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Addressing social determinants of health through Medicaid: Lessons for Ohio from other states

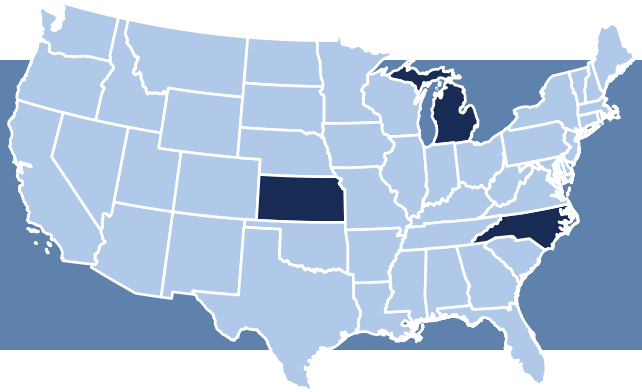
The Medicaid program was created in 1965 to provide health care services for people with low incomes who meet additional eligibility criteria. Although access to healthy food, safe housing and other community resources are foundational to good health, these social supports have not typically been reimbursable Medicaid services for most Medicaid enrollees.

However, in recognition of the health and economic impacts of housing and nutrition supports, the federal and state governments have expanded Medicaid funding mechanisms to address the social drivers of health in recent years. As a result, state Medicaid agencies and Medicaid managed care organizations (MCOs) have increasingly offered services that address members' social needs to improve health outcomes.

For example, in 2018, the Centers for Medicare and Medicaid Services (CMS) approved North Carolina's application to provide housing, nutrition, and other social services to Medicaid enrollees in select counties. This application was approved under the social drivers of health framework of the first Trump administration, while subsequent waivers were approved between 2022 and 2024 under the Biden administration's health-related social needs framework. These frameworks provided state Medicaid programs with opportunities to reimburse for a discrete set of medically necessary housing and nutrition services. States continue to offer these services through a variety of approaches and policy mechanisms.

This report highlights findings from three states that have covered housing and nutrition services through Medicaid. Although these states have used different methods, some consistent lessons learned have emerged:

1. **Gather and respond to feedback** from the wide array of groups involved with providing reimbursable nutrition and housing services during both policy development and rollout.
2. **Balance standardization and flexibility** when shaping requirements to administer and deliver reimbursable housing and nutrition supports, particularly with community-based organization (CBO) contracting, data exchange across groups and service eligibility.
3. **Develop a deliberate and connected infrastructure** that can help bridge and coordinate the multi-sector groups involved with delivering reimbursable housing and nutrition supports to enrollees.
4. **Emphasize and embed evaluation** from start to finish to understand how addressing social needs through Medicaid impacts health outcomes and costs, thereby demonstrating value and encouraging service utilization.



For more information on the experiences of other states developing and implementing Medicaid reimbursement for services related to social drivers of health, see **Understanding Lessons Learned** starting on page 3.

Multisector partners from across Ohio informed this report, including Medicaid MCOs and CBOs that provide housing, nutrition and care coordination services.

More information on the flexibility states have to support housing and nutrition services through Medicaid and approaches that have been prioritized for Ohio is available in the following:

- **Leveraging Medicaid to support housing and nutrition in Ohio (September 2024).** Describes the opportunities that were available for covering clinically appropriate, evidence-based housing and nutrition services through the Medicaid program. While some of these opportunities remain available, others were created under federal guidance during the Biden Administration, which has since been **rescinded**.
- **State policy roadmap: Leveraging Medicaid to support housing and nutrition in Ohio (March 2025).** Recommendations from a workgroup of CBOs and health system professionals on actionable next steps for policymakers and other state leaders to leverage these opportunities effectively.

Focus states

The lessons contained in this report were gathered from North Carolina, Michigan and Kansas. More information on how these states were selected can be found in the Methodology on page 11.

