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Medicaid Can Partner With Housing Providers and Others to Address Enrollees' Social Needs

By Hannah Katch

Housing, nutrition, transportation, and other needs significantly affect health outcomes, a growing body of literature shows. States seeking to improve Medicaid beneficiaries' health and limit unnecessary health care spending are increasingly focusing on how they can ensure that beneficiaries can obtain these services.

Medicaid's purpose is to provide medical assistance to eligible individuals. It can't fill the gaps left by underfunded housing, nutrition, and other social services. Federal, state, and local governments must provide more funding for these programs that directly address social needs, such as affordable housing programs. But Medicaid *can* help address these needs in innovative ways. At the beneficiary level, Medicaid can help enrollees obtain the care they need. And at the system level, Medicaid can help build the infrastructure to facilitate partnerships and data sharing across medical and other service providers that are necessary to improve coordination across programs and help enrollees get the services they need.

Medicaid provides more comprehensive benefits than private insurance, such as offering targeted case management based on enrollees' needs. Medicaid can also link individuals to community-based organizations that meet social needs, such as housing or nutrition services. States and managed care organizations can use this flexibility to build partnerships across sectors, such as partnering with housing agencies and other service providers. A number of states are using a range of Medicaid options to invest in these partnerships, with promising results. The federal government could do more to support states' efforts by streamlining programmatic reporting requirements, encouraging additional data sharing across programs, and continuing to provide funding for states to better integrate eligibility and enrollment systems.

States can build partnerships and ensure beneficiaries' health-related needs are met in a number of ways.

- **Home- and community-based services (HCBS) waivers** and a related state option let states provide services that help people stay safely in their homes, rather than in institutions such as nursing facilities. Using an HCBS waiver, Louisiana established a partnership between

its Department of Health and the Louisiana Housing Authority to reduce homelessness and unnecessary institutionalization among people with disabilities by providing permanent supportive housing. The housing authority identifies and recruits housing providers and serves as the rental subsidy administrator, using a number of federal housing funding streams to make new and existing housing available for the program.

- **The health home option** lets states provide enhanced care coordination and case management services to Medicaid enrollees with multiple chronic conditions. Missouri has two health homes: one for beneficiaries with chronic physical health conditions, and another for those diagnosed with behavioral health conditions. Both health homes rely on community-based organizations to provide care coordination and care management, and the behavioral health-focused health home has invested in developing relationships and educating other sectors to improve care for Medicaid beneficiaries.
- States contracting with **Medicaid managed care organizations** (MCOs) can require coordination between health plans and community-based organizations. Washington’s managed care contracts require their health plans to participate in regional collaboratives designed to improve coordination between health care and social services, reward high-value health care, and integrate primary and behavioral care.
- **1115 demonstration waivers** let states test new ways of providing care. California used an 1115 waiver to establish its Whole Person Care pilot program, which provides funding to 25 counties and cities across the state to invest in infrastructure linking Medicaid with social service providers as well as limited non-clinical services.

Social Factors Can Affect Health

“Social determinants of health” — the conditions in which people live, work, learn, and play — can affect health outcomes such as life expectancy, birth outcomes, child development, rates of chronic disease, and disparities in the health of people across racial groups and income levels.¹

Social determinants of health significantly affect health care use and costs. For example, a growing body of research demonstrates the link between the availability of safe, stable, and affordable housing and positive health outcomes. People experiencing homelessness or housing instability are more likely to use acute care services and less likely to use primary and preventive care that can help prevent more serious conditions.² Finding housing protects them from extreme weather conditions, provides a safe place to store medication, allows them to more easily keep doctors’ appointments, and relieves them of the trauma of living on the streets.

¹ Jennifer Sullivan, “Better State Budget, Policy Decisions Can Improve Health,” Center on Budget and Policy Priorities, February 21, 2019, <https://www.cbpp.org/research/state-budget-and-tax/better-state-budget-policy-decisions-can-improve-health>.

