Ohio **Medicaid** Basics

June 29, 2023

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Agenda

- Overview of Ohio Medicaid Basics 2023
- Updates from ODM on Medicaid redetermination
- Addressing health-related social needs with Medicaid

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April 2019

Ohio**Medicaid**Basics**2019**

Medicaid pays for healthcare services for about three million Ohioans with low incomes, including more than 1.2 million children. Medicaid spending accounts for more than one-third of Ohio's budget and almost 17% of health expenditures nationally.[1]

This publication provides an overview of Ohio's Medicaid program, including eligibility, covered services, delivery systems, financing and spending.

Who is eligible for Medicaid coverage?

Ohio Medicaid pays for healthcare services for children, older adults, pregnant women, parents, childless adults and individuals with disabilities, all with incomes below a specific amount (see figures 1 and 2).[2] It is important to note that eligibility differs by state.

For most enrollees, the income eligibility limit is set as a percentage of the Federal Poverty Level (FPL) and eligibility is based on household Modified Adjusted Gross Income (MAGI).[3] Some Medicaid eligibility categories, including Aged, Blind and Disabled (ABD), use different income counting rules and have resource limits (i.e., assets such as cash, stocks, bank accounts and property).

To be eligible for Medicaid in Ohio, a person must meet other requirements in addition to income limits. At a minimum, a person must have, or apply for, a Social Security number, be a U.S. citizen or meet Medicaid requirements for people who are not U.S. citizens (i.e., legal permanent residents, refugees and asylees)[5] and be an Ohio resident.[6]

Figure 1. **Federal poverty level (FPL), by household size, 2019**

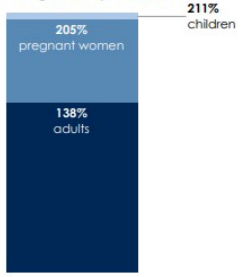
	100%	138%	205%	211%	250%	400%
1	$12,490	$17,236	$25,605	$26,354	$31,225	$49,960
2	$16,910	$23,336	$34,666	$35,680	$42,275	$67,640
3	$21,330	$29,435	$43,727	$45,006	$53,325	$85,320
4	$25,750	$35,535	$52,788	$54,333	$64,375	$103,000

Note: Refers to federal poverty levels for the 48 contiguous states and the District of Columbia (D.C.)
Source: Office of the Assistant Secretary for Planning and Evaluation. Additional analysis by the Health Policy Institute of Ohio.

3 key findings for policymakers

- **Ohio Medicaid provides access to healthcare services for about three million low-income Ohioans**, including many who cannot access or afford private or employer-sponsored health insurance.
- **Medicaid represents a significant portion of government spending in Ohio.** Federal reimbursements accounted for approximately 68% of total spending by Ohio Medicaid in state fiscal year 2018.
- To improve health value in Ohio, **state policymakers need to balance Medicaid's critical role in providing access to health care with budgetary and administrative challenges.**

Figure 2. **Ohio Medicaid income eligibility thresholds for MAGI-categories, by FPL[4], 2019**



Source: Ohio Department of Medicaid

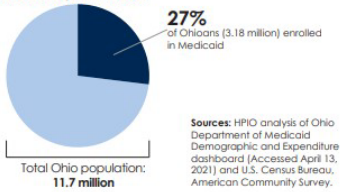
April 2021

Ohio Medicaid Basics 2021

The Medicaid program is a partnership between the federal and state governments that pays for healthcare services for approximately 3.18 million Ohioans with low incomes (see figure 1), including more than 1.28 million children. In state fiscal year (SFY) 2020, federal and state expenditures on Medicaid accounted for about 38% of Ohio's budget.[1] Additionally, $1 out of every $6 spent on health care in the U.S. is spent on Medicaid.[2]

The federal government finances a significant portion of state Medicaid programs. States are required to provide coverage for certain federally-defined eligibility groups and services. States can also receive federal funding for optional groups and services. The specific parameters around who is covered and what services are covered are defined through a combination of federal and state statutes, rules and regulations and administrative decisions.

Figure 1. **Estimated percent of Ohioans enrolled in Medicaid, March 2021**



Sources: HPIO analysis of Ohio Department of Medicaid Demographic and Expenditure dashboard (Accessed April 13, 2021) and U.S. Census Bureau, American Community Survey.

3 key findings for policymakers

- **Ohio Medicaid provides healthcare coverage for about 3.18 million Ohioans with low incomes**, including many individuals who cannot afford private or employer-sponsored health insurance.
- **Medicaid is a significant share of government spending in Ohio.** In state fiscal year 2020, Medicaid expenditures from state and federal funding sources accounted for about 38% of the state's spending.
- **Ohio Medicaid has implemented changes to streamline administrative processes, increase transparency and improve access to care and care coordination for Ohioans.** Going forward, policymakers should monitor implementation and evaluate recent changes to the program.

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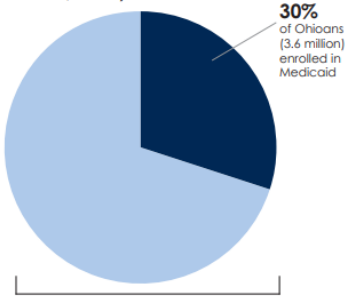
April 2023

Ohio Medicaid Basics **2023**

The Medicaid program is a partnership between the federal and state governments that pays for healthcare services for approximately 3.55 million Ohioans with low incomes, as displayed in figure 1. This includes more than 1.33 million children.[1] In state fiscal year (SFY) 2022, federal and state expenditures on Medicaid accounted for about 39% of Ohio's spending.[2] The Ohio Department of Medicaid (ODM) is the state agency charged with managing the Medicaid program in Ohio.

The federal government finances a significant portion of state Medicaid programs. States are required to provide coverage for certain federally-defined eligibility groups and services. States also can receive federal funding for optional groups and services, such as extended postpartum coverage up to one year after childbirth. The federal government can grant flexibility to states and even waive certain requirements if the statutory goals of the program are met. The details of who is covered and what services are covered by Medicaid are defined through a combination of federal and state statutes, rules and administrative decisions, such as state plan amendments.

Figure 1. **Estimated percent of Ohioans enrolled in Medicaid, January 2023**



Sources: HPIO analysis of Ohio Department of Medicaid Demographic and Expenditure dashboard (Accessed on Feb.15, 2023) and U.S. Census Bureau, American Community Survey

3 Key findings for policymakers

1. **Ohio Medicaid provides healthcare coverage for about 3.55 million Ohioans with low incomes**, most of whom are children, older adults, people with disabilities and low-income adults who could not otherwise afford private or employer-sponsored health insurance.
2. **Medicaid represents a significant share of government spending in Ohio.** In state fiscal year 2022, Medicaid expenditures from state and federal funding sources accounted for about 39% of Ohio's spending.
3. **The Ohio Department of Medicaid is in the process of implementing several large-scale program changes in 2023.** This includes the expansion of postpartum coverage to 12 months and the end of federal continuous coverage requirements, as well as programmatic updates aimed at streamlining administrative processes, increasing transparency and improving care access and coordination.

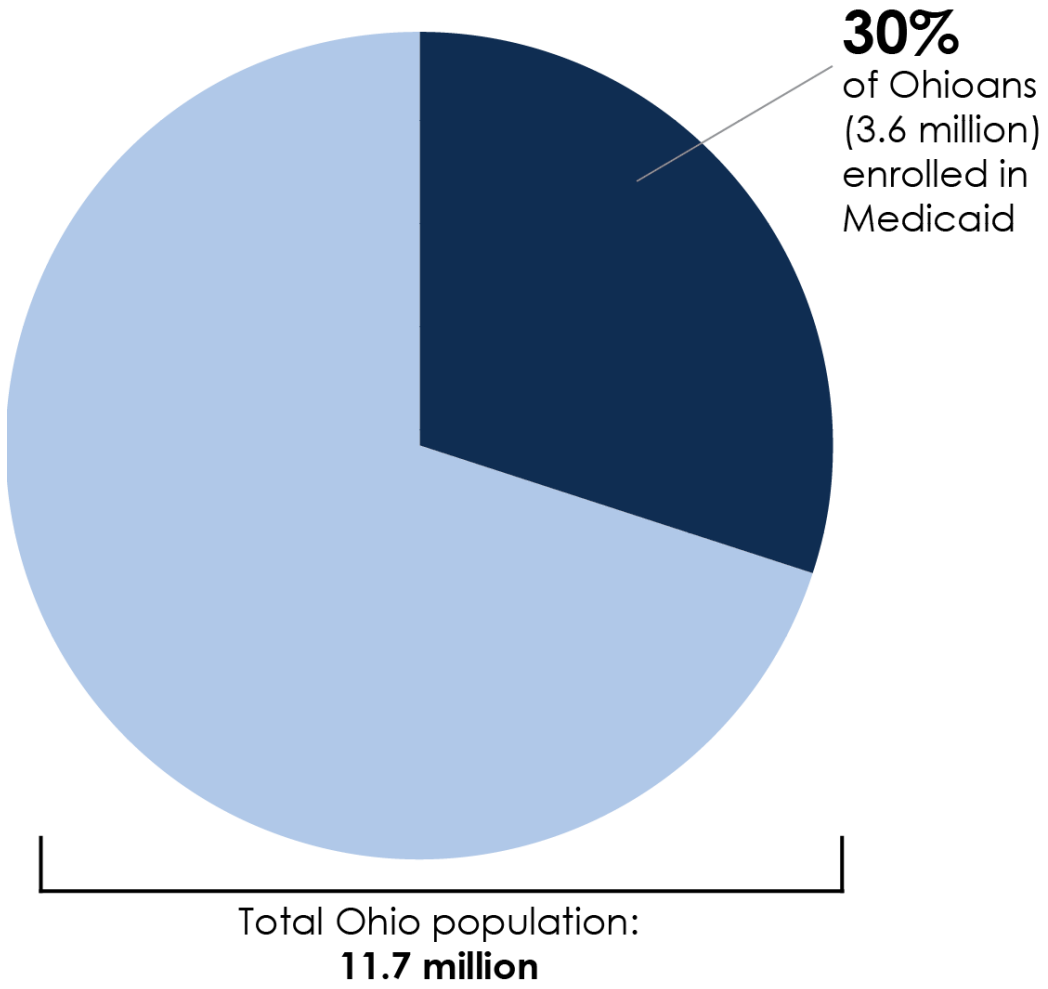
3 Key findings for policymakers

1. Ohio Medicaid provides healthcare coverage for about **3.55 million Ohioans with low incomes**

2. Medicaid is a significant share of government spending in Ohio

3. The Ohio Department of Medicaid is in the process of implementing several largescale program changes in 2023 & conducting redeterminations

