Medicaid Flexibilities to Address Health-Related Social Needs: A Stakeholders Guide

An Introduction to State Medicaid Flexibilities

Medicaid is a state and federal partnership to provide healthcare coverage to almost 20% of Americans, serving those with low incomes and with disabilities. Medicaid's evolving and expanding strategies to address Health-Related Social Needs (HRSN) are an opportunity to address common drivers of inequity. States have significant flexibility to design their own Medicaid programs, including the ability to implement HRSN benefits—defined by CMS as an "individual's unmet, adverse social conditions that contribute to poor health." These benefits must complement, not duplicate, services already in the community and are not intended to address long-term HRSNs. States can broadly make these changes in three ways: through a state plan amendment, managed care flexibilities, or a waiver. This document is a quick reference guide for these three policy pathways.

Table 1 explains the difference between these three pathways, and Table 2 explains the differences between two key options to address HRSN: In Lieu of Services (ILOS) and 1115 waivers. Short guidance following the tables explains how advocates and other community stakeholders can engage in supporting the evolution of Medicaid to address these critical social needs.

Table 1. What are the policy levers to address social needs in Medicaid?

	State Plan Amendments	Managed Care Flexibilities	Waivers
Guardrails	Must comply with all rules and regulations regarding the Medicaid program. Must be an option already identified by CMS.	Some managed care flexibilities comply with the rules and regulations of the Medicaid program while others do not. Those with more flexibility may have more limitations on scope and scale.	Can waive core requirements of the Medicaid program, such as implementing benefits statewide.
Approval Timeframe	Most are approved within three months.	On average CMS reviews and approves in five months.	On average, CMS reviews in one year.
Time Frame	State plan amendments are essentially permanent until the state chooses to change them.	States can make large-scale changes through procurements where they end all current contracts and competitively hire new (or rehire existing) MCOs under new terms. Each state has different procurement cycles. Smaller contract changes can be made throughout the term of the contract.	Most waivers are time-limited and require the state to submit paperwork to continue the waiver.
Room and Board	One of the core requirements of the Medicaid program is that it does not pay for room and board, so state plan amendment housing strategies must be around ancillary	Some managed care mechanisms can more freely fund housing investments, while others follow Medicaid restrictions on room and board. Those with more flexibility may have scalability and sustainability	CMS's new 1115 demonstration guidance allows six months of post-transition rent for individuals that meet certain clinical and

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	supports such as housing navigation.	limitations.	social risk criteria.
Resources	You can find your state's most recent State Plan Amendments here.	Managed care options to address HRSN are outlined in federal guidance here and here.	You can find your state's waiver documentation here.

Two of the ways states that fund HRSN services are through "In Lieu of Services" (a State Plan option) and 1115 waivers. In addition to the fundamental differences described in the table below, these two pathways present a number of other considerations.

Table 2. What are the differences between In Lieu of Services and 1115 HRSN Demonstration Opportunities?

	In Lieu of Services	1115 HRSN Demonstration Opportunity [1]
Service Definition	Must be a medically appropriate **substitute for a state plan service.** Must have a process to ensure providers are prescribing ILOS that are medically appropriate for each enrollee.	Must be **medically appropriate using state-defined clinical and social risk factors.** CMS has identified a willingness to approve waivers with certain housing supports, nutrition support, and HRSN case management, but other types of services can be proposed, as well.
Regulation	42 CFR § 438.3(e)(2)	42 C.F.R. Part 431, Subpart G; Social Security Act §1115
Additional Resources	State Medicaid Director Letter on In Lieu of Services	CMS Health Related Social Needs Demonstration Opportunity
Delivery System Requirement	ILOS[2] are provided at the option of managed care entities.	No required delivery system (can be offered in both Fee For Service and Managed Care)
Initial Approval Details	State approves ILOS as a medically appropriate, cost-effective substitute. Managed care entity elects to provide that ILOS. Managed care contract updated to reflect that ILOS.	State develops a 1115 demonstration proposal and abides by federal requirements for public notice and comment. CMS approves 1115 demonstration proposal and issues special terms and conditions.

[1] Note: The parameters described in this table are guardrails that CMS indicated to states that it will use in evaluating waivers. However, these parameters are not in statute or regulation, so states can propose a model that goes outside these barriers, but it may face more challenges in the approval process .