² Ehren Dohler *et al.*, “Supportive Housing Helps Vulnerable People Live and Thrive in the Community,” Center on Budget and Policy Priorities, May 31, 2016, <https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community>; *see also* Peggy Bailey, “Housing and Health Partners Can Work Together to Close the Housing Affordability Gap,” January 17, 2020, <https://www.cbpp.org/research/housing/housing-and-health-partners-can-work-together-to-close-the-housing-affordability>.

Federal, state, and local governments' underinvestment in programs that would improve health as well as state and local fiscal policies that have worsened racial and income inequities have left the U.S. population less healthy than it could be, weakening the prospects for future widespread prosperity. When compared to other developed nations, the United States performs below average, and often near the bottom of the rankings, on traditional health measures like life expectancy, infant mortality, and low birthweight.³ Health outcomes are particularly bad for certain communities of color and for low-income individuals.

Medicaid Can't Make Up for Inadequate Funding for Housing and Other Social Services

Medicaid's core mission is to respond to low-income individuals' clinical needs, including by developing new ways to deliver care. As part of that health care delivery system, states are increasingly using value-based payment models in Medicaid, which pay providers a set amount for all or most of a patient's care — rather than paying for each service they provide — while requiring that providers meet specific quality and outcomes standards. They give providers financial incentives to reduce costs and improve care by strengthening care coordination, avoiding duplicative or low-value care such as overuse of the emergency department, and helping patients obtain high-value, low-cost services, such as preventive and primary care and medications to manage chronic conditions.

The trend toward these value-based payment models has heightened the interest of states, health care providers, and health plans in ensuring that beneficiaries have access to housing, food, and other services. Many state Medicaid programs are partnering with other service organizations in arrangements aimed at improving Medicaid enrollees' health.

Medicaid can play an important role in coordinating medical and non-medical services, but it can't — nor should it — pay for housing or social services that people need to get and stay healthy.

- **Medicaid can't fill the vast funding gaps for housing and social services.** Insufficient federal and state funding for housing, child care, job training, and other critical services results in these programs serving only a small fraction of the low-income people eligible for them: only 25 percent of eligible low-income households receive federal housing assistance,⁴ while only 17 percent of children eligible for child care assistance receive it.⁵ Federal, state, and local governments need to appropriate sufficient funding for affordable housing and other key social service programs.⁶
- **The health care system isn't equipped to run affordable housing programs.** Medicaid programs don't have the capacity or expertise to manage housing stock, inspect units for

³ Organisation for Economic Co-Operation and Development, "Health at a Glance, 2017," November 10, 2017, <http://www.oecd.org/health/health-at-a-glance-19991312.htm>.

⁴ Department of Housing and Urban Development, "Worst Case Housing Needs: 2017 Report to Congress," August 2017, <https://www.huduser.gov/portal/sites/default/files/pdf/Worst-Case-Housing-Needs.pdf>.

⁵ Government Accountability Office, "Access to Subsidies and Strategies to Manage Demand Vary Across States," December 2016, <https://www.gao.gov/assets/690/681652.pdf>.

⁶ Bailey 2019, *op. cit.*

safety, or pay people's rent, and there's no reason to duplicate the housing sector's expertise. Moreover, if Medicaid programs or MCOs are responsible for providing low-income housing, individuals who increase their earnings or change Medicaid managed care plans could lose their rental assistance — creating additional barriers to care.

- **The health system needs to continue working to improve health care access.** While Medicaid can provide a bridge to social services, core health care services such as dental care, vision care, and behavioral health care are too often missing or inadequately available to Medicaid beneficiaries. In addition, provider payments for traditional health services, specialty care, and other intensive services like case management and care coordination are frequently too low. Using Medicaid to fill funding gaps in other sectors would erode Medicaid's core mission as a health care program, making it more difficult to improve access to needed health care services.

Medicaid Can Help States Build Partnerships to Coordinate Care for People With Social Service Needs

Medicaid offers states options for coordinating health care and social services and paying for health-related services such as tenancy-related services, which support the individual in being a successful tenant and therefore better able to sustain tenancy.⁷ Home- and community-based services waivers, health homes, section 1115 waivers, and other options provide further flexibility to help address health-related needs.