Estimated percent of Ohioans enrolled in Medicaid



Sources: HPIO analysis of Ohio Department of Medicaid Demographic and Expenditure dashboard (Accessed on Feb.15, 2023) and U.S. Census Bureau, American Community Survey

Medicaid eligibility

First steps

Must:

→ **Be an Ohio resident**

+

→ **Have a social security number** (or have applied for one)

+

→ **Be a U.S. citizen** (or meet requirements for non-U.S. citizen)

Who is eligible?

- **Children** ages 18 and younger in households with incomes up to 211% Federal Poverty Level (FPL) with no insurance and up to 161% FPL with non-Medicaid health coverage
- **Parents** or related caregivers in households with incomes up to 90% FPL and one or more children younger than 18 in the household
- **Pregnant women** with incomes up to 205% FPL

Adults ages 19 to 64 who have incomes less than 138% FPL

Older Ohioans and those who are blind or disabled with lower incomes

Categories

Covered Families and Children (CFC)

Group VIII

Aged, Blind and Disabled (ABD)

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

Federal poverty level (FPL)

and selected Medicaid income eligibility limits

			Medicaid eligibility categories			
			Adults (ages 19-64)	Pregnant women	Children without insurance	Medicaid Buy-In for Workers with Disabilities (MBIWD)
		Federal poverty level	**138%**	**205%**	**211%**	**250%**
Family size	**1**	$14,580	$20,120	$29,889	$30,764	$36,450
	2	$19,720	$27,214	$40,426	$41,609	$49,300
	3	$24,860	$34,307	$50,963	$52,455	$62,150
	4	$30,000	$41,400	$61,500	$63,300	$75,000

Note: Refers to federal poverty levels for the 48 contiguous states and the District of Columbia (Washington D.C.). For children, pregnant women, adults and parents/caregivers, a 5% income disregard, which is included in the figure, is allowed by federal law.
Source: Office of the Assistant Secretary for Planning and Evaluation. Additional analysis by HPIO.

Medicaid Covered Groups

Medicaid generally covers children, older adults, women who are pregnant, adults without dependents/children and people with disabilities. Below is a list of specific groups coverage.

Covered families and children (CFC)

- Children
- Pregnant women
- Parents

Group VIII

- Adults ages 19 to 64 with incomes at or below 138% FPL
- Enrollment increased during the COVID-19 pandemic

Aged, blind and disabled (ABD)

- People over age 65
- People living with disabilities
- Medicaid Buy-In for Workers with Disabilities
- People who are eligible for both Medicaid and Medicare

Differences between Medicaid and Medicare

Medic**aid**

- Pays for care for Ohioans with low incomes
- Eligibility based on income and other factors
- Primary, acute and long-term care services and supports
- Federal and state funding
- Not funded by payroll deduction

Medic**are**

- Pays for care for nearly all Ohio seniors
- Eligibility based on age or disability status and work history
- Primary and acute care only
- Federal funding
- Funded by payroll deduction

Reasons people enroll in Medicaid

- Changes in household income
- Unemployment or underemployment
- Coverage for long term services and supports (LTSS)

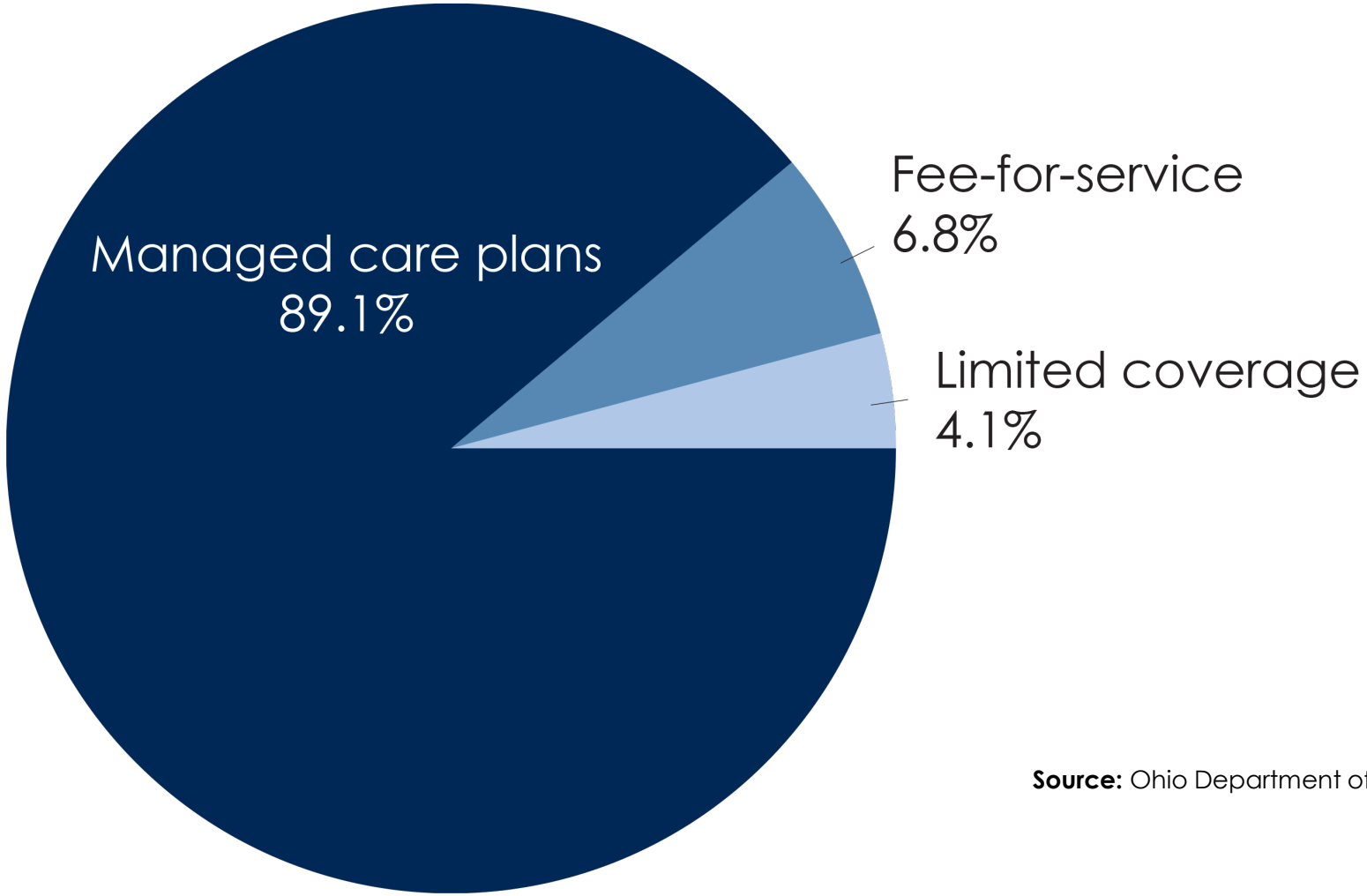
Ohio Medicaid Covered Services

Federally mandated services	Examples of optional services covered by Ohio Medicaid

• Inpatient hospital services
• Outpatient hospital services
• Healthchek (Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT))
• Nursing facility services
• Home health services
• Physician services
• Laboratory and x-ray services
• Family planning services
• Nurse midwife services
• Freestanding birth center services
• Tobacco cessation counseling for pregnant women
• Rural health clinic services
• Federally qualified health center services
• Transportation for medical care
• Certified pediatric and family nurse practitioners
	• Ambulance
	• Chiropractic services
	• Alcohol and drug screening analysis
	• Medical and surgical dental care
	• Durable medical equipment and supplies
	• Medical and surgical vision care
	• Occupational therapy
	• Podiatrist services
	• Prescription drugs
	• Private duty nursing
	• Speech therapy
	• Ambulatory surgical centers
	• Telehealth
	• Case management
	• Behavioral and mental health interventions, including:
	  ◦ Assertive Community Treatment for Adults
	  ◦ Assessment
	  ◦ Community Psychiatric Supportive Treatment (CPST)
	  ◦ Comprehensive addiction treatment services (e.g., methadone administration)
	  ◦ Counseling (individual and group)
	  ◦ Crisis intervention
	  ◦ Day treatment
	  ◦ Family counseling
	  ◦ Intensive home-based treatment for youth
	  ◦ Substance Use Disorder treatment