North Carolina

North Carolina's Medicaid program has years of experience covering social determinant of health (SDOH) services through a section 1115 demonstration waiver. This waiver was initially approved by CMS in 2018. In addition to establishing a Medicaid managed care program, the waiver created the **Healthy Opportunities Pilots** (HOP) which provided evidence-based housing, food, transportation and interpersonal safety services to high-needs Medicaid enrollees.

HOPs provided services to three rural regions of the state through a hub model that utilized network leads. The network lead organizations developed a network of community-based service providers in each region, providing technical assistance and serving as a bridge between the health plans and CBOs. North Carolina received $650 million over five years (Nov. 2019 – Oct. 2024) in federal Medicaid funds to support the pilot sites, with the ability to use up to $100 million for capacity building. State funding was dedicated to the pilot program and used to draw down these federal funds.

Funding for the HOPs ended on July 1, 2025 due to a lack of appropriations in the 2025-2027 North Carolina state budget.[1] During the pilot demonstration, HOP provided over 1.1 million services to more than 40,000 Medicaid enrollees and their families, which accounted for $237.4 million in reimbursement to local service organizations.[2] **An evaluation** of the HOPs found that these interventions can reduce cost of care, with documented declines in emergency department visits, hospitalizations and per-member spending.

What is a Section 1115 demonstration waiver?

Section 1115 demonstration waivers (i.e., 1115 waivers) allow states to waive some typical Medicaid requirements so that they can implement experimental or pilot projects to improve health outcomes and reduce healthcare costs. States with approved 1115 waivers receive federal funding for capacity building to implement the pilot services.

Michigan

In January 2025, Medicaid MCOs in Michigan began offering a set of federally approved "in lieu of" services and settings (ILOS). These **four ILOS** are geared toward addressing Medicaid members' nutrition needs.

Michigan MCOs can optionally offer the following ILOS services: Medically tailored home delivered meals, healthy home delivered meals, healthy food packs and produce prescriptions. The providers of these services, who are eligible to bill Medicaid for service delivery, are primarily CBOs (e.g., farmers markets, food pantries), healthcare providers and local health departments.

What are "in lieu of" services and settings (ILOS)?

ILOS are cost-effective, medically appropriate substitutes for 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 Medicaid MCOs the option to offer the approved services.[3] This model does not come with federal matching dollars for capacity building or service reimbursement.

Kansas

Medicaid MCOs in Kansas began providing their members with a set of **approved ILOS** as of January 1, 2025. Several of these services address the social determinants of health, including home delivered meals, adult day services and nutritional education. These services are offered as cost-effective, medically appropriate alternatives to traditionally covered services to help prevent higher-cost treatments, such as long-term care in nursing facilities.

Understanding the lessons learned

Through 10 interviews with key informants in the selected states, four key lessons emerged. These lessons can guide the development and rollout of reimbursable housing and nutrition supports within Medicaid programs in other states. These lessons span from initial policy creation to evaluation of outcomes, emphasizing important areas for decision-making and deliberation. Across this trajectory, the specific model chosen to structure Medicaid reimbursement for nutrition and housing services (e.g., ILOS; 1115 waiver) shapes the potential barriers to successful uptake, requiring careful consideration from policymakers throughout the entire process. More information on the interviews and analysis can be found in the Methodology on page 11.

Gather and respond to feedback

Lesson learned 1

Gather and respond to feedback from the wide array of groups involved with providing reimbursable nutrition and housing services, during both policy development and rollout.

Regardless of the specific approach taken, all selected states prioritized convening and gathering feedback from a variety of partner organizations during the policy development process. This is especially important given the various groups involved with administering and delivering services for housing and nutrition to Medicaid recipients, ranging from health and human services administrators, health plans, CBOs, intermediaries (described more on page 8) and more.

Each of these groups have their own specific interests and needs that can be addressed through policy development. For instance, health plans in focus states frequently acknowledged the importance of measuring impacts of housing and nutrition supports, including uptake, health outcomes and cost of care, while CBOs often described the barriers they faced with billing Medicaid for services.

