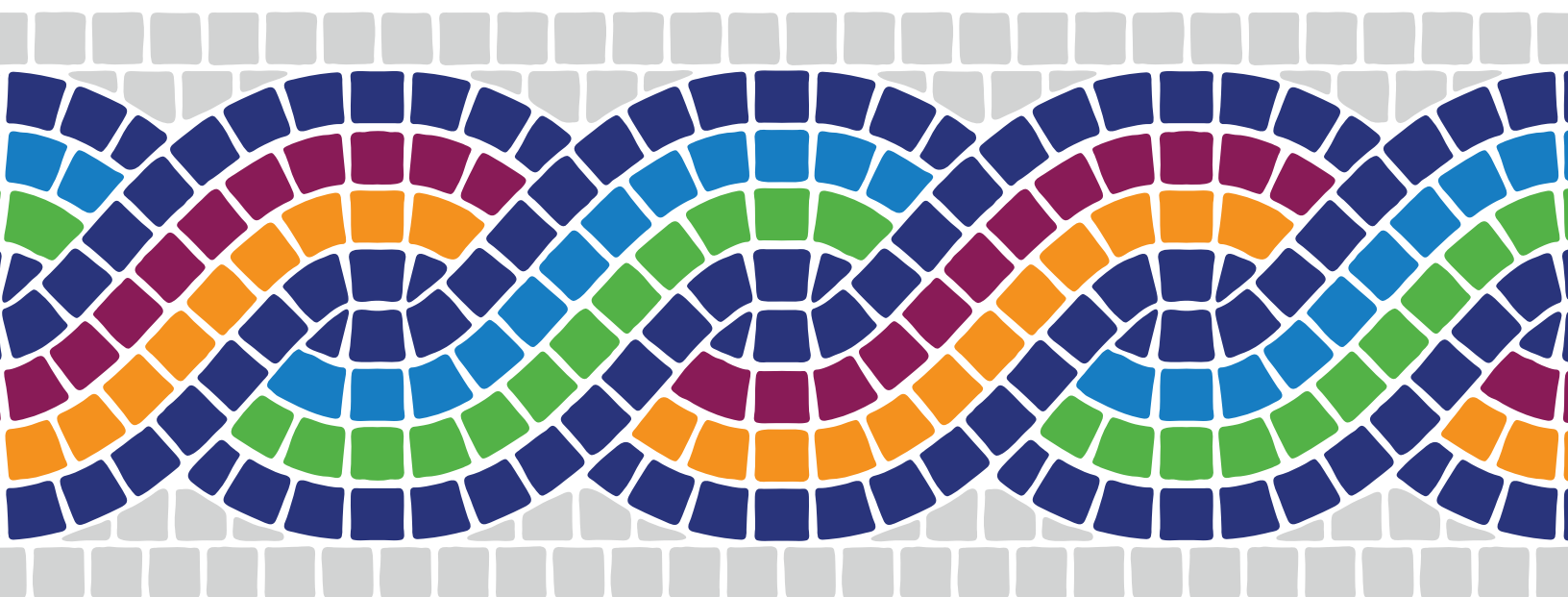


Financing Approaches to Address Social Determinants of Health via Medicaid Managed Care: A 12-State Review



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About CHCS

The Center for Health Care Strategies is a national policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. To learn more, visit www.chcs.org.

About ACAP

The Association for Community Affiliated Plans (ACAP) is a national trade association that represents not-for-profit Safety Net Health Plans. Collectively, ACAP plans serve more than 23 million enrollees, representing nearly half of all individuals enrolled in Medicaid managed care plans. For more information, visit www.communityplans.net.

ACAP oversees the ACAP Center for SDOH Innovation, which provides a rich portfolio of shared services to facilitate and demonstrate the leadership of ACAP-member Safety Net Health Plans in the field of social determinants of health. Learn more at www.sdohinnovation.org.



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Executive Summary

Over the last decade, Medicaid managed care organizations (MCOs) have invested in local communities and crafted programs to better address the individual-level health-related social needs (HRSN) of their enrollees. But sustainable funding streams for these efforts are not always available.

State Medicaid agencies can develop managed care rates to explicitly recognize services and activities that address HRSN, and provide guidance on how to report those costs in the medical loss ratio (MLR). Over the last two years, the Centers for Medicare & Medicaid Services (CMS) have given states more guidance on these flexibilities, through state Medicaid director letters and official demonstration opportunities.

With support from the Association for Community Affiliated Plans (ACAP), the Center for Health Care Strategies (CHCS) identified how 12 states are financing MCO HRSN activities and using these flexibilities. In reviewing these 12 states' approaches, CHCS found the following common themes:

1. HRSN contract requirements are commonplace, but rate impacts can be unclear.

States frequently underscore the importance of HRSN and health equity in their contracts, but specific funding for these efforts is less clear – especially for services and activities that are not benefits.

2. States rely on broad definitions in federal rule when providing MLR guidance.

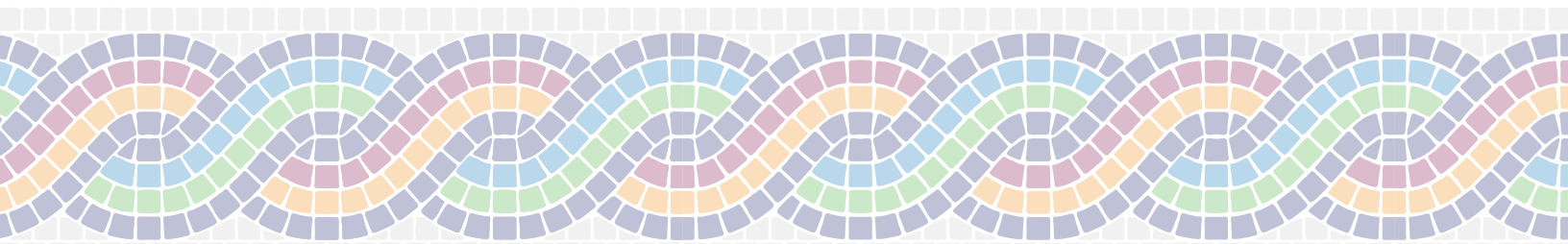
The federal rule for “activities that improve health care quality” does not contain explicit examples of HRSN services and activities, and state guidance relating to permissible expenses in the MLR numerator can be similarly broad.

3. States are using new and diverse managed care contracting levers to support provider-level and community-level HRSN-related activities.