Medicaid enrollment

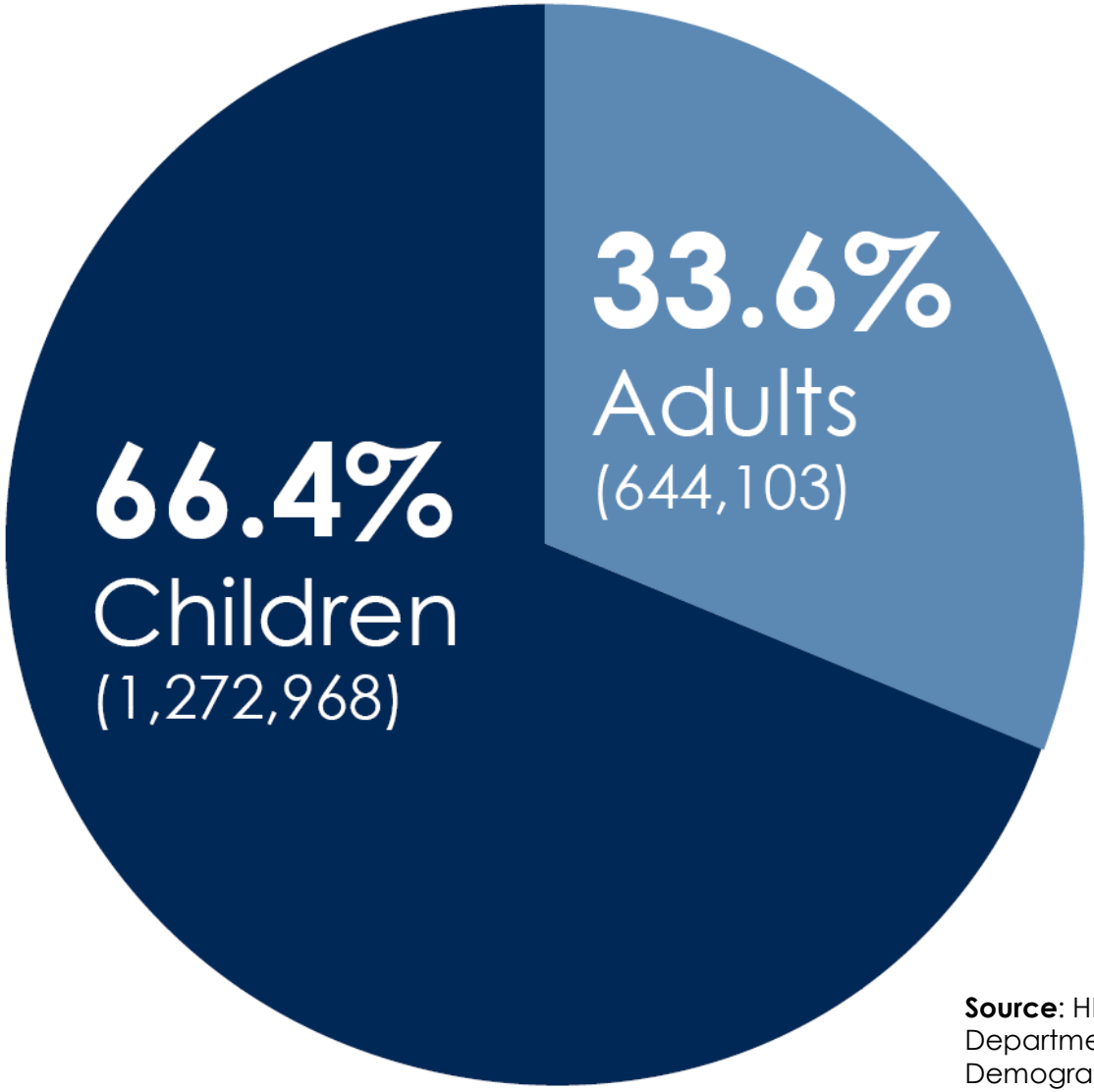
How people access healthcare services as of February 2023



Source: Ohio Department of Medicaid

Ohio Medicaid Covered Families and Children (CFC) enrollment

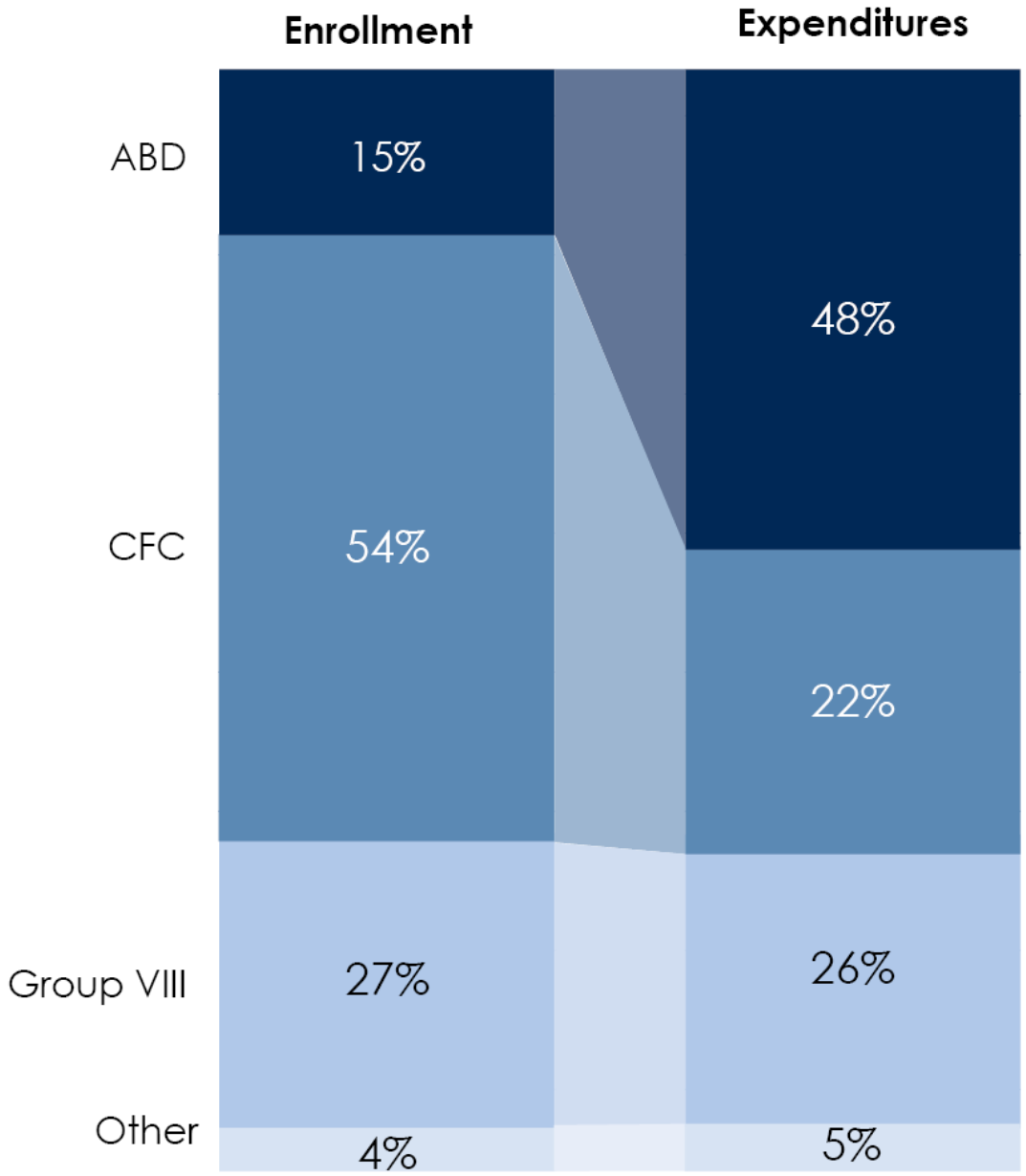
for adults and children
as of January 2023



Source: HPIO analysis of Ohio Department of Medicaid Demographic and Expenditure dashboard. Accessed Feb. 8, 2023.

