



Leveraging Medicaid Managed Care to Address Health-Related Social Needs

November 7, 2024
2:00-3:00pm ET

Please stand by, this webinar will begin shortly

STATE
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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@princeton.edu.

*Support for this webinar was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.*

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Working with state agencies and their partners
to improve health care system performance for all.

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Housekeeping Details

- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.**
- All participant lines are muted.
- After the webinar, the slide deck and a recording will be available at www.shvs.org.



Agenda

1. Health-Related Social Needs Context in Medicaid Managed Care

2. Overview of the 2024 Toolkit, *Addressing Health-Related Social Needs Through Medicaid Managed Care*

3. State Examples From the Toolkit

4. State Perspectives

5. Discussion



Health-Related Social Needs Context in Medicaid Managed Care

Medicaid Authorities to Address HRSNs

Managed Care
Programs

Home and Community
Based Services

State Plan
Authorities

1115
Demonstration

Health Home
Benefit

Program for All-Inclusive Care
for the Elderly

1115 Approved Waivers That Address HRSNs



Housing Supports: At least 19 waivers approved.



Nutrition Supports: At least 9 waivers approved.



Employment Supports: At least 6 waivers approved.



Medical Respite: At least 5 waivers approved.

As of Sept 2024, 21 states with approved “SDOH” waiver components and 16 pending according to KFF: <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table3>

The Relationship Between Unmet HRSNs and Health Equity

- The way communities and individuals experience health and healthcare is not based solely on access to medical services.
 - About [80% of health outcomes](#) can be attributed to social drivers of health such as financial stability, housing stability, food security, and the built environment.
 - Structural and institutional racism in the health and social care systems reinforce and amplify health disparities in communities that have been marginalized.
- While social drivers of health focus on community level factors that impact health, **HRSNs address social and economic factors that can impact a person's ability to maintain their health and well-being on an individual level.**
- Addressing unmet HRSNs of Medicaid members is **integral for advancing health equity** because it affects people before, during, and after they interact with a healthcare system.
- For more information on state Medicaid approaches to address equity, see State Health and Value Strategies' [Compendium of Medicaid Managed Care Contracting Strategies to Promote Health Equity](#).



Overview of the 2024 Toolkit, *Addressing Health-Related Social Needs Through Medicaid Managed Care*

Addressing Health-Related Social Needs Through Medicaid Managed Care Toolkit



Addressing Health-Related Social Needs Through Medicaid Managed Care
Prepared by Bailit Health
Updated October 2024

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<https://www.shvs.org/resource/addressing-health-related-social-needs-through-medicaid-managed-care/>

- Originally published in 2022, refreshed annually.
- Summary of different state approaches to address enrollees' HRSNs through Medicaid Managed Care (MMC).
- Examples from **21 profiled states**, including one state new to the Toolkit: **New Mexico**.

Toolkit Contents and How It Can Help States

- The 2024 HRSN toolkit includes:
 - Refreshed examples of **eight approaches** states use in MMC to address enrollees' HRSNs.
 - **Focused examples** of states with MMC initiatives to support members experiencing **housing instability** and **food insecurity**.
 - MMC procurement question examples, excerpts of HRSN-related contract language, and links to MMC procurements and contracts.
- States can use this resource to learn what other states are doing to address enrollees' HRSNs, develop managed care procurements, and update and operationalize key contract provisions.

MMC Approaches to Address HRSNs

Identifying and addressing HRSNs, including within MCO care coordination/management.

Directing MCOs to engage providers in HRSN activities.

Encouraging HRSN activities and approaches with incentives.

Encouraging use of in lieu of services (ILOS) to address HRSNs.

Addressing HRSNs through community engagement, partnerships, and/or investments.

Encouraging use of value-added services to address HRSNs.

Accounting for social risk factors in managed care payment methodologies.

Requiring use of ICD-10 Z codes.