In addition to coordinating care and providing health-related services at the beneficiary level, states can also improve how they communicate and share data across providers and sectors (such as housing providers), which can ensure that effective health services are provided in a timely way. Improved integration at the system level can make beneficiary-level coordination more efficient, without the need to navigate complex, siloed programs.

These efforts can't fill the unmet need for affordable housing and other services. But they *can* make Medicaid more efficient and improve health outcomes by bridging the gap between health care and other services where they are available.⁸

Targeted Case Management

States can use targeted case management (TCM) to provide services that help individuals access medical, social, educational, and other services they need to address a health care condition. States can provide TCM to specific populations or regions based on their needs and link individuals to community-based organizations providing social services such as housing or nutrition services.⁹

⁷ Centers for Medicare & Medicaid Services, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," June 26, 2015, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>.

⁸ Hannah Katch, "States Are Using Flexibility to Create Successful, Innovative Medicaid Programs," Center on Budget and Policy Priorities, June 13, 2016, <https://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs>.

⁹ Centers for Medicare & Medicaid Services, *op. cit.*

Targeted Case Management in Flint, Michigan

After the water supply in Flint, Michigan was contaminated with lead, the state included TCM in a larger package of services designed to help affected families obtain needed care. Licensed nurses or social workers provided comprehensive needs assessments, nutrition supports, early education programs, and referrals to other services such as lead abatement, financial services, housing, and transportation assistance to all Medicaid-eligible children and pregnant women who were served by the Flint water system.¹⁰

Home- and Community-Based Services

Since 1981, Medicaid has offered states the option of designing a package of home- and community-based services (HCBS) to offer as an alternative to institutional care.¹¹ HCBS waivers let states provide Medicaid eligibility to people who would otherwise only be eligible if they were in a nursing home or other institution. And they allow states to create packages of services specifically designed to keep people in their homes, including home modifications, respite care for family caregivers, and enhanced home health services.¹²

HCBS waivers gave states new ways to address the long-term services and supports needs of their residents, including children, adults with disabilities, and seniors, leading to a dramatic shift in the program: 57 percent of Medicaid spending on long-term services and supports went to HCBS in 2016, up from 18 percent in 1995.¹³ (See Figure 1.)

States are using Medicaid's flexibility to provide HCBS to build partnerships with community-based providers. Besides offering services such as personal care attendants who can help with routine tasks like bathing and household management, states can use these authorities to provide non-clinical services, such as tenancy-related services that help people transitioning from a health care facility to the community find housing, move and settle into a new home, or stay safely in their housing.

¹⁰ Kaiser Family Foundation, "Michigan's Medicaid Section 1115 Waiver to Address Effects of Lead Exposure in Flint," March 7, 2016, <https://www.kff.org/medicaid/fact-sheet/michigans-medicare-section-1115-waiver-to-address-effects-of-lead-exposure-in-flint/>.

¹¹ Testimony of Judith Solomon, Vice President, Center on Budget and Policy Priorities, Before the Health Subcommittee of the House Energy and Commerce Committee, "Existing Medicaid Flexibility Has Broadened Reach of Home- and Community-Based Services," Center on Budget and Policy Priorities, February 1, 2017, <https://www.cbpp.org/health/existing-medicare-flexibility-has-broadened-reach-of-home-and-community-based-services>.