To support more effective and equitable HRSN services and activities, states have begun to focus on how payment flows from MCOs to providers and community-based organizations, such as through value-based payment or community reinvestment of MCO profits and reserves.

4. Under new Section 1115 demonstrations, MCO capitation rates will reflect approved HRSN services, like never before.

Over the last year and a half, CMS has allowed states to test new HRSN services via 1115 demonstrations, and invited more states to apply for a related HRSN demonstration opportunity. Notably, these demonstrations will allow HRSN services to be treated more like benefits, and be embedded in capitation rates.



By the Numbers:

- Ten out of 12 study states expanded access to HRSN services beyond traditional 1915(c) HCBS services through a waiver or state plan amendment (SPA).
- Five states have approved HRSN services as in lieu of services.
- Six states reward MCOs for HRSN-related activities and related performance.
- Six states explicitly mention HRSN-related non-benefit costs used to develop rates.
- Seven states direct MCOs to support provider-level HRSN-related activities through value-based payment or directed payment arrangements.
- Six states provide guidance on how HRSN-related non-benefit costs can be reported in the numerator of the MLR.
- Two states apply social risk adjustment to MCO rates.
- Six states allow or direct MCOs to reinvest profits/reserves into communities, with four of those states adopting a current or future requirement.

The report elevates the following opportunities for CMS and federal policymakers to support this work moving forward:

1. Continue to use Medicaid funds to expand access to HRSN Services – but stay flexible.

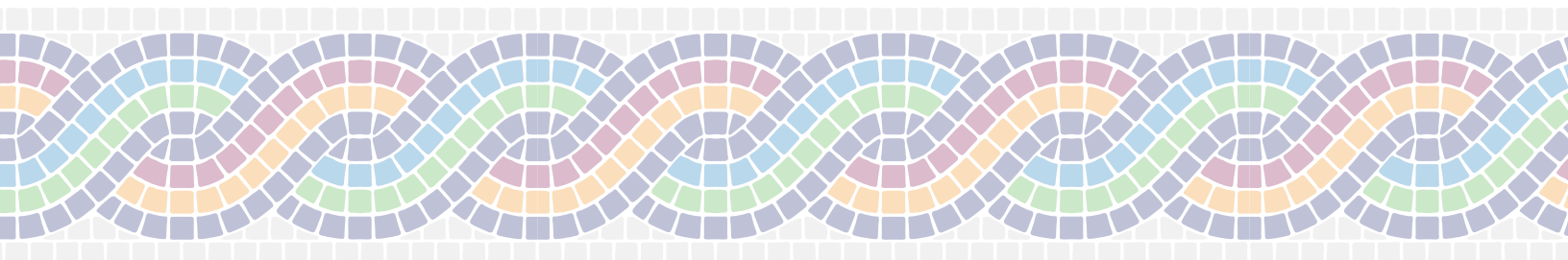
In late 2022 and early 2023, CMS announced new state opportunities to use in lieu of services and Section 1115 demonstrations to address HRSN. These opportunities are potentially transformative, and provide concrete, sustainable funding pathways for HRSN services. But not all states will be ready to take on related implementation challenges. CMS should continue to provide a flexible range of options to states interested in using their Medicaid managed care programs to advance health equity and address HRSN.

2. Support more accurate MLR reporting and capitation rates by providing explicit HRSN-related examples.

To sustain HRSN services and activities and empower internal plan champions of this work, financial support of HRSN and related flexibilities should be widely understood. Federal rules and rate development guidance can reflect increasingly common MCO activities, with explicit examples of HRSN services and activities.

3. Allow states to test new approaches to financing HRSN services and infrastructure.

CMS and states must determine what data are necessary for evaluation and billing efforts, and what processes can be adapted to support the unique needs and capabilities of CBOs providing HRSN services. Federal policymakers can continue to support braided and blended funding opportunities, and entities like community care hubs.



Introduction

Addressing individual-level health-related social needs (HRSN)* and community-level social drivers of health (SDOH) can improve health, reduce disparities, and decrease health care costs.¹

State Medicaid agencies are increasingly committed to addressing HRSN and promoting health equity, and embedding related goals into their managed care contracts and transformation initiatives.^{2,3,4,5} The Centers for Medicare & Medicaid Services (CMS) has been on a similar path. CMS published a guidance letter on existing federal flexibilities to address HRSN through Medicaid in 2021, announced a new Medicaid demonstration opportunity for housing and nutrition services in December 2022, and published in lieu of services guidance in January 2023, with an explicit nod to HRSN services.^{6,7,8} It also embedded HRSN goals as part of overarching health equity strategies, and in initiatives on data, hunger, maternal health, and home and community-based services (HCBS).^{9,10,11,12,13} Other parts of the U.S. Department of Health and Human Services, like the Office of the Assistant Secretary for Planning and Evaluation (ASPE), have also published strategies relating to identifying and addressing HRSN.¹⁴

Medicaid managed care organizations (MCOs) have been an important part of these HRSN and SDOH initiatives. MCOs can craft approaches to improve care across physical, behavioral, and social care contexts as well as provide services that address HRSN, such as housing navigation services, tenancy supports, or home-delivered meals. MCOs do this work both through dedicated staff like care coordinators and housing specialists, and through cross-sector partnerships with community-based organizations (CBOs), local government entities, and network providers.

But expanding access to these services can require significant investments in CBOs that have been historically under-resourced.¹⁵ CBOs that provide HRSN services may need more staff and resources to provide services to more people, and to build new processes and partnerships with health care organizations.¹⁶ To scale and sustain this work, both upfront and ongoing, predictable funding streams are essential.¹⁷

While most states use their contracts to encourage MCOs to develop approaches to identify and address HRSN, states have varying approaches to financially supporting HRSN services and activities. In the most recent 2022 Annual Medicaid MCO Survey by the Institute for Medicaid Innovation, Medicaid MCOs said that state Medicaid agencies can further assist MCOs to address HRSN by: increasing financial resources from the state to MCOs (100% of respondents); increasing resources to support facilitation of partnerships (81%); increasing resources to support capitated payments models, pay-for-performance programs, and risk programs with providers (76%); and facilitating contracting with CBOs (67%).¹⁸

This report explores the types of financial resources flowing to and through MCOs to support sustainable HRSN services, and related state guidance. With support from the Association for Community Affiliated Plans (ACAP), the Center for Health Care Strategies (CHCS) examined how 12 states with ACAP member plans are financing MCO activities relating to HRSN. CHCS reviewed publicly available state documents and catalogued the unique initiatives and financing methods

***A Note about Terminology:** This report uses the term health-related social needs (HRSN), rather than other commonly used terms like social determinants of health or social drivers of health (SDOH). CHCS uses this term to clarify the role MCOs and the health care system typically play (i.e., helping individuals with their HRSN), and emphasize the myriad structural and political factors that shape community-level social determinants of health.