One important aspect of this work was recognizing the existing context surrounding nutrition and housing supports in each state. Several health plan and CBO informants had prior experience with delivering these services on a smaller scale. For instance, health plan informants in Kansas described their existing programs that delivered nutrition supports to Medicaid enrollees, though these efforts tended to be narrower and dependent on less consistent funding sources. At times, this prior context meant that existing infrastructure or knowledge existed, serving as important groundwork for eventually achieving a formal reimbursement structure through Medicaid. Still, bringing all these experiences together required deliberate effort and engagement, as described by a key informant in North Carolina:

> **"I think a lot of folks are working on food as medicine, health related social needs, but there was no reimbursement structure really behind it… and so this really was the first step in North Carolina to kind of bring all of the different parties together from provider to payer to [CBO]. So I think a lot of people were doing it and then this kind of was an opportunity for us to all come together and really work towards what all of our missions are."**
>
> — North Carolina key informant

States gathered feedback through a variety of related approaches:

- Michigan's Department of Health and Human Services conducted a survey of providers and beneficiaries and held nine learning collaborative sessions with health plans, providers, CBOs and other interested parties. The state's Medicaid MCOs and nutrition-related CBOs recognized these efforts as a valuable opportunity to offer their perspective on the Medicaid reimbursement policy and potential avenues to improve it.
- North Carolina held forums around the state to engage the various groups that would be involved across the different pilot sites and build understanding of the waiver model.
- Leaders in Kansas also emphasized the importance of convening when tailoring their ILOS approach, recognizing how this step facilitates service uptake.

> **"We wanted to be collaborative about it because you know… if we don't have the buy in and we don't have the understanding of the utilization of services, we're going to get a lot of abrasion and not a lot of buy in from the providers and others to participate."**
>
> — Kansas key informant

Adapting policy to accommodate stakeholder needs

Engaging stakeholders and soliciting feedback was important not only for understanding each group's needs and interests, but also to shape the policy itself. Gathering and incorporating these multi-sector perspectives could also help refine or improve the model once rollout of housing and nutrition supports began. North Carolina embodied this refinement lens throughout the implementation of the HOP, particularly with how the network leads bridged the space between health plans and CBOs. For example, the state originally prioritized the development of billing infrastructure for CBOs as a core component of the entire model. While this was an important task, a level of recalibration was necessary to meet the objectives of the policy.

> **"I think one thing that North Carolina did is we really structured HOP, at its early implementation at the leadership level, as a technology innovation. That was, I think we've repeatedly said, a mistake. This is where the innovation comes, is in centering the strength of community-based organizations and centering the network leads as truly an entity that can bring together community-based organizations and MCOs. The technology supports that collaboration."**
>
> — North Carolina key informant

Balance standardization and flexibility

Lesson learned 2

Balance standardization and flexibility when shaping requirements to administer and deliver reimbursable housing and nutrition supports, particularly with community-based organization (CBO) contracting, data exchange across groups and service eligibility.

The decisions that states make on how to structure reimbursable housing and nutrition supports are particularly important in the context of the interconnected relationships between health plans, CBOs and the service recipients themselves. Across the different potential reimbursement policies, states must thoughtfully decide how to structure the overarching process through which a nutrition or housing service is sourced, paid for and delivered. Decisions can favor standardization, where stakeholders follow unified processes regardless of underlying context, or flexibility, where CBOs, health plans and other groups can create processes that are tailored to their specific needs.

> **"If you've got eight plans operationalizing something completely differently, that can be challenging for providers to try to navigate. But there's flexibility there too, and so there can be, you know innovations and benefits that come out of that flexibility."**
> — Kansas key informant

The tenuous balance between standardization and flexibility, which can impact policy uptake and service utilization, was illustrated by key informants across three areas: CBO contracting, data exchange and service eligibility.