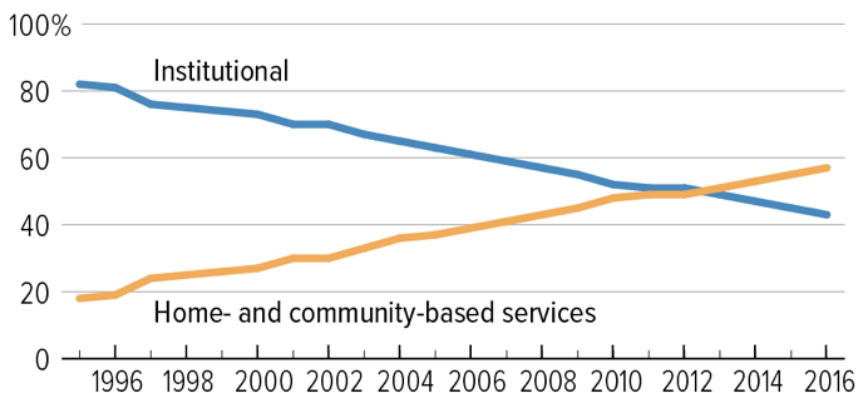
¹² The Deficit Reduction Act of 2005 authorized the 1915(i) state plan option to allow states to provide home- and community-based services to individuals who don't meet the standards for receiving care in an institution such as a nursing home. Before enactment of 1915(i), states could only provide HCBS through a waiver and then only when a beneficiary would need institutional care in the absence of the HCBS.

¹³ Steve Eiken *et al.*, "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2016," Truven Health Analytics, May 2018, <https://www.medicare.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-expenditures2016.pdf>.

FIGURE 1

States Have Shifted Spending to Home- and Community-Based Services, and Away From Institution-Based Services

Share of total Medicaid long-term care services and supports spending*



*Including for seniors and people with disabilities

Source: IBM Watson Health, "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2016"

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Louisiana's Permanent Supportive Housing Program

As part of Louisiana's disaster recovery efforts after Hurricanes Katrina and Rita, the state established a partnership between the Department of Health and the Louisiana Housing Authority to reduce homelessness and unnecessary institutionalization among people with disabilities by providing them with permanent supportive housing, a highly effective strategy that combines affordable housing with intensive coordinated services. The Louisiana Housing Authority identifies and recruits housing providers and serves as the rental subsidy administrator, using a number of federal housing funding streams, including Low Income Housing Tax Credits and the Community Development Block Grant, to make new and existing housing units available.¹⁴

Separate HCBS waivers¹⁵ provide services to Medicaid beneficiaries with physical disabilities and behavioral health conditions, including services that help individuals complete housing applications and understand their rights, move and adjust to their new homes, and negotiate with landlords.¹⁶

Money Follows the Person

¹⁴ Julia Paradise and Donna Cohen Ross, "Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples," Kaiser Family Foundation, January 27, 2017, <https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-issue-brief/>.

¹⁵ Louisiana also uses a rehabilitation services option in Medicaid to offer non-traditional services to people with behavioral health conditions.

¹⁶ Robin Wagner, Louisiana Department of Health, "Louisiana Permanent Supportive Housing," NASHP Annual Conference 2017, <https://nashp.org/wp-content/uploads/2017/06/R-Wagner-19.pdf>.

States also provide HCBS through the Money Follows the Person (MFP) program, which Congress authorized in 2005 to give states funding and flexibility to help beneficiaries safely transition from nursing facilities and other institutions to their own home, the home of a caregiver, or a community-based residential facility. MFP allows states to provide non-traditional services such as home-delivered meals, wheelchair ramps and other home modifications, and support for caregivers.

According to a Department of Health and Human Services report on the program, Money Follows the Person “has been the catalyst to interagency collaboration between health and housing to help individuals in institutions to locate and secure affordable and accessible housing. ... States have used [Money Follows the Person] funding to support health-housing collaborations, hire housing specialists who work on housing and health policy at the state level, educate and inform health agency staff and transition coordinators on the availability of housing resources, and help beneficiaries in institutional care locate and secure affordable and accessible housing in the community.” And this collaboration has led to improvements for beneficiaries, evaluations have shown. Compared to others who transition out of institutions, participants are less likely to be readmitted to institutional care after their initial transition to the community.¹⁷

However, a lack of community resources is a key challenge for states in successfully implementing the program, a national evaluation of MFP found.¹⁸ In particular, a lack of affordable housing has prevented some individuals who may have been able to transition out of a nursing facility to do so. MFP is a prime example of the need for greater federal and state investment in affordable housing resources to meet Medicaid beneficiaries’ social needs and improve outcomes.