Enrollment and expenditures

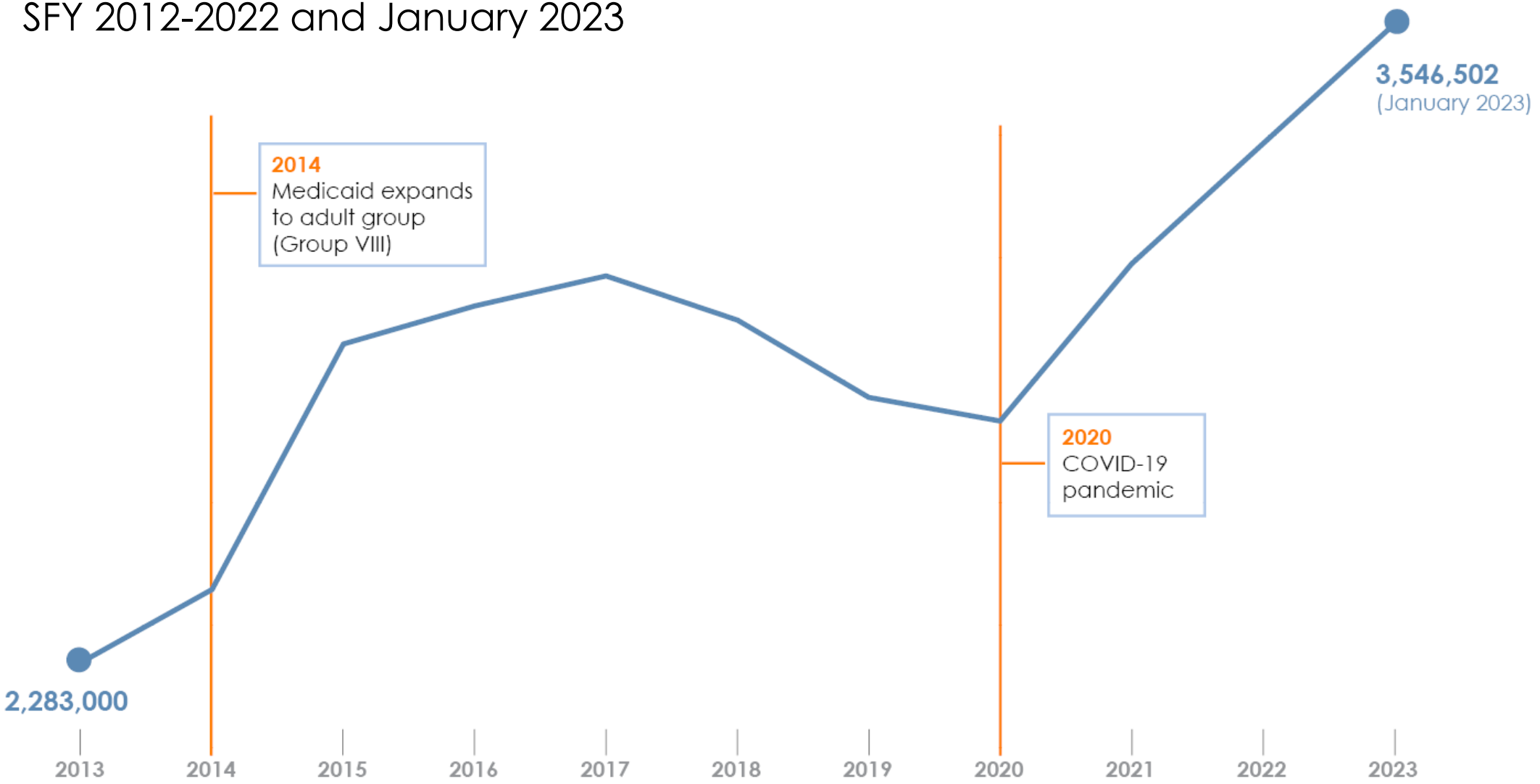
by Medicaid eligibility category, January 2023



Source: HPIO analysis of Ohio Department of Medicaid Demographics and Expenditures Dashboard. Accessed on Feb. 8, 2023.

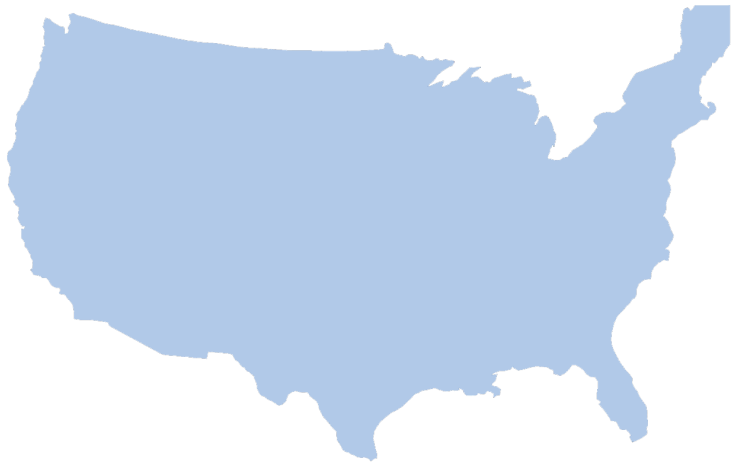
Ohio Medicaid enrollment trend

SFY 2012-2022 and January 2023



Note: Enrollment data is the average for each state fiscal year except for January 2023, which was the most current month available before HPIO analysis.
Source: SFY 2013-2023 Ohio Department of Medicaid Caseload Reports

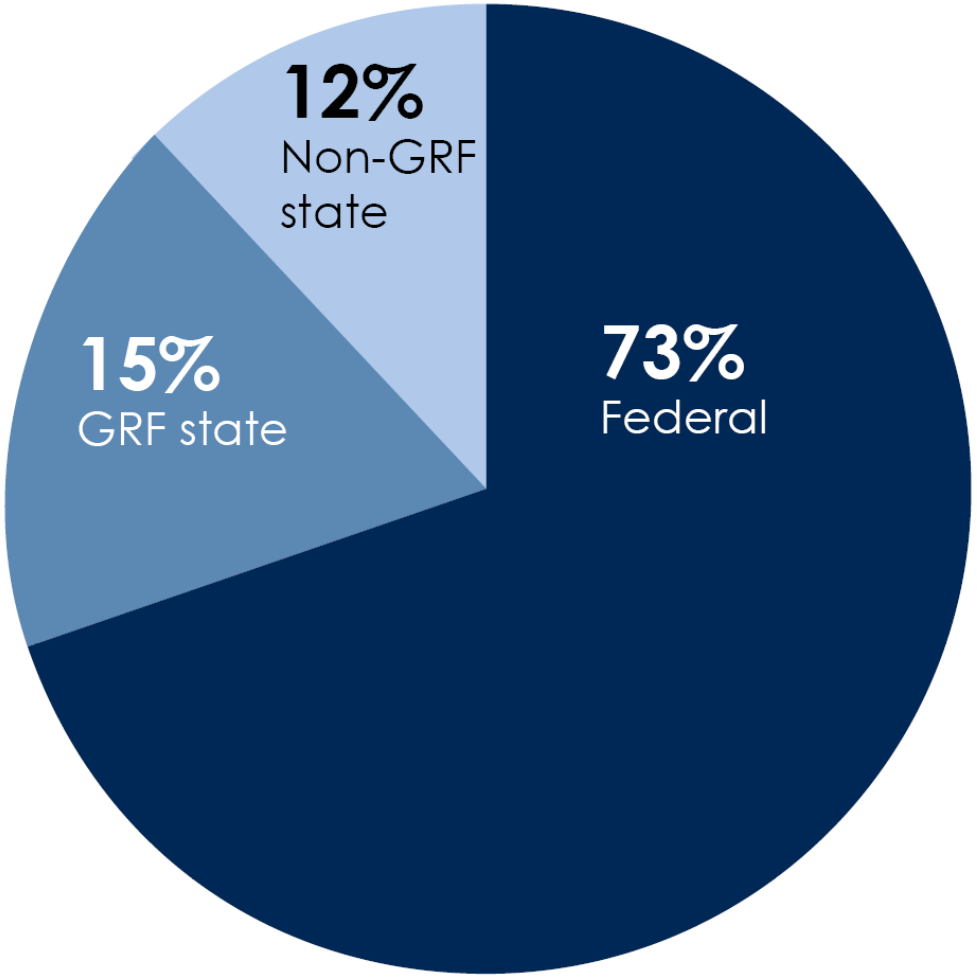
Federal Medical Assistance Percentage **(FMAP)**



FMAP is calculated based on each state's per capita income relative to the national average.