In this report, “HRSN activities” usually refers to activities such as social risk factor screening, data collection, and care management. “HRSN service” is a service designed primarily to address a health-related social need. Examples include: home modifications; one-time transition costs like first month’s rent, furniture, and deposit; medically tailored meals; asthma remediation that requires home repairs and devices; tenancy support services, housing navigation services, medical respite, and short-term transitional housing. This terminology also aligns with recent CMS guidance documents and approvals of Section 1115 demonstrations.

In the most recent 2022 Annual Medicaid MCO Survey by the Institute for Medicaid Innovation, Medicaid MCOs said that state Medicaid agencies can further assist MCOs to address HRSN by:

**Increasing
financial resources
from the state
to MCOs**

100%
of respondents

**Increasing
resources to
support facilitation
of partnerships**

81%
of respondents

**Increasing
resources to
support capitated
payments models,
pay-for-performance
programs, and
risk programs with
providers**

76%
of respondents

**Facilitating
contracting
with CBOs**

67%
of respondents

across states. Examples include: guidance on how to report services in the medical loss ratio (MLR), HRSN services approved as benefits or in lieu of services, or incentive arrangements that reward HRSN activities performed by MCOs. For information on state options, see *The Basics: Medicaid Managed Care Payment and HRSN* sidebar (page 6).

In reviewing these 12 state approaches for financing MCO HRSN activities, CHCS found the following common themes:

- 1. HRSN contract requirements are commonplace, but rate impacts can be unclear.**
- 2. States rely on broad definitions in federal rule when providing MLR guidance.**
- 3. States are using new and diverse managed care contracting levers to support provider-level and community-level HRSN-related activities.**
- 4. Under new Section 1115 demonstrations, MCO capitation rates will reflect approved HRSN services, like never before.**

This report outlines each of these themes and includes examples of related activities in the 12 scan states to inform state and MCO efforts across the nation. Finally, recognizing the need to provide adequate and sustainable funding to scale and sustain HRSN services, the report also details a set of considerations to guide CMS and federal policymakers' future efforts to bridge the worlds of health care and social care.

The Basics: Medicaid Managed Care Payment and HRSN

Can HRSN services be Medicaid benefits?

HRSN services can be formal Medicaid benefits, approved by a state plan amendment, waiver, or demonstration project. When HRSN services are formal Medicaid benefits, state Medicaid agencies can require MCOs to provide these services as part of their contract, and MCOs are paid accordingly.

CMS outlined opportunities for making HRSN services benefits in its 2021 state health official letter.¹⁹ For example, HRSN services — such as home modifications, one-time transition costs like security deposits and first month's rent, and home-delivered meals — have long been a key component of HCBS programs under Social

Security Act § 1915(c) and more recently § 1915(i). Under a new CMS demonstration opportunity announced in December 2022, states can provide housing and nutrition supports to individuals who are not traditionally eligible for these HCBS programs, and more easily achieve related cost neutrality requirements.²⁰

HRSN activities, like screening and referring individuals to services, can also be formal Medicaid services. For example, Medicaid health home or targeted case management programs can help individuals get connected to social services. States may also have more granular medical policies and billing codes that allow providers to request reimbursement for HRSN-related care management or HRSN screening.

CMS's New 1115 Demonstration Opportunity

In December 2022, CMS announced it will offer a HRSN demonstration opportunity for states. CMS will consider the following HRSN services, subject to limitations in guidance:

1. Housing supports

- Rent/temporary housing (+/- utilities) for up to 6 months (for certain individuals in transition)
- Traditional respite services
- Day habilitation programs & sobering centers
- Pre-tenancy & tenancy sustaining services
- Housing transition navigation services

2. Nutrition supports

- Nutrition counseling and education including on healthy meal preparation
- Medically-tailored meals
- Meals or pantry stocking
- Fruit & vegetable prescriptions and/or protein box

3. HRSN case management

How can Medicaid programs expand access to HRSN services via managed care?

MCOs can also voluntarily provide additional services, or design individual initiatives that improve quality. In those cases, HRSN services can fall under the following categories defined in federal rule:

- **In lieu of services** (ILOS), approved by the state as cost-effective, medically appropriate substitutes to Medicaid benefits.²¹ Unlike value-added services and quality improvement activities, costs relating to in lieu of services can be considered to develop the medical portion of the MCO capitation rate.²²
- **Value-added services**, i.e., any services that the MCO voluntarily agrees to provide.²³
- **Quality improvement activities**, such as care management that improves health care quality and performance improvement projects.^{24,25}

Other opportunities may arise in the context of the MCO's work with providers and communities. Value-based payment models, especially more flexible models like population-based payments, can create opportunities to invest in HRSN services to improve quality, close disparities, and reduce costs. States can also direct MCOs to invest a portion of their profit and reserves into local communities (i.e., **community reinvestment**), and MCOs may choose to invest in CBOs that address HRSN.

CMS's New Guidance on In Lieu Of Services

In January 2023, CMS released a state Medicaid director on ILOS, with an explicit focus on ILOS that address HRSN. Notably, the letter clarifies that ILOS can be not only a direct substitute for a service, but also a service “expected to reduce or obviate the future need to utilize state plan-covered services or settings” (e.g., medically tailored meals to potentially delay nursing facility care).

In that letter, CMS introduced ILOS requirements for states, which vary based on the ILOS Cost Percentage (i.e., total capitation payments attributable to ILOS, relative to all capitation payments). An ILOS Cost Percentage of 1.5 percent or more triggers more requirements, and an ILOS Cost Percentage of 5 percent or more “may not be approvable.”

What's in a capitation rate?