CBO contracting

Decisionmakers in each state, including the state agency leaders who helped design the policy, acknowledged the importance of local context for successful service delivery. Local CBOs often have direct ties to the communities they serve and can tailor supports to meet the specific needs of the population. Contracting with local CBOs can also keep funding within the state, supporting regional economies.

On the other hand, local CBOs may have limited capacity and little to no experience providing Medicaid-billable services. National organizations that deliver supports like medically tailored meals tend to have experience with Medicaid billing and additional logistical resources to meet service demand, which sometimes requires working in a large region where delivery must be fast and wide-ranging. However, this can come at the expense of meeting particular population needs, as national organizations are unlikely to have direct community connections.

One key difference across the three selected state approaches was the flexibility allowed with contracting CBOs to deliver nutrition and housing services. Michigan's ILOS policy prioritized the benefits of having local service providers, requiring that at least 30% of providers contracted to deliver nutrition supports are locally based. Given the nature of the ILOS model, which does not come with capacity-building funding like an 1115 waiver, this created challenges for service availability and uptake. Many local CBOs in the state lacked the infrastructure to work directly with Medicaid health plans or bill for Medicaid reimbursement. In other words, the system relied on local organizations to deliver services, but those same organizations were often unable to participate under traditional managed care requirements.

> **"Honestly, I think the biggest hurdle is just that the policy is really, really prescriptive when it comes to local providers, so local community-based organizations. There are some requirements on the percentages of providers that must be local, that has been probably the biggest barrier and the fact that a lot of these community-based organizations do not have the infrastructure to do billing for encounters."**
> — Michigan key informant

North Carolina faced similar tension with local versus national CBOs, but leaned on its network-led intermediary structure (described in more detail on page 7) to identify organizations that could meet the particular needs of each region. This approach was facilitated by the funding that comes with approved 1115 waivers, allowing network leads to directly support small CBOs during the process of building infrastructure to deliver and bill Medicaid for nutrition or housing supports.

Kansas, on the other hand, took a more flexible approach, allowing health plans to contract with any CBOs that could provide the services that were part of the ILOS policy. These could be national CBOs that have substantial prior experience billing Medicaid and other health programs for nutrition or housing supports. For health plans that were already providing similar services for specific populations through home and community-based services waivers and similar mechanisms, these vendors sometimes overlapped in the state.

KEY TAKEAWAY: Local providers can tailor services to meet population needs

Local service providers offer direct connections to the communities receiving services and can tailor services to meet population needs, but also frequently require additional capacity-building support to be able to work as a Medicaid entity.

Data exchange

Stemming from the contracting of CBOs, another area with variation across states was the requirements for data exchange, particularly as it relates to billing. As previously mentioned, CBOs (particularly local organizations) may not always have the necessary infrastructure for the complex interchange of data, some of which may be protected health information for Medicaid recipients. Michigan's local CBO rule required more flexibility in this space, given that many of these organizations did not meet all the conventional standards for billing as a Medicaid entity.

> **"You cannot expect them to come up to your level of where you want them to be… from day one. If all they can do is submit an invoice to you, then you have to accept that invoice and then you turn it into a claim that then comes into your system."**
> — Michigan key informant

North Carolina leveraged a commercial uniform billing platform called Unite Us that CBOs and network leads could use to track referrals, send invoices and remain in continuous contact with other groups. These efforts required significant levels of onboarding and training, especially for organizations that had little experience working with Medicaid. Despite these challenges, the standardized approach taken by the state had important benefits, especially when it came to overarching data collection for the pilot.

> **"It definitely has its quirks in terms of billing. It is not our favorite for billing… It can be very difficult to not only invoice, but also track your reimbursements because it just goes like invoice by invoice rather than like patient by patient. So, it was quite cumbersome in that, but it was a great opportunity for us to kind of have a closed loop referral system that not only we were using, but other organizations were using as well."**
> — North Carolina key informant

KEY TAKEAWAY: Unified data exchanges can create more cohesive system

Unified data exchange between CBOs, health plans and other entities like care managers requires significant upfront investment but can create a more cohesive data system once fully implemented.