Federal & state partnership

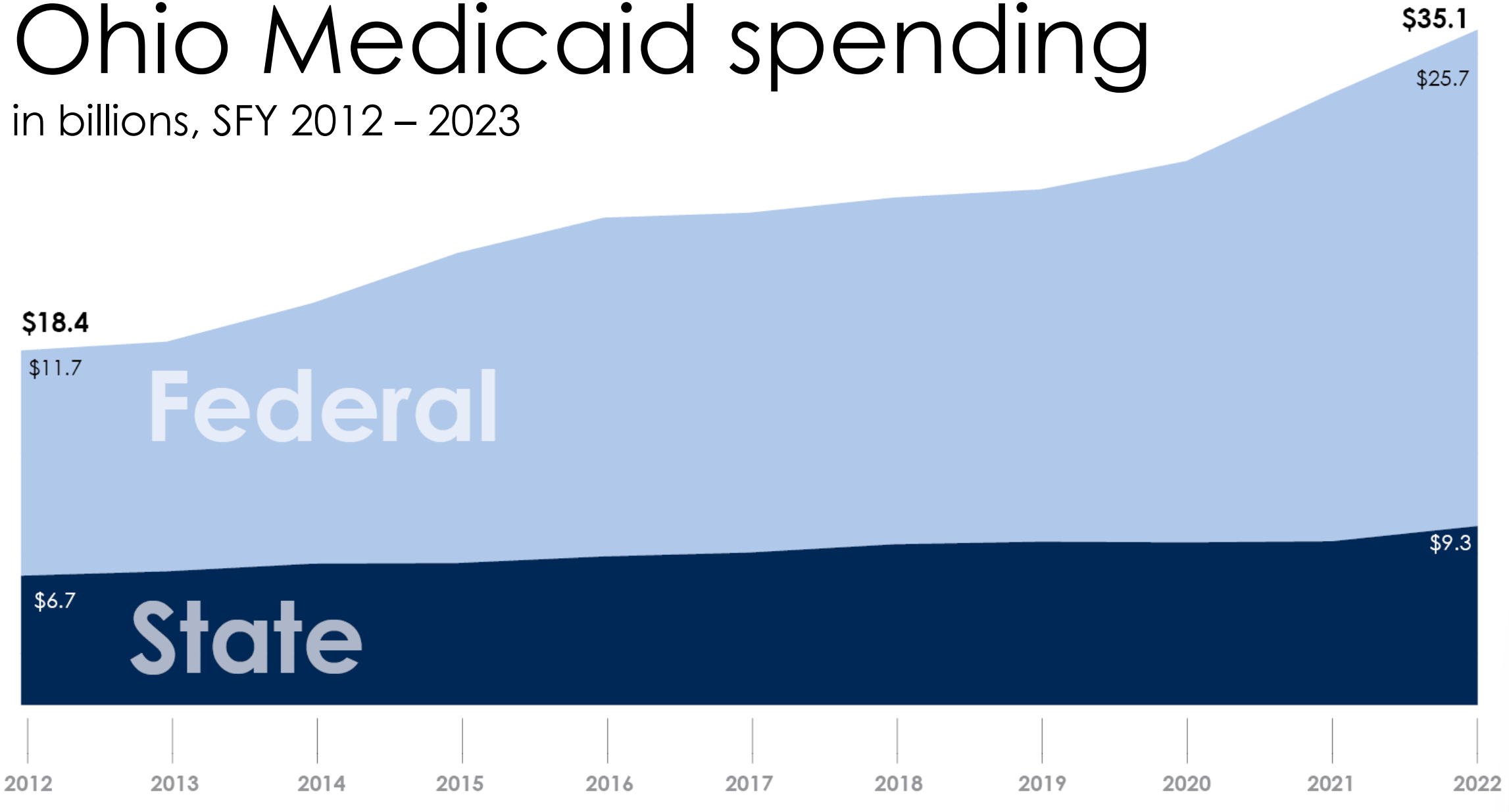
Ohio Medicaid spending, by source, SFY 2022



Source: Ohio Legislative Services Commission

Ohio Medicaid spending

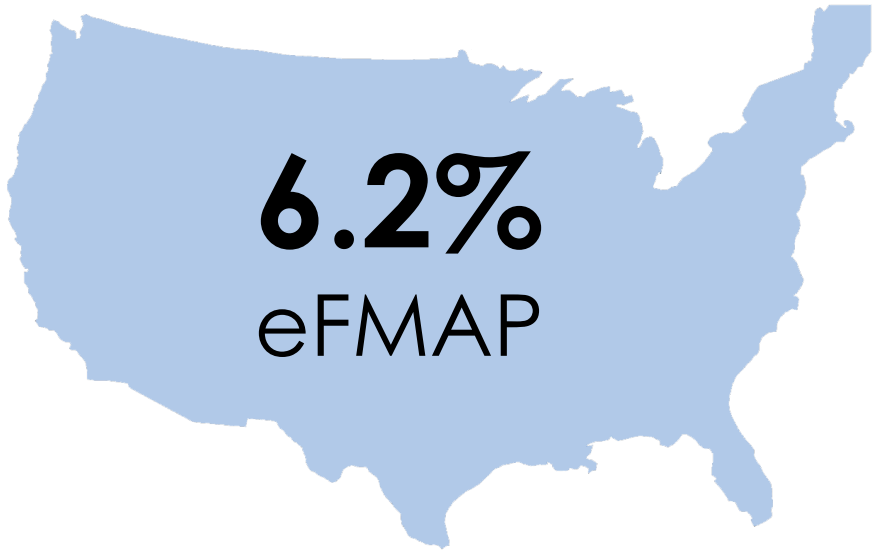
in billions, SFY 2012 – 2023



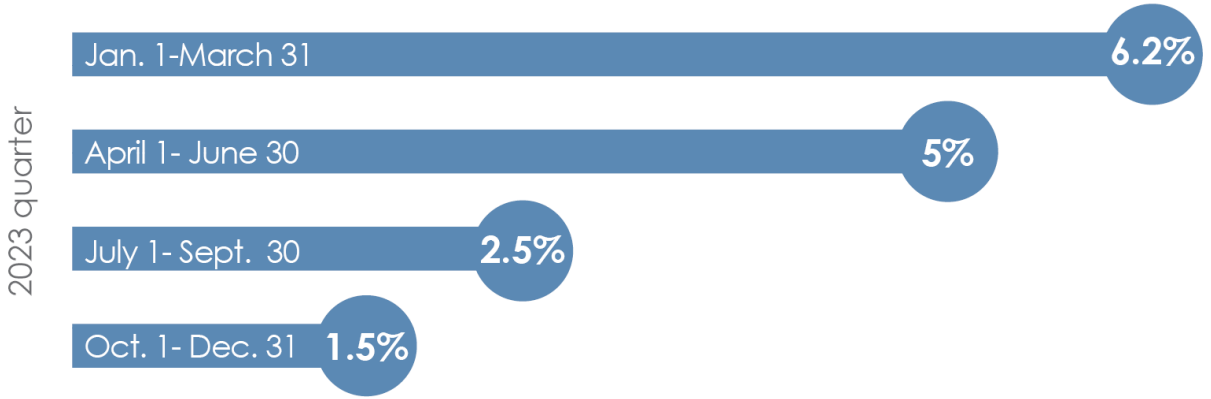
Source: Ohio Department of Medicaid (via Ohio Legislative Service Commission

Medicaid and COVID-19

Federal government provided states with



Medicaid eFMAP phase down



Next Generation of Ohio Medicaid

Initiative and vendor	Purpose	Status
Managed care organization procurement **Vendors selected:** • 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	• Ensure better care coordination and benefit provision and increase transparency for MCos • Address social drivers of health, equity and population health.	New Medicaid managed care agreements went into effect on Feb.1, 2023.
Single Pharmacy Benefit Manager (SPBM) **Vendor selected:** Gainwell Technologies	Manage prescription drug benefits for Ohioans enrolled in Medicaid on behalf of health insurers, Medicare Part D drug plans, large employers and other payors to increase transparency.	• On Oct. 1, 2022, the SPBM began providing pharmacy services across all Medicaid MCOs and members (from more than 2,600 pharmacy locations).
Ohio Resilience through Integrated Systems and Excellence (OhioRISE) **Vendor selected:** Aetna Better Health of Ohio	Provide expanded, specialized treatment options and coordination of support services for Ohio children and adolescents enrolled in Medicaid who have complex behavioral health needs.	• Launched on July 1, 2022. • As of March 23, 2023, there were 18,963 children and youth enrolled in OhioRISE.

Summary

- Ohio Medicaid provides healthcare coverage for about **3.55 million Ohioans with low incomes**.
- Ohio Medicaid accounts for about **39% of the state's spending**.
- Ohio Department of Medicaid is implementing new changes including Medicaid redetermination and Next Generation of Ohio Medicaid Managed care.

Additional resources

- **Medicaid, access and coverage**, HPIO
- **Medicare & Medicaid Basics**, Centers for Medicare & Medicaid Services (April 2022)
- **Medicaid Primer**, Ohio Legislative Service Commission (November 2022)
- **Medicaid: An Overview**, Congressional Research Service (February 2023)
- **10 Things to Know About Medicaid Managed Care**, KFF, (March 2023)
- **10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision**, KFF (April 2023)

CONTACT INFORMATION

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Questions?

POLL QUESTIONS

Patrick Beatty

Deputy Director – Chief Policy Officer

Ohio Department of Medicaid

Unwinding Update

Ohio Department of Medicaid

June 30, 2023

Background

- The Consolidated Appropriations Act, 2023 (CAA) ended the continuous coverage provision that prohibited states from disenrolling members from Medicaid during the COVID-19 Public Health Emergency (PHE).
- Accordingly, states are required to renew the Medicaid eligibility of all members, including those who may not have been renewed since March 2020, within 14 months.
- Ohio initiated its return to routine operations in February, 2023, and will redetermine the eligibility of its 3.5 million Medicaid members between February 2023 to April 2024.
- ODM has held several trainings and webinars for county workers and partners, health plans, and other key Medicaid stakeholders to publicize these substantial changes to Medicaid eligibility operations.
- ODM is accountable to the federal Centers for Medicare & Medicaid Services (CMS) and the Ohio General Assembly to complete renewals in a timely manner to meet the target completion date of April 2024. Failure to complete timely processing of renewals could result in financial penalties to Ohio Medicaid.

Federal Requirements & FMAP Funding

- **As a condition of receiving the enhanced federal medical assistance percentage (FMAP), ODM must comply with federal requirements established in the CAA, 2023, during the return to routine eligibility operations period.**

- **To continue to receive the increased FMAP through Dec. 31, states must continue meet certain conditions:**
  - » Maintenance of Effort: States may not impose eligibility standards, methodologies, or procedures that are more restrictive than those in effect on Jan. 1, 2020.
  - » Maintenance of Medicaid Premium Levels
  - » Coverage without Cost Sharing for COVID-19 Testing, Vaccines, and Treatment: States must continue to cover these services without cost sharing.