California Community Transitions and Health Plan of San Mateo

California’s Health Plan of San Mateo, a nonprofit MCO run by San Mateo County, leverages MFP resources to support cross-sector collaboration. The health plan screens individuals who are dually eligible for Medicaid and Medicare for social service needs and links beneficiaries with services that include housing, nutrition services, transportation, and home improvements that can help them continue to live in the community, such as wheelchair ramps. By partnering with San Francisco’s Institute of Aging and a local housing agency, Health Plan of San Mateo offers case management and resources to enrollees who are unstably housed or unnecessarily living in health care facilities due to a lack of housing.¹⁹ The community partnerships have yielded results: as of August 2019, 190 participants had transitioned into housing secured by the program.²⁰

Health Plan of San Mateo uses some health plan reserves to fund the program, along with funds provided by MFP, state waiver programs, and the federal government’s Financial Alignment Initiative for people dually enrolled in Medicare and Medicaid. The plan also helps enrollees access

¹⁷ Department of Health and Human Services, “Report to the President and Congress: The Money Follows the Person (MFP) Rebalancing Demonstration,” June 2017, <https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf>.

¹⁸ *Ibid.*

¹⁹ Health Plan of San Mateo, <https://www.hpsm.org/special-initiatives/healthy-at-home/community-care-settings>.

²⁰ *Ibid.*

an array of affordable housing resources, including Section 8 housing vouchers and supportive housing programs.²¹

Medicaid's Health Home Program

The Affordable Care Act included enhanced federal Medicaid funding for states to provide “health home” services aimed at providing intensive care coordination services to high-cost, high-need beneficiaries with one or more chronic physical or behavioral health condition. Medicaid health home programs typically rely on care coordinators, social workers, and community support workers — and sometimes teams of providers — to offer comprehensive care management, care coordination, support transitioning between institutions or from an institution to the community, and help for enrollees trying to find appropriate community and social services. Care coordinators are often community-based providers with experience serving a specific population, such as individuals experiencing homelessness.

The federal health home option provides states with two years (eight fiscal quarters) of enhanced federal Medicaid funding at a 90 percent matching rate for health home services, after which reimbursement for those services drops to the state's regular federal matching rate (states' regular matching rate for the traditional Medicaid population is between 50 percent and 77 percent). States implementing the health home option have used the program to strengthen linkages between Medicaid and community-based services, improve transitions of care for people with complex health care needs, and support integration of behavioral and physical health services.²²

Availability of community-based resources has played a critical role in the success of health home programs, according to a national evaluation.²³ Access to reliable transportation and affordable housing units were identified as the highest areas of need for health home members and among the most challenging for providers to meet.

Missouri's Health Homes

In 2012, Missouri's Medicaid and mental health agencies established separate health home programs for beneficiaries with multiple chronic conditions and those with behavioral health conditions. The programs coordinate care for individuals transitioning from one care setting to another, such as from a hospital to a nursing facility. They also integrate behavioral health care with primary care services — such as by sharing electronic medical records between providers or co-locating behavioral and physical health care services in the same clinic —to reduce avoidable

²¹ Brianna Ensslin and Deborah Brodsky, “Housing Options for High-Need Dually Eligible Individuals: Health Plan of San Mateo Pilot,” Center for Health Care Strategies, March 2016, <https://www.chcs.org/resource/housing-options-for-high-need-dually-eligible-individuals-health-plan-of-san-mateo-pilot/>.

²² Kathy Moses and Brianna Ensslin, “Seizing the Opportunity: Early Medicaid Health Home Lessons,” Center for Health Care Strategies, March 2014, <https://www.chcs.org/resource/seizing-the-opportunity-early-medicaid-health-home-lessons/>.