State Examples From the Toolkit

HRSN Approaches Used In Florida's 2023 MMC Procurement

Approach	Description of Florida's Approach in MCO Model Contract Documents
Identifying and Addressing HRSN Through Care Coordination/ Management	Will require MCOs to use findings from enrollee screenings to initiate access to care coordination/case management services, expanded benefits, and referrals to community partners to address HRSNs.
Use of Z Codes	Will requires MCOs to require primary care providers to assess members' HRSNs, document needs in enrollees' records using Z Codes, and include Z Codes on claims.
Use of Value-Added Services	Will encourages MCOs to offer "expanded benefits" related to housing assistance, food assistance, among others.
Use of ILOS	Encourages MCOs to provide ILOS for housing assistance and targeted case management for members experiencing or at risk for homelessness.
Directing MCOs to Engage Providers in HRSN Activities	Within MCO VBP programs, will emphasize supplemental payments to address HRSNs and encourage MCOs to use the enrollees' area deprivation index or other social vulnerability index rankings to adjust provider risk when calculating VBP targets.
Encouraging HRSN Activities Through Incentives	MCOs may be subject to sanctions or liquidated damages for poor HEDIS performance, including Social Need Screening and Intervention performance measure(s).
Accounting for Social Risk in MCO Payments	Potential to consider HRSNs, including housing insecurity, in diagnostic-based risk adjustment methodology for future MCO capitation rates.
Addressing HRSN Through Community Partnerships etc.	Will require MCOs to establish community partnerships for HCBS services and supports, including community organizations that address HRSNs.

Examples of States With HRSN Initiatives Targeting Housing Instability



- Requires MCOs to provide housing supports to certain members, such as those at risk of homelessness.
- Supports include housing search assistance, support for applying for housing and benefits, advocacy and negotiation with landlords/tenants, moving assistance, and eviction prevention.



- Requires MCO care/case management policies to include formal referral and assistance and collaboration with housing providers for members experiencing homelessness.



- Will require MCOs to employ a housing coordinator to help members secure and maintain community-based housing.
- Authorizes “assistance in finding and keeping housing” as approved in lieu of services, subject to CMS approval.

Examples of States With HRSN Initiatives Targeting Food Insecurity



- Requires MCOs to coordinate non-medical interventions for high needs members, including food services such as food and nutrition access case management, evidence-based group nutrition classes, healthy food boxes or meals, fruit and vegetable prescriptions, and medically tailored meal delivery.



- Requires MCOs' subcontracted community partners to assist members with identified needs with referrals to SNAP or WIC and follow up with members to ensure needs are met.



- Includes nutrition supports (medically supportive food/ meals/medically tailored meals) as approved in lieu of services.



State Perspectives

About Our State Presenters

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Nevada Medicaid's Approach to In Lieu of Services (ILOS)

Division of Health Care Financing and Policy

Jaimie Evins, Chief of Managed Care and Quality Assurance

November 7, 2024



Department of Health and Human Services

Helping people. It's who we are and what we do.



Topics

1. Managed Care Organizations (MCOs) Proposals
2. Available Services
3. Eligibility Requirements
4. MCO Process
5. 1115 Demonstration Waiver
6. ILOS Links



Managed Care Organization Proposals

- Each MCO submitted an implementation plan for review
- Target implementation is within 6 months of CMS approval
- Nevada is working with a vendor to develop a policy guide intended to be a resource for the MCOs and providers to implement the various ILOS.



Available Services

- **Specialized Case Management Services -- 7.4.3.2.9.1**
 - Qualified provider to perform the intake screening and assessment of the members preferences and barriers related to successful tenancy if eligible for housing supports and developing an individualized plans for the member.
- **Housing Transitions Supports – section 7.4.3.2.9.2**
 - Services that assist Medicaid members with efforts to secure housing.
- **Housing-related Deposits – section 7.4.3.2.9.3**
 - Assistance provided to a Medicaid recipient to help identify, secure, an/or finance one-time services and modifications necessary for establishing a household
- **Housing Sustainment Services – section 7.4.3.2.9.4**
 - Services provided to Medicaid recipients to assist with sustaining safe and stable tenancy once housing is secured.