[2] Certain populations, such as Tribal Members, have the ability to opt out of Managed Care, so even in states that have Medicaid Managed Care these services would only reach enrollees in Managed Care. This is an important equity consideration as states and advocates consider options.

Table 2. What are the differences between In Lieu of Services and 1115 HRSN Demonstration Opportunities?		
	In Lieu of Services	**1115 HRSN Demonstration Opportunity** [1]
	CMS Approves Managed Care Contract.	Details of implementation are often finalized via demonstration protocols submitted throughout the life of the demonstration.
Investment Limitations	The cost of ILOS service is included in the development of the managed care rate (unlike other HRSN strategies which might require that the plan use administrative funds, profit, or other mechanisms). Total cost of all offered ILOS (including behavioral health ILOS but excluding short-term stays in institutions for mental disease) cannot exceed **5% of the managed care program.**	HRSN expenditure authority cannot exceed **3% of state's annual total Medicaid spend.**
Infrastructure Investments	No separate federal funding is available for infrastructure other than what is built into the managed care rate or incentive arrangement negotiated with the MCO.	Up to 15% of HRSN spend can be allocated to infrastructure.
Cost Effective/Budget Neutrality	ILOS must be cost effective, when evaluated in the aggregate. ILOS can be more preventive in nature (i.e., reduce the need for certain covered services like inpatient admission).	1115 waivers are typically required to be budget neutral. CMS has made it slightly easier to achieve budget neutrality for HRSN services by assuming that without the waiver there may also be increases in cost for the served population.
Evaluation	All states are encouraged to evaluate their ILOS program, but those whose ILOS program costs more than 1.5% of their managed care program are required to conduct a retrospective evaluation of their ILOS services and their impact on the Medicaid program.	An evaluation is a core part of an 1115 demonstration. States submit evaluation design documents and related reports to CMS.
Implementation Considerations	States cannot require that MCOs offer the benefit or that enrollees utilize the benefit over the standard state plan benefit. States also cannot dictate reimbursement rates, although they can set up guardrails, as for other benefits.	Must be the choice of the beneficiary who can opt out at any time. Must be integrated with existing social services.
Find Out What Your State	CHCS showcase of 12 states	Kaiser Family Foundation is tracking 1115 waivers by state

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	In Lieu of Services	**1115 HRSN Demonstration Opportunity** [1]
Offers	Go to your state's Medicaid agency website to learn more about your state's benefits.	

How Can I Engage?

Medicaid is a taxpayer-funded program—meaning, it's your Medicaid program—and is made better by engagement from the community, especially people who are enrolled in the Medicaid program or who advocate for enrollees. For advocates and professionals in health systems and community-based organizations, here are some ways to engage.

Support your state Medicaid agency in designing and implementing an HRSN program.
You can start by using the links above to learn more about what your state currently does or does not offer. If Medicaid enrollees in your state have a need that is critical for their health that is not currently addressed by the Medicaid program, you can 1) collect data about the need and its impact on health, and 2) approach your state Medicaid agency about adding a new benefit. Medicaid agencies are part of the executive branch, so you can use relationships or connections in your Governor's office or go directly to state staff. Medicaid programs may not be able to make changes until the end of their current MCO contracts, when they will do a competitive Request for Proposals to solicit proposals for new MCOs. Depending on when that RFP process last occurred and the term of your state's contracts (anywhere from 5-10 years), you may have to engage in a multi-year process to implement these new strategies. Once a state has decided to pursue an HRSN benefit, your work is not done! The success of HRSN strategies often lies in the details. For 1115 waivers, there will be public notice where you can submit your comments. For state plan amendments and MCO RFPs, states may do similar levels of engagement, where you can comment on draft policies in public forums or in writing.

Support your MCOs, community-based organizations, and Medicaid enrollees in implementing and accessing HRSN programs.
Once the state has designed an HRSN option, MCOs and CBOs may decide whether or not they participate, and enrollees always have a choice to participate. Think about how you can engage your local MCOs and CBOs and raise awareness among Medicaid enrollees about the resources available to them.

Advocate for CMS to protect these avenues.
CMS, as part of the executive branch of the federal government, changes leadership every time the administration changes. These new leaders may have different priorities and have some flexibility to take slightly different approaches to reviewing requests from states. The guidance CMS recently released around 1115 waivers and HRSN benefits could be changed under the next administration. Advocate for federal legislators to formalize and protect these options for states who are interested in pursuing them but may not be able to pursue them for several years.

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