MCOs receive per member per month payments to support care for Medicaid enrollees. These payments can be adjusted to account for the clinical and social risks of the MCO's enrollees. Adjustment for social risks is commonly referred to as **social risk adjustment**.²⁶

A capitation rate has two core components:²⁷

- **Projected Benefit Costs.** This portion of the rate is designed to support the cost of providing Medicaid benefits to enrollees. HRSN services can be considered in projected benefit costs if the services are Medicaid benefits (i.e., services approved via state plan, waiver, or demonstration), or approved in lieu of services. Value-added services cannot be considered to develop the rate.
- **Projected Non-Benefit Costs.** This portion of the rate is designed to support reasonable expenses related to MCO administration and operation, which may include: (1) quality improvement activities; (2) care coordination and care management; and (3) other material non-benefit costs associated with the MCO's contractual requirements. HRSN-related activities — such as screening for health-related social needs and addressing those needs through referrals, benefit enrollment support, and evidence-based interventions — may fit into these categories.²⁸ This administrative portion of the rate is much smaller than the medical portion of the rate.

What is premium slide?

Premium slide is an oft-cited disincentive to more MCO investment in addressing HRSNs.²⁹ Essentially, plans could be penalized for investing in HRSN services that result in lower health care costs. This can happen when HRSN services and interventions result in Medicaid enrollees using fewer covered medical services, like emergency department visits and inpatient hospitalizations. If the costs associated with HRSN services are not incorporated into rate development, and plans are not financially rewarded for performance on improvements in cost and quality, this downward cost and utilization trend may result in lower future capitation rates for plans.

What's a Medical Loss Ratio?

The medical loss ratio (MLR) measures what proportion of MCO activities are devoted to providing and improving care for enrollees, relative to all revenue. Capitation rates should allow MCOs to reasonably achieve a MLR of at least 85 percent for the rate year.³⁰

The MLR is a ratio, with a numerator and denominator:

- **Numerator.** The numerator of the MLR includes three categories: (1) incurred claims; (2) activities that improve quality; and (3) fraud prevention activities.³¹ HRSN-related services can be reported in incurred claims (i.e., as benefits, value-added services that improve quality, or in lieu of services), and other initiatives can be activities that improve health care quality (e.g., care coordination and management, chronic disease management and related coaching programs).
- **Denominator.** The denominator should reflect adjusted premium revenue — minus taxes, licensing, and regulatory fees and certain community benefit expenditures.³² Adjusted premium revenue does not include funds received from incentive arrangements.

Why is it important for expenses to be in the MLR numerator?

In some states, MCOs may owe the state money if a plan's MLR or similar calculation is too low (usually below 85%).³³ This payment may look slightly different in each state, based on its individual risk corridor or other risk mitigation practices. For example, states may use various terms like MLR remittance, gain share, or experience rebate. MCOs have an interest in reporting qualifying activities in the numerator, and lowering the denominator.

What other payments can MCOs receive?

MCO payment can depend on plan performance on quality measures or HRSN services. For example, states may have:

- **Withhold arrangement:** States can withhold a percentage of funds from the capitation rate, and return those funds contingent on plans' quality performance.
- **Incentive arrangement:** States can reward plans for their performance with additional funds (for a total payment of up to 105% of the capitation rate).

MCOs can also receive separate payments to support distinct initiatives — for example, a separate PMPM to support a community-based care management program, or to support a HRSN services pilot in a 1115 demonstration.

Project Methodology

To capture the diverse array of initiatives and financing methods used by MCOs to address HRSN, CHCS reviewed guidance related to HRSN activities in 12 states, including: Arizona, California, Massachusetts, Minnesota, North Carolina, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and Virginia. CHCS considered a variety of factors to choose these 12 states, including known HRSN-related innovations, geographic location, population size, political environment, and number of ACAP member plans.

For each state, CHCS reviewed policies promoting MCO investment in HRSN interventions and activities. Specifically, CHCS assessed whether the state:

- expanded access to HRSN services (with a specific focus on: community health worker services state plan amendments, 1915(i) or 1915(i)-like HCBS, and 1115 demonstrations)
- approves HRSN services as in lieu of services
- rewards MCOs for HRSN-related activities and related performance
- explains how the capitation rate supports HRSN-related non-benefit costs
- directs MCOs to promote provider-level implementation of HRSN-related activities through value-based payment or directed payment arrangements
- provides specific guidance on how HRSN-related non-benefit costs can be reported in the numerator of the MLR
- applies social risk adjustment to MCO rates
- requires MCOs to reinvest profits/reserves into HRSN-related activities, or provides related flexibilities for excess profits

For more information on why these categories are relevant, see *The Basics: Medicaid Managed Care Payment and HRSN* (page 6). CHCS' analysis also captured notable HRSN and health equity initiatives, and goals occurring in states that may not be related to financing methods but are nonetheless important context.

In addition to the individual state scans, CHCS interviewed three states, two subject matter experts, and two multi-state community health plans.

Research Findings

Medicaid funds can directly and indirectly fund HRSN services and activities, and states have a variety of implementation options. As such, state approaches vary widely. States may make some HRSN services benefits, and thus embed related expected costs in the medical portion of the rate. Other states may direct MCOs to explore HRSN strategies in more indirect ways, in the context of value-based payment models for providers or to meet disparity reduction targets.

Below are four central themes from this 12-state scan. A more detailed state-by-state analysis is included in the Appendix.

State Financing Approaches Related to HRSN

HRSN-Related Approach	AZ	CA	MA	MN	NC	NY	OH	OR	PA	TX	VA	WA
Community Health Worker SPA	X	X		X				X				
1915(i) or 1915(i)-like HCBS				X	X	X		X		X	X	X
Expanded HRSN Services via 1115	X	X	X		X	X		X			X	X
In Lieu of Services		X		X	X	X		X				
MCO Performance Incentives		X	X	X	X		X	X				
Projected non-benefit costs explained		X			X		X	X	X	X		
VBP/Directed Payment	X	X		X		X	X		X	X		
MLR Reporting Guidance	X		X		X			X	X	X		
Social Risk Adjustment of MCO Rates	X		X									
Community Reinvestment	X	X			X		X	X	X			

1. HRSN contract requirements are commonplace, but rate impacts can be unclear.

States are increasingly requiring their managed care organizations to do more related to HRSN and promote health equity.^{34,35,36} In most states, these requirements relate to quality improvement and care coordination and management. For example, the state may direct MCOs to screen for social risk factors, refer members to community resources, and determine whether the enrollee received services.³⁷ States may also direct MCOs to implement evidence-based interventions to reduce health disparities, which can include community care coordination activities performed by a community health worker or performance improvement projects for individuals that are experiencing homelessness or food insecurity.