Service eligibility

One final dimension where flexibility and standardization varied across states was the identification of specific populations that were eligible for nutrition and housing supports. Given the research base that demonstrates the overarching health benefits of healthy food access and stable housing, broad sets of condition categories for service eligibility can be beneficial, reaching a larger Medicaid population. Michigan, for example, included wide-ranging clinical risk factors for ILOS eligibility. Earlier versions of the policy allowed Medicaid enrollees to qualify for nutrition ILOS with not only physical health conditions but also some mental health conditions (though this was eventually revised to focus on physical health conditions only).

The use of broader condition categories had downsides, however, mainly in tying nutrition supports to improvements for specific disease states. Some stakeholders also worried that rapid uptake of service referrals could overwhelm infrastructure, especially in context of the ILOS model where there is no funding for implementation of the policy or direct reimbursement for services themselves.

> **"I think that what I see as the most difficult part is that plans really would like to test this policy, but they want to test it in a way in which they control more variables. And I actually think that that would have led to higher volume from the beginning if they could say, for instance, we would like to work with this disease state and we would like to start in the Detroit metro area like we're going to work in the five counties of [the] Detroit metro."**
> — Michigan key informant

Key informants in Kansas also identified with the importance of selecting specific conditions that could benefit from the selected nutrition and housing ILOS. Focusing on very specific disease states allows for more direct measurement of service impact, which can be important for long-term sustainability of these models.

KEY TAKEAWAY: Broad nutrtion, housing support eligibility maximizes uptake

Broad recipient eligibility for nutrition and housing supports can maximize the uptake of policies to address social drivers of health but can create difficulties in assessing direct impacts on specific disease outcomes and cost of care.

In summary, across the areas of CBO contracting, data exchange and service eligibility, focus states took varying approaches to policy design and implementation, at times prioritizing flexibility over standardization, or vice versa. These decisions contributed to the ability of states to increase service availability and uptake. Importantly, the availability of funding for building capacity and establishing core infrastructure was critical to the eventual outcomes and consequences of these decisions.

Develop a deliberate and connected service delivery structure

Lesson learned 3

Develop a deliberate and connected infrastructure that can help bridge and coordinate the multi-sector groups involved with delivering reimbursable housing and nutrition supports to enrollees.

Central coordination and an intermediary structure are essential when implementing complex, multi-sector policies such as those involved with reimbursing nutrition and housing supports through Medicaid. There are significant challenges with aligning fundamentally different systems—such

as health plans and food banks—that often operate with distinct languages, expectations and capacities. Without a central coordinating entity, even basic communication can break down: state guidance may be interpreted differently by health plans, while CBOs may struggle to navigate billing, contracting and compliance requirements. An intermediary bridges these divides by translating across stakeholders, ensuring that all involved operate from a shared understanding.

Intermediary role in delivering reimbursable nutrition and housing supports

Connecting Medicaid enrollees with nutrition and housing services is a cross-sector initiative requiring collaboration across groups that may not have existing relationships and communication infrastructure, including between health plans and the CBOs that source and deliver the services. Intermediaries can bridge these gaps and coordinate key functions to facilitate policy uptake and service delivery.

In North Carolina's HOP Model, intermediaries called network leads worked directly with CBOs (called Human Services Organizations in their model), creating the network of organizations to develop capacity to work with Medicaid health plans and deliver services.

North Carolina's HOP demonstrates how this intermediary role functions when it is intentionally designed into the system. There, state leaders established a "hub model," in which network leads served as formal intermediaries between health plans and CBOs. These entities were not only responsible for contracting and ensuring network adequacy, but also building foundational infrastructure and CBO capacity through onboarding processes, standardized expectations and technical assistance for billing, data reporting and other functions. While some organizations are equipped to contract directly with health plans, many prefer to focus on service delivery and rely on network leads for administrative support. By offering model contracts, capacity building support and standardized processes, the intermediary reduces barriers to participation and enables a more inclusive and effective provider network.