- **CMS also added new conditions for states to receive the increased FMAP:**
  - » Compliance with Federal Renewal Requirements: including regulations regarding ex parte renewals, renewal forms, reasonable timeframe and modalities to return the renewal form, determination of eligibility on all bases, advance notice and fair hearing rights, assessment of eligibility for other insurance affordability programs and transfer accounts as appropriate, and the reconsideration period.
  - » Up-to-Date Contact Information: A state must attempt to update contact information for every individual going through the renewal process, including the beneficiary's mailing address, phone number, and email address. CMS asks states to consider various sources for this information, have a plan to confirm information is up to date and have attempted to update information recently, and document their strategies to obtain updated information.
  - » Contact Beneficiaries Using More than One Modality prior to Terminating Enrollment on the Basis of Returned Mail: States must make a good faith effort to contact individuals when they receive returned mail. States must have a process to obtain up-to-date mailing addresses and additional contact information and must attempt to reach an individual through at least two modalities using the most up-to-date contact information that the state has.

- **Currently, the temporary increased FMAP is 6.2 percent. The CAA, 2023 amended the Families First Coronavirus Response Act to decrease the temporary FMAP increase gradually through Dec. 31, 2023, as follows:**
  - » April 1–June 30: 5 percent
  - » July 1–Sept. 30: 2.5 percent
  - » Oct. 1–Dec 31: 1.5 percent

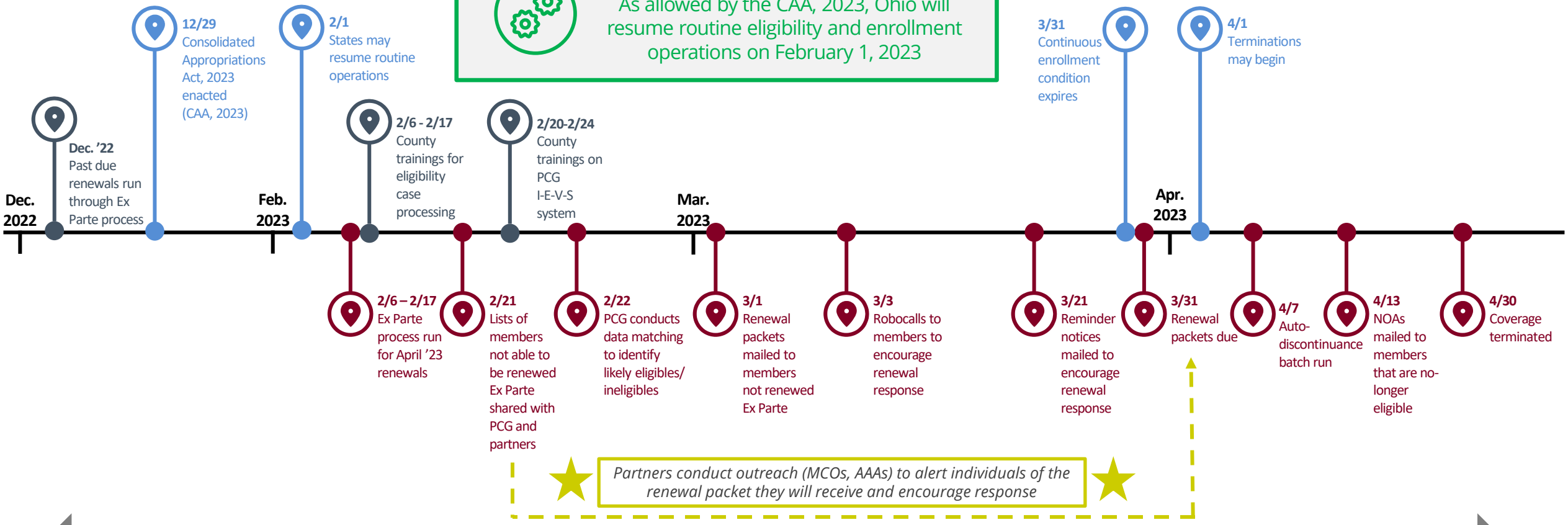
Ohio's Return to Routine Renewal Operations

Legend
- Ohio Department of Medicaid activity
- Key Federal dates
- Monthly Medicaid renewal process*

**Note: illustrative example for renewals due in April 2023. This process will repeat monthly throughout the Unwinding period.*

RETURN TO ROUTINE OPERATIONS

As allowed by the CAA, 2023, Ohio will resume routine eligibility and enrollment operations on February 1, 2023



Efforts to ensure member contact information is up to date

ODM has received authority from CMS via a 1902(e)(14)(A) waiver to partner with MCOs to update beneficiary contact information and establish linkages with the United States Postal Service and National Change of Address database. In the coming months, robocalls will be deployed to confirm accuracy of member addresses before the renewal process begins.

April and May 2023 Performance Stats

By the Numbers April

RENEWALS AND OUTCOMES	NUMBER
5. Total beneficiaries due for renewal in the reporting period (5a+5b+5c+5d)	220,961
5a. Of the beneficiaries included in Metric 5, the number renewed and retained in Medicaid or CHIP (those who remained enrolled) [5a(1) + 5a(2)]	152,416
5a(1) Number of beneficiaries renewed on an *ex parte* basis	111,151
5a(2) Number of beneficiaries renewed using a pre-populated renewal form	41,265
5b. Of the beneficiaries included in Metric 5, the number determined ineligible for Medicaid or CHIP (and transferred to Marketplace)	9,869
5c. Of the beneficiaries included in Metric 5, the number terminated for procedural reasons (i.e. failure to respond)	36,161
5d. Of the beneficiaries included in Metric 5, the number whose renewal was not completed	22,515
6. Month in which renewals due in the reporting month were initiated	Feb-23
7. Number of beneficiaries due for a renewal since the beginning of the state's unwinding period whose renewal has not yet been completed	22,515

By the Numbers May

RENEWALS AND OUTCOMES	NUMBER
5. Total beneficiaries due for renewal in the reporting period (5a+5b+5c+5d)	241,475
5a. Of the beneficiaries included in Metric 5, the number renewed and retained in Medicaid or CHIP (those who remained enrolled) [5a(1) + 5a(2)]	165,894
5a(1) Number of beneficiaries renewed on an *ex parte* basis	122,020
5a(2) Number of beneficiaries renewed using a pre-populated renewal form	43,874
5b. Of the beneficiaries included in Metric 5, the number determined ineligible for Medicaid or CHIP (and transferred to Marketplace)	13,678
5c. Of the beneficiaries included in Metric 5, the number terminated for procedural reasons (i.e. failure to respond)	34,660
5d. Of the beneficiaries included in Metric 5, the number whose renewal was not completed	27,243
6. Month in which renewals due in the reporting month were initiated	Mar-23
7. Number of beneficiaries due for a renewal since the beginning of the state's unwinding period whose renewal has not yet been completed	35,909

General Observations

- Ex parte renewals are running over 50%
- Ex parte rates vary across eligibility categories. ABD groups have a higher rate of renewal
- 90% of renewal cases are being processed timely

- Monthly percentiles
- 70% of individuals up for renewal retain their coverage
- 15% of individuals lose coverage for procedural reasons (failure to respond)
- 5% of individuals are transferred to the federal marketplace

Questions?

Elizabeth Hinton

Associate Director
Program on Medicaid and Uninsured
KFF

Addressing Health-Related Social Needs with Medicaid

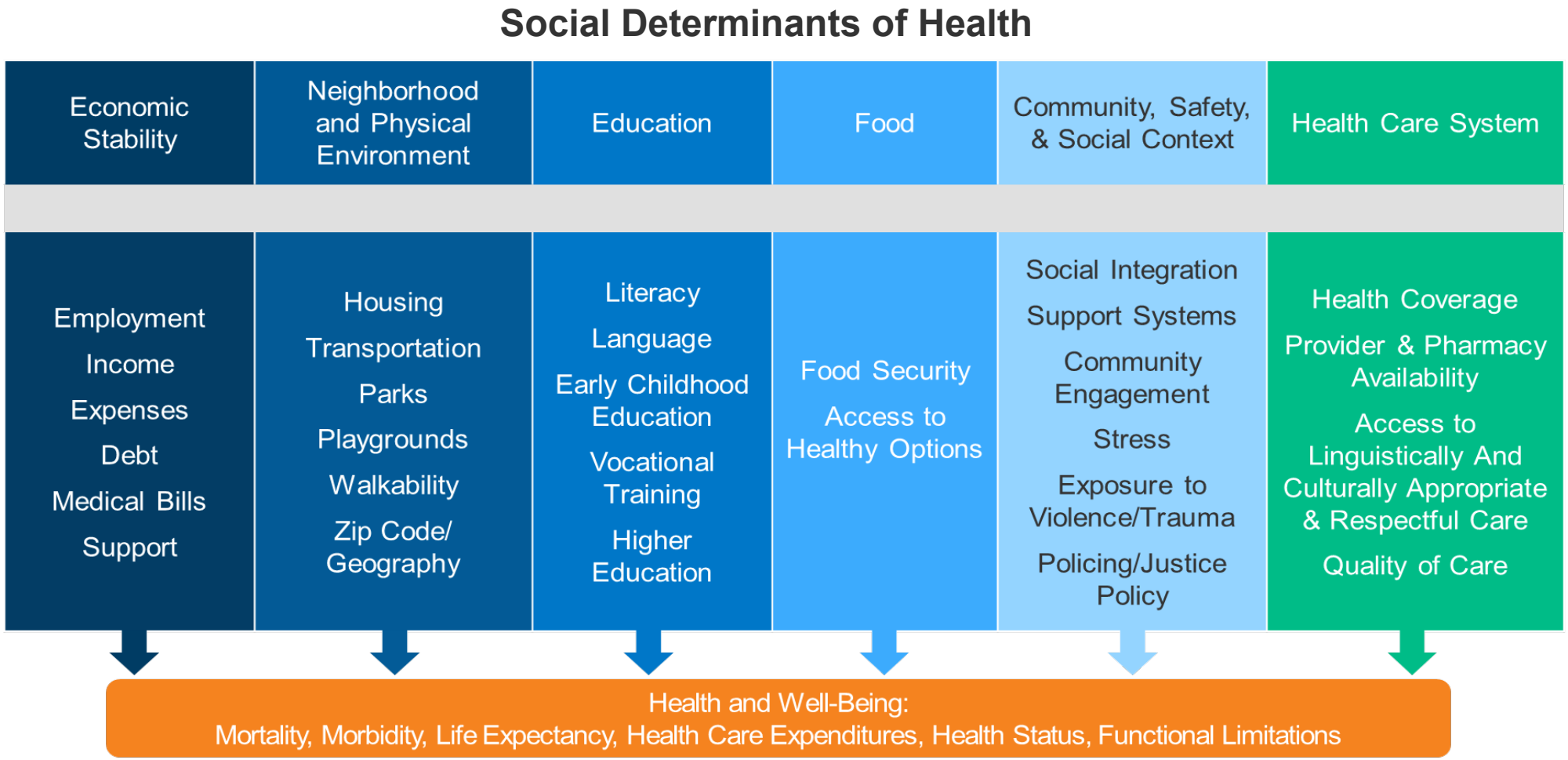
Libby Hinton
Associate Director, Program on Medicaid and the Uninsured
June 29, 2023