²³ U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, “Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Progress and Lessons From the First States Implementing Health Home Programs, Annual Report – Year Four,” May 1, 2016, <https://aspe.hhs.gov/basic-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-progress-and-lessons-first-states-implementing-health-home-programs-annual-report-year-four>.

hospital stays.²⁴ Managed care organizations support care coordination by sharing data with the health home providers, including notifying them when enrollees are admitted to the hospital.²⁵

Health home services for people with behavioral health conditions are provided by community mental health centers and staffed by a team of providers including a nurse case manager, administrative support staff, and a primary care physician.²⁶ The community mental health centers also go beyond individual-level care coordination, working toward systems-level integration by partnering with other sectors to provide education about behavioral health conditions and linkages to support treatment. For example, the health centers employ community mental health liaisons who establish ongoing relationships with law enforcement and court personnel to educate them on best practices for interacting with people with behavioral health conditions and available community resources.²⁷

Managed Care

Medicaid managed care organizations have substantial flexibility — and increasingly, financial incentives — to partner with community-based social service providers to ensure that MCO enrollees can access resources they need to maintain their health.

MCOs have limited flexibility to pay directly for non-clinical services. They can pay for alternative services “in lieu of” services or settings described in the state plan, if the state determines it is medically appropriate and cost effective to do so. For example, instead of a prenatal visit in a clinician’s office, a state may let MCOs offer home visiting to pregnant women that would include prenatal care as well as other preventive care and parenting supports. MCOs can also provide “value-added services,” which are services that the plan “voluntarily agrees to provide.” For example, the federal Centers for Medicare & Medicaid Services (CMS) encouraged MCOs to provide value-added services such as “mosquito repellents... protective clothing, window screens, and other environmental modifications to combat the spread of the Zika virus.”²⁸

There are limits on what MCOs can provide. Their monthly payments — called capitation rates — are based in large part on MCO enrollees’ use of Medicaid-covered services in the prior year. But because “value-added” services aren’t considered Medicaid services, the state can’t include spending on these services in the development of its capitation rate for the next year.

²⁴ Moses and Ensslin 2014, *op cit.*

²⁵ U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, “Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report – Year Three,” July 2015, <https://aspe.hhs.gov/pdf-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-annual-report-year-three>.

²⁶ Brenda C. Spillman, Barbara A. Ormond, and Elizabeth Richardson, “Medicaid Health Homes in Missouri: Review of Pre-Existing Initiatives and State Plan Amendment(s) for the State’s First Health Homes Under Section 2703 of the Affordable Care Act,” U.S. Department of Health and Human Services, Assistance Secretary for Planning and Evaluation, July 29, 2012, <https://aspe.hhs.gov/system/files/pdf/137856/HHOption2-MO.pdf>.

²⁷ Missouri Department of Health, “Role of Community Mental Health Liaison: Strengthening Missouri’s Mental Health System Initiative,” December 2016, <https://dmh.mo.gov/mentalillness/progs/docs/role.pdf>.

²⁸ Centers for Medicare & Medicaid Services, “Medicaid Benefits Available for the Prevention, Detection, and Response to the Zika Virus,” June 1, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060116.pdf>.

Many state MCO contracts encourage or require MCOs to connect members to the community resources they need, and some states give preference during the competitive bidding process to MCOs that have experience doing so. Some states are even including financial incentives for MCOs to ensure that beneficiaries with social service needs are connected with community resources, such as by including social needs-related metrics in pay-for-performance programs (such as providing bonus payments to MCOs that implement interventions to lower beneficiaries' rates of low birthweight, which can relate to a pregnant woman's access to both social and clinical services).²⁹

While MCOs can pay for limited non-clinical services and coordinate with community-based providers, most have limited experience partnering with small providers and lack a network or experience contracting with these providers, such as developing appropriate rates for non-clinical services. Similarly, small community-based providers often lack the capacity or infrastructure to partner with large health plans, such as the ability to effectively negotiate rates or the systems required to collect and report data. However, some MCOs are investing in the capacity to coordinate services with social service providers. State Medicaid agencies could encourage this practice and improve care coordination by encouraging or requiring investments in these partnerships.

