibility for all that kind of stuff is helpful."
>
> "You have to let everyone [in the organization] know from top to bottom that this is how it works from the case managers who might be helping support and make sure folks learn how to do billing… [We ask people to] please do this and folks forget."
>
> — Ohio key informants

Reflections from other states: State and community buy-in

Key informants from other states both mentioned the importance of buy-in from state policymakers and community-based organizations for successful launch of HRSN reimbursement through Medicaid. Leadership from the state Medicaid agency, legislature and other policymakers is critical for building collaboration and developing the necessary statewide infrastructure.

> "It was critical to have senior leadership buy-in… in the [state Medicaid] department. I think that the bigger challenge comes in with getting buy-in from within the state… We had to get legislative support within the state well-aligned to be able to meet state funding components that would be needed."
>
> "But I knew then, in 2021, that there was just a lot of interest and support and it was very bipartisan... And our healthcare authority who governs our state Medicaid has been involved from the beginning."
>
> – Key informants (other states)

Community buy-in is also needed to ensure that state policy is implemented in ways that match community needs, and that organizations are working together, sharing information and building a new infrastructure together. One state found that large-scale direct service providers, who received the majority of the contracts to provide Medicaid nutrition services (meal provisions), were less familiar with the needs and cultures of local communities, including food preferences. It was noted that community members did not like the food that was offered and did not eat the items provided. Local organizations may be more aware of the cultural needs and preferences of their communities and may be able to provide meal provisions that community members are more likely to eat and enjoy. Key informants found that community buy-in for service delivery was a key ingredient for success.

6 Next steps

Partners across Ohio can support the sustainable financing of health-related social needs (HRSN) services. Below are a set of action steps that state and local leaders, including policymakers, Medicaid Managed Care Organizations (MCOs), healthcare system leaders, community-based organizations (CBOs) and philanthropic funders, can take to:

- Determine and advance an approach Ohio can take to finance housing and nutrition services through Medicaid
- Build capacity and infrastructure within community-based organizations and state systems
- Support implementation of a state strategy to finance HRSN services through Medicaid
- Evaluate the impact of Medicaid funding for HRSN services

Strategic collaboration among these partners can also increase momentum and advance the statewide conversation about securing additional Medicaid funding for these programs through one of several flexibilities offered by CMS. The following action steps have been identified based on the findings of the landscape analysis and key informant interviews.

Step 1 Determine and advance an approach Ohio can take to finance housing and nutrition services through Medicaid

1. **Medicaid financing approach**. MCOs, CBOs, healthcare systems and other partners can review this report and explore the advantages and disadvantages of the various approaches available to finance a set of housing and nutrition services through Medicaid (described in Part 4).
2. **Policy leadership**. MCOs, CBOs and funders can prioritize a set of housing and nutrition services that could be Medicaid-reimbursable services in Ohio, determine how the state could benefit from Medicaid coverage of those services and develop a policy action plan.
3. **Policymaker engagement training**. CBOs and policy experts can provide training to other partners on how to engage with policymakers, including legislators, ODM, and MCOs, on issues related to Medicaid HRSN funding and related policies.

Step 2 Build capacity and infrastructure within community-based organizations and state systems

4. **Data transparency**. MCOs can improve data sharing (e.g., service authorization, referrals, service outcomes) with CBOs, and work together to create a universal standard for data sharing.
5. **Data standards**. CBOs, MCOs, health systems and policymakers can work together to establish data standards for housing, nutrition and other HRSN services and implement those standards into policy, practice and payment models. Stakeholders in Ohio can consider the Gravity Project as a national resource in data standards.
6. **Technology and software systems**. CBOs can acquire, and philanthropy can fund, the implementation of secure technology systems that meet the standard for Medicaid billing, service authorization, referrals, MCO contracting and HIPAA compliance.
7. **Capacity-building support**. Funders can support CBOs' ability to scale their programs so that the services they offer may cover more people enrolled in Medicaid and/or be eligible for inclusion as a Medicaid benefit. This could include core operating support and capacity-building projects such as the hiring of additional staff and the purchase of equipment (e.g., refrigerated trucks for transporting food).

step

3 Support implementation of a state strategy to finance HRSN services through Medicaid

8. **Medicaid policy change**. ODM can partner with Centers for Medicare and Medicaid Services to make policy changes necessary to cover a set of housing and nutrition services in Ohio.
9. **Legal assistance for CBOs**. CBOs can acquire, and funders can fund as needed, legal assistance to increase understanding of the Medicaid program and negotiating contracts and terms with ODM or MCOs.
10. **Model contracts**. ODM and/or MCOs can work together to create model contracts between MCOs and CBOs to reduce administrative burden and ensure parity in contract terms between agencies.
11. **Technical assistance (TA) coalition**. CBOs can develop a TA coalition which assists local organizations with Medicaid billing, contracting and enhancing internal policies. TA can also include partnering with state and national Medicaid experts who can provide specific or general expertise.
12. **Billing structure**. ODM, MCOs and CBOs can identify alternatives to individual CBOs billing Medicaid for HRSN services, including exploring examples from other states (such as North Carolina) that have established billing structures that alleviate administrative burden.
13. **Upfront funding to supplement reimbursement lag**. Funders can provide loans or grants to close the gap between when a provider delivers a service and when they are reimbursed by Medicaid for the service. It can take weeks or months for service providers to receive Medicaid reimbursements, leaving small organizations especially financially vulnerable.
14. **Fill gaps in funding that cannot be covered by Medicaid**. Funders can continue to fund housing and healthy food access services cannot be covered by Medicaid, such as long-term rental assistance and the purchase of food for pantries.

step

4 Evaluate the impact of Medicaid funding for HRSN services

15. **Community reinvestment funding assessment**. MCOs, in partnership with CBOs that have received community reinvestment funding, can assess the approach, identify outcomes and provide recommendations on how to best align the community reinvestment dollars to community needs.
16. **Program evaluation**. Policymakers can require and CBOs can perform process and outcome evaluations of the HRSN services programs offered in Ohio to understand the impact on access to housing and nutrition, health outcomes, healthcare spending and equity.

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