KFF

The independent source for health policy research, polling, and news.

Figure 44

Though health care is essential to health, research shows that health outcomes are driven by many factors.



SOURCE: "Medicaid Authorities and Options to Address Social Determinants of Health (SDOH)," https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/

Figure 45

State Plan Authority

KFF

Section 1115 Waivers

KFF

Figure 47

Section 1115 waivers offer states an avenue to test new approaches in Medicaid that differ from federal requirements.

- **Authority and Purpose:** Federal government can approve waivers that permit states to use federal Medicaid funds in ways that federal rules do not otherwise allow, as long as the initiative is a demonstration project that is likely to assist in promoting Medicaid objectives.
- **Financing:** Section 1115 waivers must be budget neutral for the federal government.
- **Transparency, Public Input, and Evaluation:** Public notice and comment periods are required prior to waiver approval. States must have a publicly available evaluation strategy for the waiver.
- **Scope and Themes:**
  - States may obtain "comprehensive" Section 1115 waivers that make broad changes in Medicaid eligibility, benefits, provider payments, and other rules across their programs; other waivers may be more narrow and address specific populations or benefits.
  - Waivers generally reflect priorities identified by the states and the federal CMS, as well as changing priorities from one presidential administration to another.

SOURCE: "The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election," https://www.kff.org/medicaid/issue-brief/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election/

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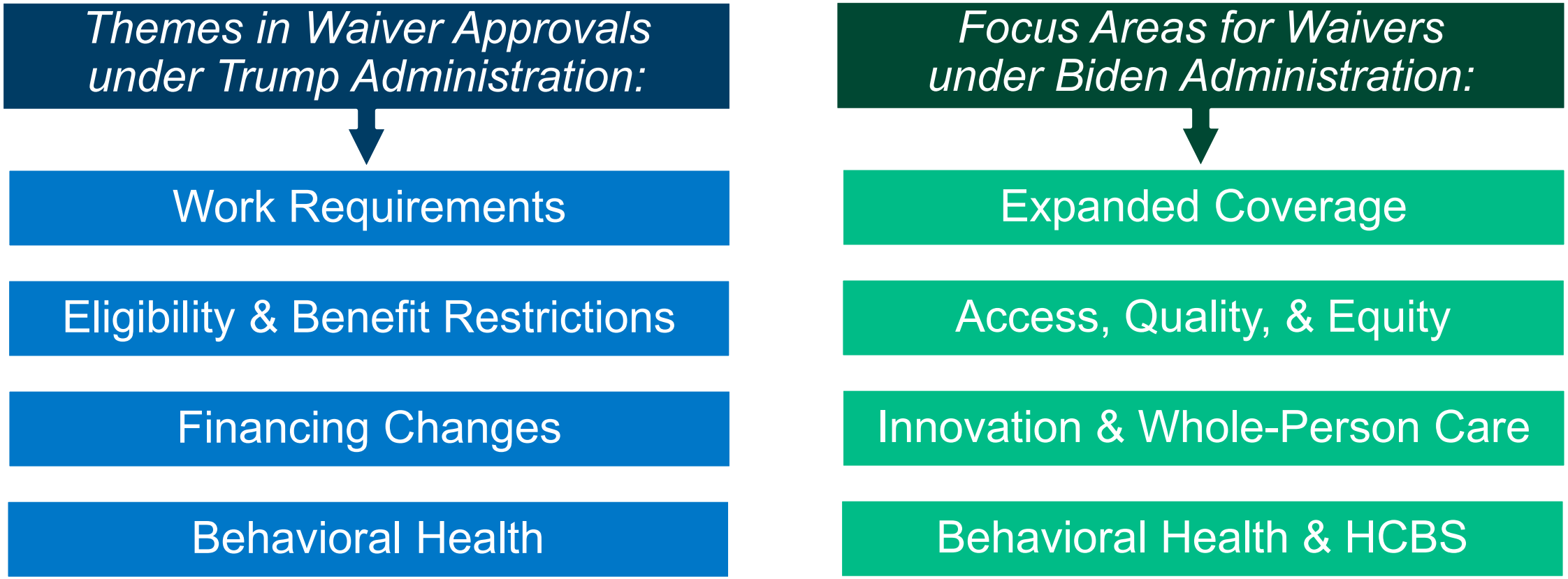
Figure 48

Section 1115 waiver themes and priority areas change under different administrations.



NOTE: HCBS = home and community-based services.
SOURCES: "The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election," https://www.kff.org/medicaid/issue-brief/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election/; "What to Watch in Medicaid Section 1115 Waivers One Year into the Biden Administration," https://www.kff.org/medicaid/issue-brief/what-to-watch-in-medicaid-section-1115-waivers-one-year-into-the-biden-administration/

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Figure 49

In 2022, CMS presented a framework for states to use waivers to address health-related social needs (HRSN).

SOURCE: “A Look at Recent Medicaid Guidance to Address Social Determinants of Health and Health-Related Social Needs,” https://www.kff.org/policy-watch/a-look-at-recent-medicaid-guidance-to-address-social-determinants-of-health-and-health-related-social-needs/

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Figure 50

Examples of States with Approved Section 1115 Health-Related Social Needs Provisions

State	Target Populations	Housing Supports	Nutrition Supports
AR	Enrollees participating in one of three Life360 HOMEs, e.g. with behavioral health needs in rural areas, with high-risk pregnancies, or at high-risk for long-term poverty	• Pre-tenancy & tenancy sustaining services • Housing transition navigation services • One-time transition & moving costs • Housing deposits	• Nutrition counseling & education, including health meal preparation
MA	Enrollees who meet health and risk criteria, e.g. have behavioral health needs & homeless, justice-involved, or facing eviction	• Pre-tenancy & tenancy sustaining services • Housing transition navigation services • One-time transition & moving costs • Housing deposits • Devices to maintain healthy temperatures & air • Home accessibility modifications	• Nutrition counseling & education • Meals delivered to the home ≤6 months) • Medically-tailored food prescriptions (for up to 6 months) • Cooking supplies
OR	Enrollees experiencing major life transitions (e.g. release from incarceration or living in region with extreme weather events)	• Post-transition rent/housing (≤6 months) • Utility costs • Pre-tenancy & tenancy sustaining services • Housing transition navigation services • One-time transition & moving costs • Housing deposits • Devices to maintain healthy temperatures & air • Home accessibility modifications	• Nutrition counseling & education • Medically-tailored meals (≤6 months) • Fruit & vegetable prescriptions (≤6 months) • Meal or pantry stocking