> **"You know, a lot of times it's like, well, why a network and why don't you just have a health plan do direct contracting with a food organization… I think the biggest thing about having a network is that collective impact. It is shared metrics, it is shared data, but it is also quality improvement."**
> — North Carolina key informant

In Michigan, stakeholders described difficulties connecting state policy, health plan expectations and provider capabilities. Even when policy goals were clearly defined, each group operated within its own "language" and set of norms, potentially leading to confusion around functions like billing, contracting and service delivery. For CBOs, particularly those new to Medicaid, simply learning how to engage with MCOs posed a significant barrier. While learning collaboratives created shared spaces for communication, they also highlighted the need for a more formalized intermediary structure that could continuously translate, align and operationalize policy across stakeholders.

From the managed care perspective in Michigan, these challenges were further compounded by structural constraints. As previously described, health plans were required to contract with local providers, yet many CBOs lacked the infrastructure, such as technology, billing systems and compliance capacity, to meet contracting standards. In response, some stakeholders, such as the state's food bank network, began to informally assume intermediary roles, serving as central points of contact that relayed information between the state, health plans and local CBO partners.

> **"We triangulate a lot of information between the plans, our local partners and the department. So we're kind of right in the middle. There actually aren't a lot of community-based organizations participating in the implementation right now. So other than our network and then a couple of other meal providers, we have become kind of the voice of the . . . community-based organizations initial experience with implementation with this policy."**
> — Michigan key informant

Emphasize and embed evaluation

Lesson learned 4

Emphasize and embed evaluation from start to finish to understand how addressing social needs through Medicaid impacts health outcomes and costs, thereby demonstrating value and encouraging service utilization.

Evaluation efforts across Michigan, North Carolina and Kansas reveal interconnected challenges shaped by policy design, data limitations and competing definitions of value. Evaluation of ILOS is still taking shape, especially in Michigan, where the flexible approach has enabled the state to start with qualitative, process-focused approaches and gradually build toward more rigorous evaluation of outcomes over time. In contrast, 1115 waivers require a more formal and standardized approach to evaluation from the start, which has produced stronger evidence early on.

Across states, stakeholders emphasize people-centered outcomes, such as improved quality of life and care engagement, as foundational. However, these considerations must be balanced with the MCO's requirement to demonstrate return on investment (ROI), even when benefits are not easily monetized. This is especially true for an ILOS approach where there is no allocated funding for service reimbursement, as the nutrition and housing supports are designed to "replace" health care utilization. New research evidence continues to support the impacts of services addressing health-related social needs on cost of care for patients with high social risk,[4] but these savings may not be immediately realized.

Because of this, a key challenge is connecting outcomes to cost. Stakeholders highlighted the difficulty of attributing social interventions, such as food supports, to specific health outcomes, particularly for complex populations, alongside limited access to claims data and insufficient IT infrastructure. These constraints are more pronounced in Michigan and Kansas, where evaluation capacity is still developing. At the same time, cost of care remains the primary driver of successful policy uptake: programs are expected to break even, despite delayed savings and significant upfront investments in services and infrastructure, creating financial risk and caution around scaling.

> **"There's no funding in the health plan line for them to provide these services. There's an expectation that there's going to be some type of ROI, but that ROI is not going to be seen right away and then you're also working with community-based organizations that don't have the infrastructure that they need or that the plans need to be able to contract with them. So, then you're not just investing in the benefit, you're you also have to make some investments."**
> — Michigan key informant

Evaluation of ILOS implementation in Michigan underscores how limited upfront financing constrains both investment and service utilization. As one stakeholder noted, "*one of the most difficult parts about this policy is that because there aren't funds flowing directly to the MCO's… they have no start-up funds… so they have to make a business decision about how much money they're going to invest.*"

The lack of embedded start-up or capacity-building funding with the ILOS model may drive cautious behavior, where health plans prioritize limiting costs, even if future savings are expected from

substituting medical treatments with nutrition supports: "*. . .the policy is very big, but the plans are very reticent to spend.*" This resulted in a slower than expected rollout. From an evaluative standpoint, slower initial uptake not only limited early access to services but also slows the production of evidence needed to demonstrate value.