Eligibility Requirements

- Member must be given an assessment by a qualified provider.
- Members who are homeless or at risk of experiencing homelessness as defined under 24 CFR 91.5 AND must be experiencing one or more of the following:
 - Severe Emotional Disturbance (SED) diagnosis
 - Serious Mental Illness (SMI) diagnosis
 - Substance Use Disorder (SUD) diagnosis
 - At risk of institutionalization or overdose or in need of residential services because of an SUD, SED, or other behavioral health condition
 - At risk for experiencing a behavioral health crisis or utilizing the emergency department
 - Pregnant or had a recent live birth within the last sixty (60) days
 - Discharged from a correctional or medical facility within the last ninety (90) days
 - Transitioning, or will be transitioning within the next thirty (30) days, from an institutional or inpatient setting to the home or community setting
 - Victim of human trafficking or domestic violence (DV)



MCO Process

MCOs must:

- Have a consistent process for screening eligibility
- Have qualified providers document eligibility
- Work with local governments & entities to identify funding sources to cover rent/utilities
- Ensure qualified providers conduct assessments in a manner that is culturally & linguistically appropriate without bias.



1115 Demonstration Waiver

- Nevada is seeking to amend the [1115 Demonstration Waiver](#) for Substance Use Disorder (SUD) treatment in an Institutions for Mental Disease (IMD) to provide a limited demonstration waiver of the IMD exclusion for adults with a serious mental illness (SMI) and children with a Serious Emotional Disturbance (SED) as well as provide housing and nutrition supports as health-related social needs (HRSN) to eligible members based on clinical and social risk factors.
- [Public Notice Document](#) that provides a summary of the overall 1115 amendment application that includes a table of the proposed services.



ILOS Links

- Link for ILOS webpage: [Housing Supports & Services](#)
- Fact sheet: [Nevada Medicaid Housing Supports & Services](#)
- 1115 Demonstration Waiver Amendment:
<https://dhcfp.nv.gov/Pgms/Waivers/1115/>

Arizona Medicaid's Approach to Addressing Health-Related Social Needs

November 7, 2024

Susan Podshadley, Program Director
AHCCCS Whole Person Care Initiative

Today's Topics

- **AHCCCS Whole Person Care Initiative (WPCI)**
 - Areas of Focus
 - CommunityCares Statewide Closed-Loop Referral System (CLRS)
 - Requirements & Incentives for Health Plans & Providers
- **AHCCCS Housing**
 - Housing and Health Opportunities (H2O) Program
 - Data Warehouse for Enterprise Linkage Arizona (DWEL-AZ)
 - Partnership with WIC, SNAP, & TANF to Address Food Insecurity & Nutrition
 - Pathways to Hope Transitional Housing Facility
- **Future Plans**

AHCCCS & Whole Person Care

- AHCCCS' Whole Person Care Initiative is our next step toward integrated care by improving member Health-Related Social Needs (HRSN)
- Our areas of focus include:
 - Housing & basic amenities
 - Food
 - Transportation
 - Pre- & post-employment services
 - Education & childhood development
 - Justice/Legal support
 - Interpersonal & environmental safety
 - Social support & non-discrimination
 - Severe heat analysis, education, & interventions
 - Access to outdoor spaces & parks
- CommunityCares Statewide Closed-Loop Referral System (CLRS)

Health-Related Social Needs
+
Health Equity

Requirements & Incentives

Health Plan Requirements

- Use the CLRS to screen & refer members enrolled in care management
 - Educate providers on HRSN z codes & encourage their use
 - Maintain a publicly available *Community Resource Guide* with local HRSN resources
 - This is both a health plan & provider requirement
 - Employ a housing specialist located in the health plan's service area
 - Participate in the Community Reinvestment Program
-