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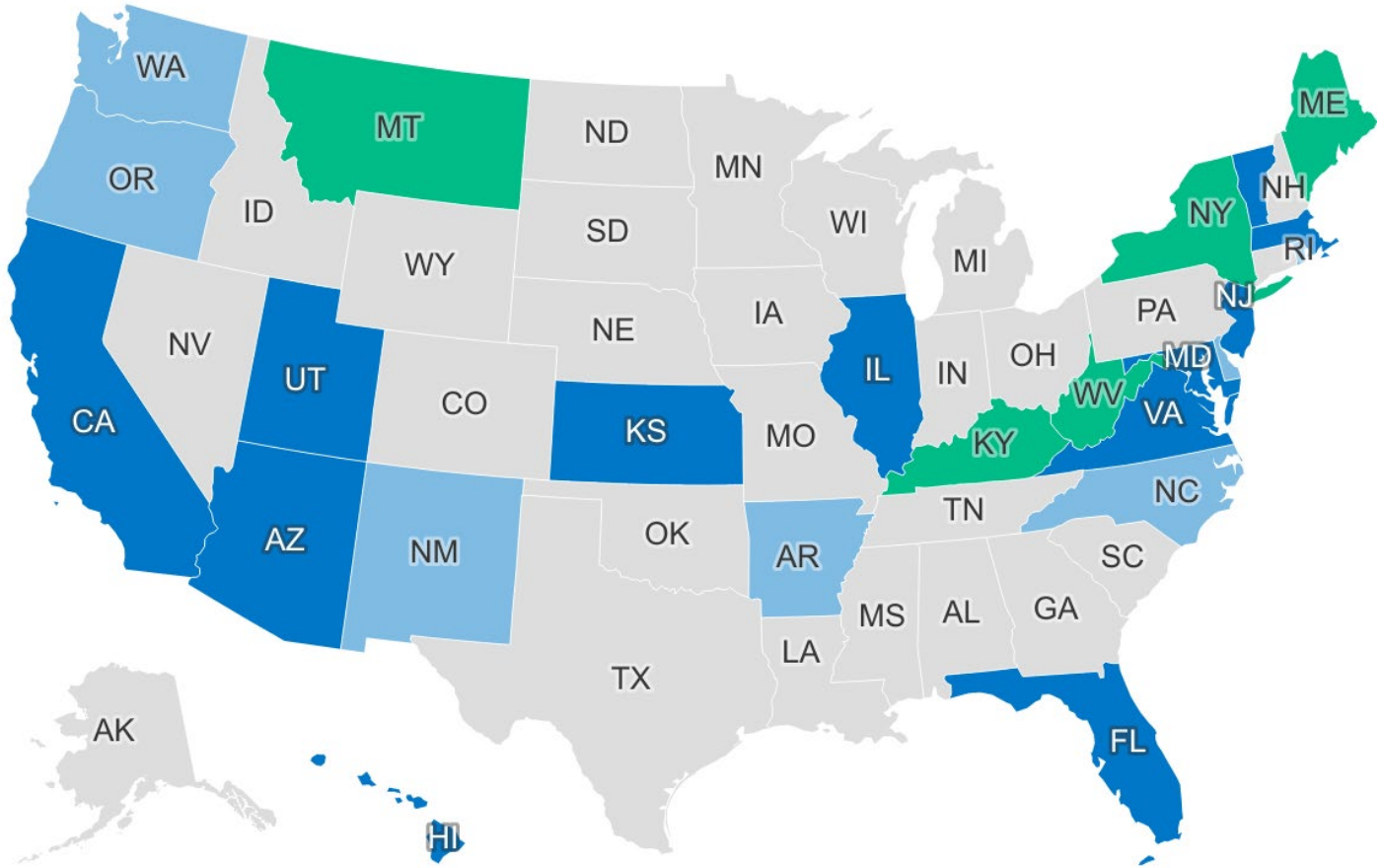
SOURCE: "https://www.kff.org/medicaid/issue-brief/section-1115-waiver-watch-approvals-to-address-health-related-social-needs/

Figure 51

As of June 2023, 24 states have an approved or pending Section 1115 waiver with SDOH-related provisions.

# of states with:

- Approved waiver (12)
- Approved waiver & pending request (7)
- Pending request (5)



SOURCE: KFF Medicaid Waiver Tracker, https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

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Medicaid Managed Care Flexibility

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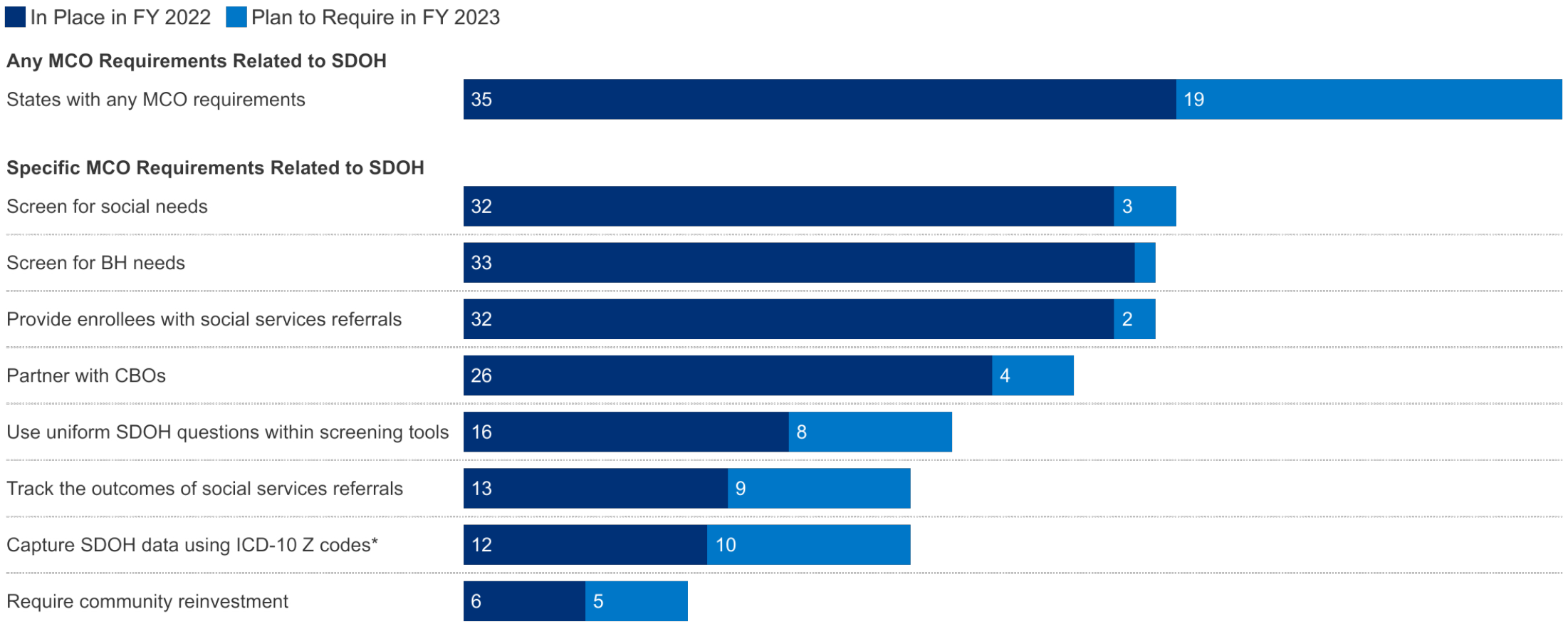
Figure 53

In FY 2022, most states that contract with managed care plans had at least one contract requirement related to SDOH.



NOTE: n=38 responding MCO states (MCO=managed care organization). Response rates per policy varied. “BH”=behavioral health. “CBOs”=community-based organizations. ICD-10 Z codes are subset of ICD-10 diagnosis codes that reflect patient social characteristics.

SOURCE: “10 Things to Know About Medicaid Managed Care,” https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

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Figure 54

In 2023, CMS released guidance that allows states to make expanded use of “in lieu of” services (ILOS) authority, including to address HRSN.

- ILOS = services or settings that ***substitute*** for standard Medicaid benefits (e.g., in-home prenatal visits for at-risk pregnant enrollees as an alternative to in-office)
- These services *must* be:
  - medically appropriate and cost-effective
  - voluntary for the plan (to offer) and for the beneficiary (to receive)
- Costs of the ILOS are **built into managed care rates**
- The new CMS ILOS guidance:
  - clarifies ILOS can be *preventive* instead of an *immediate* substitute (e.g., medically tailored meals to potentially delay nursing facility care, providing a dehumidifier for a child with severe asthma before the next time they need emergency care)
  - establishes financial guardrails and other requirements

SOURCE: “A Look at Recent Medicaid Guidance to Address Social Determinants of Health and Health-Related Social Needs,” https://www.kff.org/policy-watch/a-look-at-recent-medicaid-guidance-to-address-social-determinants-of-health-and-health-related-social-needs/

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Figure 55

New guidance follows the approval of a CA proposal to use ILOS to offer a range of health-related services through managed care.

CA Community Supports

- Asthma remediation
- Medically-supportive food/meals/medically tailored meals
- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Sobering centers
- Respite services
- Day habilitation programs
- Nursing facility transition
- Community transition services
- Personal care and homemaker Services
- Environmental accessibility adaptations (home modifications)

SOURCE: “California Efforts to Address Behavioral Health and SDOH: A Look at Whole Person Care Pilots” https://www.kff.org/medicaid/issue-brief/california-efforts-to-address-behavioral-health-and-sdoh-a-look-at-whole-person-care-pilots/

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Figure 56

Looking Ahead / Wrap Up

- While there are limits, states can use Medicaid to address enrollee social needs
- Options: SPA coverage, Section 1115, managed care flexibility (e.g., ILOS, contract requirements), integrated care models
- New guidance released by CMS expands opportunities for states to cover HRSN
- Considerations and challenges (can vary according to option pursued):
  - financing / funding sustainability
  - changing administrations (may affect 1115 waiver priorities)
  - implementation (working with non-traditional providers / CBOs, coordination w/ other state and local agencies etc.)
  - monitoring / evaluation requirements
- Other related areas to watch: Re-entry / pre-release 1115 waivers

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Questions?

POLL QUESTIONS

Ways to influence policy

- Write letters, emails or make phone calls
- Provide district specific data
- Provide analysis of a bill
- Provide testimony at a legislative hearing
- Provide a one-page fact sheet
- Organize community partners to visit key policymakers
- Invite policymakers to visits your organization or speak at a meeting you host

POLL QUESTIONS

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