These evaluation barriers for ILOS approaches can be contrasted with a waiver-based model, where evaluation is not only required but also partially funded by the federal government. North Carolina's 1115 waiver provides the strongest evidence that these interventions can reduce cost of care, with documented declines in emergency department visits, hospitalizations, and per-member spending.

Across states, stakeholders also pointed to broader community and economic benefits, such as job creation and local investment, though these are not typically captured in Medicaid cost frameworks. This highlights an ongoing policy tension: ILOS and similar interventions must demonstrate measurable financial value for the health plans, even as their broader social impacts remain difficult to quantify.

> **"I think that we need to be very cautious in making the distinction between helping underserved communities because they are poor and they need food and quality food, which is the right thing to do, which that is related to systematic issues and then the concept of the utilization of nutrition to support health improvement . . . because we mix those concepts, then it's very hard to prove concepts. . . We are using food to rescue people that are hungry or that are struggling, but this is not going to have an impact on their health. I mean providing one, two or three weeks of meals is not going to have an impact on their chronic condition."**
>
> — Kansas key informant

Conclusion

In order to achieve an effective approach to delivering reimbursable housing and nutrition services through Medicaid, states face a series of important decisions. They also need to be adaptable as policies are rolled out and to meet real-world issues. For example, even after committing to an ILOS approach, states must still structure service delivery network requirements, facilitate cross-sector data exchange and set guidance for evaluation.

More recent policy developments are relevant for states considering approaches to cover housing and nutrition services through Medicaid. For example, CMS rescinded existing guidance that facilitated approval of 1115 waivers for health-related social needs.[5] North Carolina's Healthy Opportunities Pilot has been paused due a lack of state funding, which is occurring in the context of broader cuts to Medicaid funding.

In context of the current policy environment, states may choose more incremental approaches to delivering nutrition and housing services through Medicaid. The lessons learned from the three selected states can still provide critical insights into how these policies should be structured. In Ohio, community reinvestment for Medicaid MCOs offers a framework through which investments can still be made in the necessary infrastructure to connect enrollees with critical social supports. Findings from these states also demonstrate the importance of securing consistent and reliable funding for these initiatives. Decision-makers should consider how the experiences of states with 1115 waivers and ILOS may facilitate a more effective approach to delivering these services, while also building a foundation for a more comprehensive and financially sustainable policy in the future.

Methodology

Qualitative data collection and analysis for the report were guided by the overarching research question: "What has been the experience of developing, implementing, and executing reimbursable SDOH supports in Michigan/North Carolina/Kansas?"

Recruitment strategy

Participants were recruited using a purposive sampling approach leveraging existing professional networks and state-level contacts with expertise in HRSN work, particularly in relation to Section 1115 waivers and ILOS initiatives, given the potential of these mechanisms to increase availability of social supports through Medicaid. Initial outreach targeted stakeholders in Michigan, North Carolina and Iowa.

During the recruitment process, challenges were encountered in identifying and securing participation from appropriate stakeholders in Iowa within the timeline. As a result, Kansas was selected as a replacement state due to the availability of established contacts and the state's use of an ILOS model for SDOH supports.

Key Informant Interviews

HPIO facilitated nine key informant interviews via Microsoft Teams from November 2025 to February 2026 with a total of 14 participants. Stakeholders from four organizations in Michigan, three organizations in North Carolina and two organizations in Kansas participated in the interviews.