Managed care rates should be based on Medicaid services and in lieu of services, and be adequate to support care coordination activities and other contractual requirements.³⁸ But explicit financial support for HRSN services is not always visible. Only six of the 12 states had publicly available information about rate assumptions or adjustments for HRSN activities that were not benefits. That grey area may make it more difficult for MCOs to sustain and expand HRSN services performed by community partners and plan employees, and promising interventions may stay at pilot stages. But that same grey area can also give MCOs flexibility; because the services are not benefits, they can work with CBOs that are not enrolled Medicaid providers and do not have the ability to submit medical claims.

States, for instance, often direct MCOs to connect enrollees with community health workers, but stop short of making community health worker services a distinct Medicaid benefit. In these cases, states can clarify relevant funding streams for that workforce. For example, Washington State supports community health workers through federally qualified health center (FQHC) encounter rates, the Maternity Support Services program, and Accountable Communities of Health, but has noted in its waiver request to CMS that payment for community health workers “has been largely limited to administrative expenditures and alternative payment models due to perceived payment barriers and policy gaps.”³⁹ Pennsylvania issues a separate PMPM payment to plans for community-based care management activities performed by community health workers and community-based organizations. And Ohio requires MCOs to work with qualified community hubs and their certified community health workers for certain pregnant enrollees, and adjusted care management expectations in the non-benefit portion of the rates accordingly.⁴⁰

STATE SPOTLIGHT: **Pennsylvania**

Physical Health MCOs in Pennsylvania receive a separate per member per month payment to support community-based care management activities. The funds must be used to support partnerships with CBOs, hospital and health systems, and providers, and to encourage the use of preventive services, mitigate HRSN barriers, reduce health care disparities, and improve maternal and child health.

Approaches to HRSN-related expenses in value-based payment (VBP) models can also differ. New York and Pennsylvania require that advanced value-based payment arrangements include CBOs and HRSN-related activities, but have different approaches to classifying those costs. New York allows MCO expenditures for SDOH interventions to be classified as medical expenditures,⁴¹ but Pennsylvania provided guidance with more caveats: some MCO-to-CBO payments would be classified as value-added services or administrative expenses, with a limited impact on future rates.⁴² These different approaches are consistent with varied actuarial approaches to advanced value-based payments to providers, such as population-based payments (PBPs) (i.e., upfront payments to providers based on the number of patients they serve rather than the number of services they provide).⁴³ Some actuaries treat the PBPs as medical expenses in their totality. Other actuaries may want to understand what components of these PBPs relate to covered services, quality improvement costs, and non-covered services, respectively, and use those categorizations to develop future MCO capitation rates. State approaches that rely on advanced value-based payments to sustain HRSN activities can inadvertently exclude federally qualified health centers, which are paid via the prospective payment system and must adopt unique VBP models when taking on risk.

STATE SPOTLIGHT: **California**

California’s MCOs can voluntarily offer 14 Community Supports, including asthma remediation, housing navigation, and medically supportive food and meals. CMS approved 12 of the 14 Community Supports as in lieu of services, and two services via 1115 demonstrations. During the first year of implementation, MCOs received a rate adjustment for similar services they provided in the past. In the future, capitation rates will reflect cost and utilization of Community Supports.

2. States rely on broad definitions in federal rule when providing MLR guidance.

HRSN services can be included in the numerator of the medical loss ratio (i.e., as value-added services under incurred claims or as activities that improve health care quality). Six states provided (or will provide) specific guidance on how plans should report HRSN-related activities in the MLR, but often did so by evoking the

broad language at 45 C.F.R. § 158.150. Arizona's MLR template prompts MCOs to include [non-covered services] that "improve health and reduce costs, including interventions intended to address social determinants of health." Oregon and Texas have slightly longer standalone guidance on the intersection of quality improvement costs and HRSN, but largely rely on definitions in federal rule. North Carolina allows "voluntary contributions to health-related resources and initiatives that advance public health and health equity and align with [the state's] quality strategy" in the numerator of the MLR, and provides explicit examples.⁴⁴ See examples below.

Examples of HRSN Activities That Can be Included in the MLR Numerator

NC ⁴⁵	<ul style="list-style-type: none"> Housing initiatives or support for community-based organizations that provide meals, transportation, or other essential services.
OR ⁴⁶	<ul style="list-style-type: none"> Food services and supports (e.g., vouchers, meal delivery, farmers market in a food desert); Housing services and supports (e.g., temporary housing or shelter, utilities, critical repairs, environmental remediation, including lead) Other non-covered social and community health services and supports (e.g., social needs screening and referral, including community resource and referral technology and EHR integration; multi-sector interventions to improve population health; interventions to address other SDOH and Health Equity, including employment and built environment improvements)
TX ⁴⁷	<ul style="list-style-type: none"> Screening clients for needs related to SDOH Connecting patients with community resources (including obtaining authorization for coverage of services if applicable and helping to set up an appointment to receive the services); may include Service Coordination and Service Management costs if they are not allocated as medical spending Following up on the results of any additional services provided through referrals or by the managed care plan and communicating those results to a patient's medical provider Services to connect target populations to community services and provide patient education, including when those services are provided by a promotora or community health worker Supporting transitions to housing after homelessness or inpatient discharge

3. States are using new and diverse managed care contracting levers to support provider- and community-level HRSN-related activities.

To identify and address HRSN of their enrollees, MCOs often partner with network providers and local CBOs, which are essential building blocks for more equitable HRSN initiatives. For example, primary care teams can leverage existing trusted relationships with enrollees to screen for social risk factors using a trauma-informed approach. Food pantries can work to address enrollees' HRSN in person – helping enrollees apply for SNAP,

WIC, or other public benefits on site, and providing them with food and meals that address their needs.

To support this work at the provider level, some states have directed MCOs to pay providers in ways that reward HRSN activities. Of the 12 states explored in this report, seven direct MCOs to pay providers using models that somehow reward or incorporate HRSN-related activities. Arizona's Targeted Investments 2.0 Program will provide incentive payments to providers that implement procedures that use a closed loop referral system, and conduct population health analyses related to HRSN. Under the Texas Incentives for Physicians and Professional Services (TIPPS) directed payment program, providers will receive a specific rate enhancement tied to, among other factors, food insecurity screening.

In addition, states are also developing performance incentives for MCOs that encourage HRSN activities, including incentive payments and quality withhold arrangements. In select states, the incentives specifically reward MCOs for efforts related to strategically and sustainably addressing HRSN through capacity-building and partnerships.