Provider Incentives

- [AHCCCS Targeted Investments Program \(TIP\)](#) - Financial incentive program to encourage providers to meet milestones focused on addressing HRSN
- [Differential Adjusted Payment \(DAP\) Program](#) - Financial incentive program for using the CLRS to screen & refer members for HRSN

AHCCCS Community Reinvestment Program

- AHCCCS requires our health plans to invest a % of their profits back into the communities they serve, specifically for programs and projects focused on HRSN
- Examples of programs include:
 - Food access programs & food literacy
 - Eviction prevention & utility assistance
 - Post-Incarceration support for community integration
 - Winter coat programs, especially for rural & tribal areas
 - Showers, haircuts, hygiene supplies, & services ([Cloud Covered Streets](#))
 - Events for free laundry services ([Social Spin](#))

Program Links

- [ACOM 303 - Community Reinvestment](#)
 - (Update Coming January 2025)
- [CRI Plan Template](#)
- [CRI Report Template](#)

AHCCCS' Housing Programs

- Housing properties & statewide housing administrator
- Housing & Health Opportunities (H2O) through 1115 Waiver
- Data Warehouse for Enterprise Linkage Arizona (DWEL-AZ)
- Data sharing partnership with WIC, SNAP, & TANF to address food insecurity & nutrition
- Pathways to Hope Transitional Housing Facility

Pathways for Hope Transitional Housing Facility

- 50 bed transitional shelter with clinic next door for physical & behavioral health care
 - Residents can live there for up to 2 years
 - Designed to support members with skill building to transition to permanent housing
- Located in downtown Phoenix near services & transportation lines
- Scheduled to open Summer 2025

Shelter

- Trauma informed & gender inclusive design
- Activity room & patio
- Warming kitchen
- Pet-friendly with crates & dog run
- Onsite laundry
- Beds with personal storage
- Hot Room for prevention of bed bugs
- Special accommodations beyond ADA compliance

Clinic (Separate from Shelter)

- Outpatient primary care
- Outpatient behavioral health therapy & psychiatry
- Labs services
- High quality health care providers
- Services delivered with compassion, integrity, accountability, & innovation
- Will serve anyone with an AHCCCS health insurance plan

On the Horizon

- Enhancements to the Community Reinvestment Program
 - [ACOM 303](#)
- Continue H2O & evaluate its success
- Policy & services for addressing social isolation among members in long term care
 - *AMPM 1240-K: Supported Community Connections* (Coming Soon)
- Planning a future 1115 waiver to request new authorities for addressing food insecurity & nutrition

Key Takeaways

- Arizona has a variety of programs to address HRSN for Medicaid members & we plan to expand them
- We use the CommunityCares Statewide Closed-Loop Referral System (CLRS) to support screening & referrals for HRSN resources
- We have several health plan contract requirements for addressing HRSN
- There are multiple financial incentive programs available to encourage providers to address HRSN

FAQ: How does the CommunityCares Closed-Loop Referral System work?



Staff Contact Information

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**Don't hesitate to reach out,
we love talking with other states & organizations!**

Additional Resources

- AHCCCS Whole Person Care Initiative
 - www.azahcccs.gov/wpci
- Overview of the CommunityCares Statewide Closed-Loop Referral System
 - www.azahcccs.gov/communitycares
- CommunityCares Website
 - www.contexture.org/communitycares
- AHCCCS Housing Programs
 - <https://www.azahcccs.gov/housing>
- Housing and Health Opportunities (H2O) 1115 Waiver Demonstration
 - <https://www.azahcccs.gov/Resources/Federal/HousingWaiverRequest.html>
- AHCCCS Community Reinvestment Policy - ACOM 303
 - <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/303.pdf>

Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar



Thank you

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Appendix

Renderings of the Pathways for Hope Transitional Housing Facility

Set to Open Summer 2025