HPIO interviewed representatives from the following organizations:

- Michigan Department of Health and Human Services
- Foodbank Council of Michigan
- Michigan Primary Care Association
- Michigan Association of Health Plans
- Foodbank of Central and Eastern North Carolina
- North Carolina Department of Health and Human Services
- Cape Fear Healthy Opportunities Program (North Carolina)
- Kansas Department of Health and Environment
- United Healthcare (Kansas)

HPIO used a semi-structured interview script that was based on the overarching research question:

1. From your perspective, who have been the primary drivers of developing and implementing [reimbursable SDOH supports] in [your state] (e.g., state Medicaid department, community stakeholders, health plans)?
2. Could you tell us a little more about the underlying context in [your state] before the implementation of [reimbursable SDOH supports], from the perspective of [your group]?
3. How have stakeholders been involved in the process of building the infrastructure for reimbursable HRSN services in your state (before, during and now)?
4. How has [your group] been involved in the overall process of building the infrastructure for [reimbursable SDOH supports] in your state (before, during and now)?
5. How many types of housing and nutrition services are being covered in your state?
6. What has been the process of building your provider network and contracting with CBOs? What successes and challenges have you experienced in contracting with CBOs?
7. How is data exchanged between MCOs and service providers/community-based organizations (e.g., through claims only, through an interoperable data system)?
8. What role do care coordinators play in the overall HRSN service infrastructure?
9. How is data exchanged between MCOs and service providers/community-based organizations (e.g., through claims only, through an interoperable data system)?
10. How (if at all) was the evaluation framework for [reimbursable SDOH supports] developed in your state? When in the process was the evaluation plan developed?
11. If your state utilizes community reinvestment, what is the relationship between ILOS and community reinvestment in your state, if any?
12. How has the [reimbursable SDOH supports] program in your state impacted the total cost of care? Is there evidence that savings on medical care are being achieved?
13. Is there anything else you want to add that you think is important related to your experience?

Interviewers obtained verbal consent from all participants to record the discussions, and all participants agreed. Participants were also informed that direct quotes would be used in the report, but that no comments or opinions would be attributed to specific individuals or organizations.

Analysis

Interviews were transcribed using the Microsoft Teams' transcription feature and subsequently reviewed by HPIO staff to resolve discrepancies and ensure alignment with staff notes. Two HPIO staff members iteratively coded the transcripts using Atlas.ti qualitative analysis software, applying open coding techniques. HPIO conducted a thematic analysis using a hybrid approach that combined inductive coding with deductive codes developed during an initial review and cleaning of the transcripts.

Notes

1. "Healthy Opportunities Pilots Update," NC Medicaid, Division of Health Benefits, North Carolina Department of Health and Human Services, June 2, 2025, https://medicaid.ncdhhs.gov/blog/2025/06/02/healthy-opportunities-pilots-update. *Note:* The federal government renewed North Carolina's 1115 waiver in December 2024 for an additional 5-year period, including an expansion of the Healthy Opportunities Pilot. However, the pilot could only continue if state funding was appropriated. https://medicaid.ncdhhs.gov/meetingsnotices/proposed-program-design/nc-section-1115-demonstration-waiver
2. University of North Carolina Cecil G. Sheps Center for Health Services Research, "Healthy Opportunities Pilots Rapid Cycle Assessment 1 Summary," North Carolina Department of Health and Human Services, 2023.
3. "42 CFR 438.3 -- Standard Contract Requirements.," accessed April 20, 2026, https://www.ecfr.gov/current/title-42/part-438/section-438.3.
4. Riad Elmor et al., "Payer-Led Social Needs Interventions Can Reduce Cost of Care for Medicaid Beneficiaries with High Clinical Risk," *NEJM Catalyst Innovations in Care Delivery* 7, no. 4 (2026), https://catalyst.nejm.org/doi/pdf/10.1056/CAT.25.0236.
5. "The Medicaid HRSN Pivot: What's Next for States, Plans, and Providers?," Health Management Associates, June 20, 2025, https://www.healthmanagement.com/blog/the-medicaid-hrsn-pivot-whats-next-for-states-plans-and-providers/.

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