Of the 12 states explored for this report, six states have HRSN-related incentives for MCOs, and three of those states include specific incentives for capacity-building efforts. Through California's Homelessness Incentive Program, managed care plans not only earn incentive

funds for screening members for housing insecurity, but earn additional funds for making investments to keep individuals housed through partnerships with local public health jurisdictions, county behavioral health, public hospitals, county social services, and local housing departments.

States have also developed community reinvestment requirements.⁴⁸ These direct MCOs to reinvest a portion of revenue or profits into the communities they are serving.⁴⁹ Of the 12 states studied in this report, six states have either community reinvestment requirements or flexibilities for excess profits.

Examples of Value-Based and Directed MCO Payment Programs that Include HRSN Activities

AZ	<p>Differential Adjustment Payment. Providers, including hospitals, behavioral health clinics, physicians, and other providers are eligible for differential adjustment payment increases based on commitment to use and use of and SDOH Closed Loop Referral Platform.⁵⁰</p> <p>Targeted Investments 1.0 and 2.0 Programs. As part of the Targeted Investments Program (1.0), Arizona issued directed lump sum payments in its capitation rates paid to managed care entities pursuant to 42 CFR 438.6(c). The Targeted Investments Program included benchmarks for HRSN screening. TI 2.0 will direct managed care organizations to make specific incentive payments to providers for closed loop referral systems and population health analyses related to HRSN.⁵¹</p>
CA	<p>Equity and Practice Transformation Payments will support pediatric, primary care, OB/GYN and behavioral health providers. Funding will support “upstream interventions to address social drivers of health and improve early childhood outcomes” and infrastructure to support data exchange and advanced data analytics (approved in 22-23 budget, not yet implemented).⁵²</p>
MN	<p>Integrated Health Care Partnerships. The state pays IHPs quarterly population-based payments, and MCOs pay shared savings payments (or recoup shared losses), as directed by the state. Population-based payments for IHPs are risk adjusted for social risk factors, and IHPs are held accountable for health equity interventions and related measures that often address HRSN.⁵³</p>
PA	<p>Maternity Care Bundled Payment Model. The model includes components relating to care team composition (i.e., incorporating CHWs and doulas); SDOH/HRSN screening; and a health equity score.⁵⁴</p>
TX	<p>The Texas Incentives for Physicians and Professional Services directed payment program includes a rate enhancement for food insecurity screening.⁵⁵</p>

Examples of MCO Community Investment Requirements

AZ ⁵⁶	<p>6% of annual profits to community reinvestment <i>Effective since 2019</i></p>
CA ⁵⁷	<p>5% of the portion of Contractor's annual net income that is less than or equal to 7.5 percent of Contract Revenues for the year, and 7.5 percent of the portion of Contractor's annual net income that is greater than 7.5 percent. <i>Effective January 1, 2024</i></p>
OH ⁵⁸	<p>3% of its annual after-tax profits to community reinvestment. The MCO must increase the percentage of the MCO's contributions by 1% point each subsequent year, for a maximum of 5% of the MCO's annual after-tax profits. <i>Effective 2023</i></p>
OR ⁵⁹	<p>A CCO's SHARE designation is subject to a minimum formula set by OHA. <i>Effective 2023</i></p>
PA ⁶⁰	<p>PH-MCOs that realize profits in excess of 3% may retain a portion of those excess gains if they are devoted to investments in provider network development, non-medical support services to address HRSN, achieving health equity, and developing communities. <i>Effective 2023</i></p>

Examples of HRSN-Related MCO Performance Incentives

CA	<p>Housing and Homelessness Incentive Program. Medi-Cal managed care plans are able to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed.⁶¹ Managed care plans and the local planning body that coordinates housing and services funding for individuals experiencing homelessness (i.e., the Continuum of Care), in partnership with local public health jurisdictions, county behavioral health, public hospitals, county social services, and local housing departments, must submit a Homelessness Plan to the state.⁶²</p> <p>Incentive Payment Program. Intended to support the implementation and expansion of Enhanced Care Management and Community Supports by incentivizing managed care plans (MCPs) to drive MCP delivery system investment in provider capacity and delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and promote health equity; achieve improvements in quality performance; and encourage take-up of Community Supports.⁶³</p>
MA	<p>ACO Measures. Measures include HRSN screening, LTSS Community Partner Engagement, and Community Tenure (i.e., the percentage of eligible days that ACO members 18-64 with bipolar disorder, schizophrenia, or psychosis (BSP) diagnoses, and separately, for other members 18-64 who have at least 3 consecutive months of LTSS utilization reside in their home or in a community setting without utilizing acute, chronic, or post-acute institutional health care services during the measurement year).⁶⁴ MassHealth also intends to hold certain health system entities financially accountable for identification and monitoring of health inequities (e.g., through stratified reporting of quality metric performance by social risk factors).</p>
NC	<p>Auto-Assignment Preference. MCOs that voluntarily contribute 0.1% of their annual capitation revenue to HRSN resources are rewarded with a preference in auto-assignment, which promotes enrollment in that MCO.⁶⁵</p>
OH	<p>Quality Withhold Program. Performance evaluation considers, among other factors, the following: (1) collaboration with community entities, providers, and other stakeholders; (2) collaboration with other Medicaid and non-Medicaid health plans for collective impact; (3) population health management and quality improvement activities that include: “Active primary and secondary research to develop changes to the MCP’s normal processes (e.g., care management, vendor agreements, data tracking and analysis, coverage of services, addressing of health-related social needs) to better serve individuals impacted by the pandemic/experiencing disparities.”⁶⁶</p>
OR	<p>Quality Pool Incentive Payment Program includes an incentive measure for social risk factor screening.⁶⁷</p> <p>The Performance-Based Reward (PBR) initiative rewards CCOs with a higher profit margin when costs are held lower, quality is maintained, and CCOs invest in qualified health-related services spending.⁶⁸</p>

4. Under new 1115 demonstrations, MCO capitation rates will reflect approved HRSN services, like never before.

Over the past year and a half, CMS approved several 1115 demonstrations that authorize funding for HRSN services and HRSN infrastructure (e.g., technology; workforce development; development of business or operational practices; and outreach, education, and stakeholder convening) — including in California, Oregon, Massachusetts, Arizona, and Arkansas.⁶⁹

In December 2022, CMS announced a demonstration opportunity for states interested in similar HRSN initiatives, provided a menu of approvable housing and nutrition supports, and issued a related framework.^{70,71} CMS has approved similar services under past

administrations, with North Carolina’s Healthy Opportunities Pilot as a notable example. However, CMS often supported separate funding pools for these HRSN-related pilot programs, and states were able to issue grant-like payments to participating entities. CMS also gravitated to services that could have largely been approved via other authorities (e.g., “1915(i)-like” HCBS).