Washington's Medicaid Managed Care Contracts

In 2015, Washington launched a multi-agency effort known as "Healthier Washington," which comprised nine geographic regions governed by partners from health care, public health, and other sectors such as school districts, criminal justice agencies, social service agencies, and tribes.³⁰ These regional collaboratives are designed to improve coordination between health care and social services, reward high-value health care, and integrate primary and behavioral care.³¹

In its 2019 contracts, Washington required its MCOs to develop a written plan for coordination with its Healthier Washington region, describing "how the MCO will coordinate and collaborate with health care and other allied systems" that serve their members. The plans are required to define the roles and responsibilities for enrollees served by more than one system (i.e., individuals enrolled in an MCO who are also receiving social services); include a coordinated process for helping members who are moving out of facilities and back into their communities; and include a process for the MCO, behavioral health system, and first responders to manage crisis services and prevent individuals with behavioral health care needs from being incarcerated when possible.³²

²⁹ Center for Health Care Strategies, "Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations," December 2018, <https://www.chcs.org/resource/addressing-social-determinants-of-health-via-medicare-managed-care-contracts-and-section-1115-demonstrations/>.

³⁰ Anna Spencer and Bianca Freda, "Advancing State Innovation Model Goals through Accountable Communities for Health," Center for Health Care Strategies, October 2016, https://www.chcs.org/media/SIM-ACH-Brief_101316_final.pdf.

³¹ Washington State Health Care Authority, "Washington State Health Care Innovation Plan," January 2014, https://www.hca.wa.gov/sites/default/files/program/SHCIP_InnovationPlan.pdf.

³² Washington State Health Care Authority, Washington Apple Health – Fully Integrated Managed Care Contract, July 1, 2019, https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf.

Section 1115 Demonstration Projects

Under section 1115 of the Social Security Act, the HHS secretary can let states deviate from certain Medicaid requirements to implement a demonstration project that's likely to promote Medicaid's objectives. States can also use "expenditure authority" under such waivers to draw down federal Medicaid funds for services that Medicaid doesn't ordinarily cover, although total federal funding for these demonstrations can't exceed the federal funds the state would have received without the waiver.

Section 1115 waivers enable states to move beyond individual-level care coordination to invest in system-level integration. Using 1115 authority, several states are attempting to create system-level change, in addition to providing additional services directly to beneficiaries. These programs test approaches to improving programmatic coordination and integration, which can make beneficiary-level coordination more efficient if the systems are designed to provide streamlined clinical and social services.

Minnesota's Hennepin Health

Hennepin County, which comprises Minneapolis and its surrounding suburbs, pioneered a new way to care for hard-to-reach Medicaid beneficiaries in 2011, focusing on newly eligible adults with chronic conditions who frequently used the emergency department. The county health department, the public hospital, a community health center, and a Medicaid health plan partnered to create an accountable care organization called Hennepin Health to care for the county's highest-need patients. Between 2012 and 2014, 90 percent of Hennepin Health's members reported a mental health diagnosis and 43 percent lacked stable housing.³³

The partner organizations created teams of health and social service providers to coordinate clinical and social services for their members, including services for substance use disorders and stable housing. Hennepin uses algorithms to analyze new members' past medical histories and health care use patterns as well as supplemental data from the corrections department, foster care system, and housing providers to build the right set of services to support the beneficiary. Individuals who have multiple address changes are flagged as potentially unstably housed, for example, and their case manager provides follow-up to determine whether they need housing-related services. After a high-risk member is identified, community health workers reach out to people wherever they can find them, including in shelters or jails.³⁴

The team of providers may include housing and social service navigators and vocational service counselors, depending on the beneficiary's needs. One key Hennepin Health partner is a vocational counseling and work support organization, which can help members serving short-term prison sentences search for jobs ahead of their release.³⁵

³³ Shana F. Sandberg *et al.*, "Hennepin Health: A Safety-Net Accountable Care Organization for the Expanded Medicaid Population," *Health Affairs*, November 2014, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0648>.

³⁴ Martha Hostetter, Sarah Klein, and Douglas McCarthy, "Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries," Commonwealth Fund, October 2016, https://www.commonwealthfund.org/sites/default/files/2018-09/1905_Hostetter_hennepin_hlt_case_study_v2.pdf.