CMS’ new approach is distinctive because:

- CMS has encouraged states to treat these services more like benefits, and less like pilot programs. States will offer HRSN services through managed care organizations, embed HRSN services in MCO capitation rates, and require plans to report services in the numerator of the medical loss ratio as incurred claims. In three of the four states with recent 1115 demonstrations in this scan, fee for service enrollees will also have access to the services.
- More people will be eligible for these services, beyond populations that typically qualify for HCBS

services under Social Security Act § 1915(c) and 1915(i). CMS is explicitly interested in testing whether these services may benefit a broader array of Medicaid enrollees with clinical and social risk factors.

- In two states, CMS authorized rent and temporary housing for six months, and reversed its previously hardline stance against room and board costs beyond one-time transition costs and institutional stays. With these approvals, CMS hopes to test whether stable housing will “improve individual’s health outcomes . . . and their utilization of appropriate care” and increase “the likelihood that they will keep receiving and benefitting from the Medicaid-covered services to which they are entitled.”
- In fall 2022, CMS made it easier for states to achieve cost neutrality for 1115 demonstrations authorizing HRSN services.⁷² With this new guidance, CMS treats HRSN services like services that could otherwise be approved via other authorities (i.e., capped

“hypothetical expenditures”), and therefore states did not have to identify “savings” to offset these requests. To preserve access and funding for core health services, CMS caps HRSN expenditure authority at three percent of total annual Medicaid spend, and requires rates for primary care providers, obstetrics, and behavioral care to increase rates or maintain levels that are at least 80 percent of Medicare rates.⁷³

Priority populations for these new CMS-approved HRSN services include individuals who are homeless or at risk of homelessness, have a serious mental illness/substance use disorder, and are transitioning from institutions (incarceration, nursing facility, IMD/ state hospital/mental health inpatient). And in Oregon and potentially Washington (pending CMS review of the state’s waiver request), a new priority population includes people who need air filtration systems and air conditioners during climate emergencies (i.e., fires and unusually hot weather).

HRSN Services & Infrastructure Approved through 1115 Demonstrations

AZ ⁷⁴	<p>Approved HRSN Services: Housing supports, including rent/temporary housing for up to six months post transition from certain settings.</p> <p>Delivery System: Offered to fee-for-service (FFS) and managed care enrollees.</p> <p>MCO Financial Impact:</p> <ul style="list-style-type: none"> ■ HRSN services will be in MCO capitation rates. ■ CMS approved expenditure authority for HRSN services infrastructure but noted that these expenses should not be embedded in MCO capitation rates.
CA ⁷⁵	<p>Approved optional HRSN Services: Recuperative care and short-term post-hospitalization housing (not benefits, but provided at the option of MCOs).</p> <p>Delivery System: Offered exclusively through managed care.</p> <p>MCO Financial Impact:</p> <ul style="list-style-type: none"> ■ Cost and utilization will be in MCO capitation rates, but only if plans elect to provide Community Supports. ■ CMS approved expenditure authority for capacity building, technical assistance, and collaborative planning, but these funds will not flow to the plans. Plans will be rewarded for capacity-building efforts through separate funding in the Incentive Payment Program.
MA ⁷⁶	<p>Approved HRSN services: Housing and nutrition supports.</p> <p>Delivery system: Some “Flexible Services HRSN Services” are only available to ACO enrollees, but “Community Support Program HRSN Services” available to both FFS and managed care enrollees.</p> <p>MCO Financial Impact:</p> <ul style="list-style-type: none"> ■ HRSN services will be in MCO capitation rates. ■ CMS approved expenditure authority for HRSN services infrastructure, but noted that these expenses should not be embedded in MCO capitation rates.
OR ⁷⁷	<p>Approved HRSN Services: Housing supports (including rent/temporary housing for up to six months post transition from certain settings), nutrition supports, and clinically indicated devices to maintain healthy temperatures and clean air during climate emergencies</p> <p>Delivery System: Offered to FFS and managed care enrollees.</p> <p>MCO Financial Impact:</p> <ul style="list-style-type: none"> ■ HRSN services will be in MCO capitation rates. ■ CMS approved expenditure authority for HRSN services infrastructure, but noted that these expenses should not be embedded in MCO capitation rates.

Federal Policy Recommendations

Over the past decade, Medicaid's focus on addressing HRSN has evolved. States have largely embraced whole-person care as a goal in their Medicaid managed care programs, and are increasingly willing to define specific HRSN services for MCOs to implement. CMS has also demonstrated support for this work. For example, CMS has noted that it plans to finalize a health equity measure slate, and will work with states to approve more 1115 demonstrations and in lieu of services that address HRSN, using CMS frameworks released in December 2022 and January 2023.^{78,79,80} In Medicaid and Medicare, CMS has sought to expand social risk screening, improve coordination with community-based organizations (CBOs), encourage the standardized collection of social needs data, and promote the uptake of value-based payment (VBP) models that can support HRSN-related services.

However, social services have been historically underfunded, relative to health care, and more work will be needed to build local capacity to address these needs and bridge the worlds of health care and social care. To scale and sustain HRSN services and activities, adequate, transparent financing — within and outside of Medicaid managed care — is needed. To that end, CMS and federal policymakers can consider the following.

1. Continue to use Medicaid funds to expand access to HRSN Services – but stay flexible.

CMS has demonstrated an unprecedented commitment to expanding access to HRSN services, creating new pathways for HRSN services to be treated like benefits and for more Medicaid members. It allowed California's health plans to provide certain HRSN-related services as in lieu of services, and for Arizona, Massachusetts, and Oregon to cover an array of HRSN services and include them in rates. CMS guidance on in lieu of services released in January 2023 gives new states the ability to pursue these types of services without detailed waivers and demonstration projects.

These benefit and in lieu of services pathways could be transformative. Given that costs associated with benefits and in lieu of services are embedded in managed care capitation rates, making a service a benefit or in lieu of service is the most direct financial pathway to scale and sustain HRSN services via Medicaid programs. But the path also may include significant challenges. For example, states have begun to adapt medical billing and provider enrollment processes to these new HRSN initiatives, and encourage the generation of claims and shadow claims. These steps can be labor-intensive for plans, states, and CBOs alike.

CMS can continue to support states that wish to expand access to HRSN services, through guidance, dissemination of timely learnings, and technical assistance.⁸¹ In particular, CMS can continue to detail what financing options are available to states that do not wish to enter into 1115 demonstration negotiations, and would prefer to use flexible managed care tools outlined in 42 C.F.R. Part 438 to provide HRSN services and build HRSN infrastructure, like incentive arrangements, value-based payment, directed payment arrangements, or dedicated funds in the administrative portion of the capitation rate. CMS can also encourage states to engage safety-net providers in these efforts, including VBP initiatives, and monitor health equity impacts using available data.

CMS can also outline how states can use their MCOs to support enrollment in other public benefits like the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and financially support that work through rates or incentive payments. States like North Carolina, Pennsylvania, and Washington have demonstrated an interest in working with MCOs to boost these enrollment rates, for example.⁸²

2. Support more accurate MLR reporting and capitation rates by providing explicit HRSN-related examples.

HRSN initiatives are now a norm and not an exception. For example, in a recent Institute of Medicaid Innovation survey, 90 percent of Medicaid MCOs had a program for individuals experiencing homelessness, and 71 percent had a program for pregnant and postpartum individuals addressing HRSN.⁸³

To sustain HRSN services and empower internal plan champions to support this work, financial support of HRSN and related flexibilities should be widely understood — beyond behind-the-scenes rate development and federal rate review processes. CMS can explicitly mention these activities in managed care templates, guidance, and rules. For example, CMS could:

- Update the federal definition of “activities that improve health care quality” at 45 C.F.R. § 158.150 to include explicit examples of common HRSN-related activities. Potential examples may include:
 - ▶ Providing evidence-based HRSN interventions to close disparities, such as asthma remediation, supportive housing services, or medically tailored meals;
 - ▶ Supporting community-based care management programs that integrate community health workers, refer enrollees to HRSN services, and track whether services were received; and
 - ▶ Investments in CBO capacity to scale HRSN services and activities.⁸⁴
- Amend CMS’ Medicaid Managed Care Rate Development Guide to explicitly refer to opportunities to consider HRSN services in the projected non-benefit costs portion of the rate.⁸⁵
- Clarify how states without a demonstration project or waiver can support managed care efforts to strengthen CBO capacity and core HRSN infrastructure through managed care rate setting or other financial levers, particularly for states interested in approving HRSN services as in lieu of services.
- Outline how payments from MCOs to CBOs to support startup and expansion of HRSN-related services can be classified for rate-setting purposes.

CMS can summarize current flexibilities and future activities in a state guidance letter or roadmap, as CMS recently did for health equity data.⁸⁶

3. Allow states to test new approaches to financing HRSN services and infrastructure.

Even as Medicaid initiatives to address HRSN become more common, Medicaid funding will continue to be one of several available funding streams for HRSN services and infrastructure.⁸⁷ CMS and states will have to determine what data is necessary for evaluation and billing efforts, and what processes can be adapted to the unique needs and capabilities of CBOs providing HRSN services. For example, CBOs may experience difficulties submitting Medicaid claims; navigating multiple managed care portals, reporting requirements, and workflows; and weathering unsteady cash flows during program rollout. To move this work forward, CMS and states should determine the role of Medicaid funding in the landscape, and choose a path that seeks to integrate CBOs in ways that respects their roles as HRSN service providers and not traditional health care providers.

CMS can continue to partner with states to flex traditional financial flows and accountability measures, and test new approaches to ensure that Medicaid funds will be used to enhance existing capacity and address the real-world needs of new and existing community partners. For example, CMS can consider ways that Medicaid funds can be pooled, braided, or blended with other funds to support backbone organizations like health equity zones, accountable communities of health, and community care hubs.^{88,89,90,91,92} These types of structures can help convene cross-sector partners and MCO competitors, co-design HRSN services with local communities, and provide administrative and evaluative support for CBOs interfacing with health care organizations. Tools like outcomes-based financing can complement these pooled funding arrangements by mobilizing upfront capacity-building funds for CBOs and nominating central outcome measures. CMS and states also can consider whether fee-for-service rate schedules and related billing increments are an appropriate first step for this work, and if it makes sense to adopt more flexible payment models that respect how these services are typically delivered.

CMS has approved funding for similar concepts. For example, CMS approved funding for network leads that organize CBOs participating in North Carolina’s Healthy Opportunities Pilots, and for collaborative planning and implementation groups in California, which include CBOs, counties, and health plans interested in coordinating HRSN service delivery and related capacity-building in particular regions.^{93,94} CMS also has

broadly authorized HRSN infrastructure expenditures relating to “obtaining community input” and “stakeholder convening,” as in Massachusetts, Arizona, and Oregon, and will need to work with states on a related protocol. Other requests are still pending. At the time of this writing, CMS has yet to approve Oregon’s request for community investment collaboratives, and proposals for regional entities and collaborations in New Jersey, New York, and Washington. But CMS staff seem receptive to the concept, authoring a prominent blog post in Health Affairs in November 2022 on community care hubs.⁹⁵

CMS can also consider ways in which it can work with other federal agencies to develop initiatives that comprehensively braid and blend funding sources around housing, nutrition, and interpersonal violence, among other HRSN domains, and ensure that related oversight mechanisms do not stifle innovation. This more comprehensive approach, while complex, may help create a foundation for sustainably funded, less fragmented efforts in the future. It allows CBOs with diverse federal funding streams to spend less time navigating individual program reporting requirements, and more time providing services.

Looking Forward

This report focuses only on one small aspect of funding to address HRSN for communities: funds that flow to and through Medicaid MCOs. Other policies and programs will need to be mobilized to more fully impact health in communities that have been marginalized.

In the coming years, state Medicaid agencies will begin to expand access to HRSN services, and find ways

to support this work both financially and logistically, with health equity as a goal. The road ahead will likely include rough starts, intense periods of change management, and many opportunities for learning and collaboration. But this work has the potential to advance more whole-person, equitable care for Medicaid enrollees.

APPENDICES: STATE-BY-STATE ANALYSIS

A set of online appendices profiles several states’ efforts to address and finance HRSN.

For more, visit www.communityplans.net/state-profiles.



Endnotes

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