³⁵ *Ibid.*

California's Whole Person Care Pilots

California is using a section 1115 waiver for its Whole Person Care pilot program, which provides funding to 25 counties and cities across the state to invest in infrastructure linking Medicaid with social service providers and to provide limited non-clinical services, such as tenancy-related services. The program is designed to facilitate the coordination of services and data sharing across the spectrum of health and other services, including acute care, primary and specialty care, long-term care, housing, and nutrition services.³⁶

For example, California's Marin County — where the median home value is \$1.1 million³⁷ and affordable housing is scarce — partnered with the local housing authority to set aside housing vouchers for enrollees in the Whole Person Care pilot. The county provided intensive case management services through Medicaid to those receiving vouchers, increasing the likelihood that they would be able to remain stably housed.³⁸ Evaluation of the demonstration is underway, which should show whether the program is sustainable and replicable.

North Carolina's Enhanced Case Management Program

North Carolina received federal approval in October 2018 to transition its delivery system to managed care and establish a Health Opportunities Pilot, designed to coordinate medical and social services for Medicaid beneficiaries with unmet needs that were affecting their health, similar to California's Whole Person Care pilots. As part of this pilot, the state will require MCOs to implement standardized screening questions to assess non-medical needs. MCOs will have access to a statewide tool to identify community resources.³⁹

The pilot will enable MCOs in select regions to provide enhanced case management and other support services for certain high-risk Medicaid beneficiaries. MCOs in these regions will also be able to use Medicaid funds to partner with community-based social services providers to offer non-clinical services such as tenancy-related supports and medically tailored meal delivery to Medicaid beneficiaries with an established need for these services.⁴⁰

The pilot is designed to build sustainable partnerships between Medicaid and social services providers. North Carolina received federal approval to use up to \$100 million of the pilot's \$650

³⁶ Lucy Pagel, Tanya Schwartz, and Jennifer Ryan, "The California Whole Person Care Pilot Program: County Partnerships to Improve the Health of Medi-Cal Beneficiaries," Harbage Consulting, February 2017, http://harbageconsulting.com/wp-content/uploads/2017/02/WPC-Summary_Final_02282017.pdf.

³⁷ Liam Dillon, "Marin County has long resisted growth in the name of environmentalism. But high housing costs and segregation persist," *Los Angeles Times*, January 7, 2018, <https://www.latimes.com/politics/la-pol-ca-marin-county-affordable-housing-20170107-story.html>.

³⁸ Lucy Pagel, Carol Backstrom, and Hilary Haycock, "Whole Person Care: A Mid-Point Check-In," Harbage Consulting, March 29, 2019, <https://www.chcf.org/publication/whole-person-care-pilot-program-mid-point-check/>.

³⁹ North Carolina Department of Health and Human Services, "North Carolina's Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders," February 15, 2019, https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf.

⁴⁰ *Ibid.*

million over the waiver's five-year term to invest in infrastructure such as data-sharing technology to support sustainable coordination.⁴¹

Next Steps

Addressing Medicaid beneficiaries' social needs requires a substantial investment, as does continuing and enhancing state efforts to coordinate the delivery of health care with these other services. Congress and CMS should support states' efforts and expand opportunities for Medicaid to partner with other sectors to address enrollees' social needs.

For example, states often struggle to share data between agencies and to encourage data sharing among health providers, health plans, and other service providers. States also struggle with duplicative or inconsistent reporting requirements. While federal policymakers should be cautious about any proposals that could undermine consumer protections, they could consider opportunities to streamline reporting requirements, encourage additional data sharing across programs, and continue to provide funding for states to better integrate eligibility and enrollment systems to reduce burdens for enrollees and state and local administrators alike. Where states are using existing waiver authorities to improve service coordination, CMS should evaluate the evidence and, where it is strong enough, work with Congress to create state options to help more states replicate effective strategies. Conversely, CMS should *not* let states maintain or replicate unsuccessful models.

Congress can holistically address the social determinants of health by fully funding the programs that Medicaid beneficiaries need beyond health care, such as affordable housing programs, the funding for which falls far short of need. The health care system can't address these factors until policymakers fully fund the programs that Medicaid enrollees need to live healthy lives.

⁴¹ *Ibid.*