Issue Brief
July 2016

Milbank Memorial Fund

The Reforming States Group

NYS HEALTH FOUNDATION
Improving the state of New York's health

Medicaid Coverage of Social Interventions: A Road Map for States

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Extensive research demonstrates the impact of social factors—such as income, access to food and housing, and employment status—on the health and health outcomes of Americans, particularly lower-income populations. These findings are not lost on federal and state officials who seek to provide Medicaid beneficiaries with quality, cost-effective care. In developing strategies to address both the medical and social determinants of health, states face several challenges, including, primarily, how to provide a revenue stream to cover the cost of the social services. After all, Medicaid is first and foremost a health insurance program. Nonetheless, under some circumstances, Medicaid is available to cover the costs of social service interventions linked to the health of Medicaid enrollees.

Faced with mounting evidence about these social factors, state Medicaid agencies are looking for ways to integrate social interventions into their coverage, payment, and delivery models. As federal and state Medicaid officials look to improve health outcomes and to do it cost effectively, they must decide how far to go in tackling social issues, recognizing that Medicaid is not a social services program, and that there are limits on how it can be used.

This issue brief was prepared at the request of the Milbank Memorial Fund's Reforming States Group (RSG), with support from the New York State Health Foundation, to help policymakers better understand Medicaid coverage for social interventions. Supported by the Fund since 1992, the RSG is a bipartisan group of state executive and legislative leaders who, with a small group of international colleagues, meet annually to share information, develop professional networks, and commission joint projects.

Building on earlier work by organizations such as the National Academy for State Health Policy and the Center for Health Care Strategies,[1,2] this brief provides a practical guide for policymakers who want to know when and how states can use Medicaid to facilitate access to social services. It is based on a review of the relevant laws and regulations as well as interviews with leading state and federal experts. The brief begins with background information about why social support services are coming to the fore. We then offer a road map for policymakers on the legal authorities on which they may rely to extend Medicaid coverage to social interventions. First, we describe the legal and regulatory provisions that authorize Medicaid coverage of social support services. Then, we explain Medicaid's role in specific social supports—and provide examples from states that are providing these services through Medicaid. Table 1 at the conclusion of the brief summarizes these social supports and the authorities for covering them in state Medicaid programs.

The four specific areas of social support services that are covered in this report are of particular interest to states—and are also areas in which Medicaid has a role. The four areas are:

- Linkages to social service programs that can offer help with food assistance, rent, child-care costs, heating bills, and other major household expenses;
- Stable housing provided through services that help people find and remain in homes, including assistance locating a home, making home repairs, and training in navigating relationships with landlords or other tenants;
- Employment and job stability, including ways to help people prepare to enter the job market or to find and keep a job; and
- Peer and community supports addressed by care coordinators who offer support and assistance in navigating the system, as well as by peer support specialists who come from a beneficiary's community or who have had similar experiences and can offer counseling, advice, and other support.

As with any guide, individual states will want to review their specific plans to address social factors with the Centers for Medicare & Medicaid Services (CMS) to ensure compliance with federal laws and regulations, particularly because CMS's approach to such issues is in a period of evolution.

Background

A growing body of evidence indicates that medical care is not the only factor that drives health outcomes; a person's economic circumstances, education level, family life, neighborhood, and physical environment play an equal or even more significant role. Building on earlier work by organizations such as the National Academy for State Health Policy and the Center for Health Care Strategies,[3,4] researchers, payers, and providers increasingly are recognizing that these social and economic circumstances often drive health outcomes as much as, if not more than, clinical interventions. According to Booske and colleagues, up to 40% of health outcomes are driven by nonmedical factors such as income, education, and occupation, compared to only 20% driven by clinical care.[5] In addition, The Commonwealth Fund reports that nearly 80% of physicians believe that addressing patients' social needs is as important to improving health and outcomes as addressing their medical conditions.[6]

For coverage of low-income people, in particular, this means that spending money on medical services alone—without a coordinated, effective strategy for addressing a range of social issues—can result in inefficient use of health care dollars and limited opportunities to work with Medicaid clients to improve their health.

In combination with the growing research base, changes in the health care landscape are bringing even more interest to connecting people to social support services. These changes include the growing rate of mental health and substance use disorders and the opioid epidemic, in particular; growth in the use of payment and delivery models that reward providers for outcomes; and, in states that have elected to expand Medicaid, an increase in the number of low-income adults enrolled in coverage with health conditions linked to or exacerbated by social and economic challenges.

As they explore if and how they should deploy interventions aimed at social and economic issues, Medicaid agencies face the reality that the United States has a relatively modest social safety net, particularly compared to its expansive health care system. The United States spends significantly more on health care than other countries ($9,086 per capita, compared to the Organization for Economic Co-operation and Development {OECD} median of $3,661),[7] but far less on social services. In fact, in a 2013 study of 11 comparable OECD countries, researchers found the United States to be the only country where the percentage of Gross Domestic Product spent on health care was greater than that spent on social services.[8] The relatively low level of spending on social support services in the United States creates additional pressure on Medicaid to provide these services—when possible and cost-effective—in order to improve health outcomes and prevent unnecessary medical expenditures.

Medicaid has already begun playing a role in connecting people to resources and helping to supplement the limited social safety net in the areas of noncovered social services, housing, employment, and peer and community supports. In recent years, the federal government has made a renewed commitment to help states navigate and finance this type of work through

new guidance, technical assistance from the newly established Innovation Accelerator Program, and funding from the CMS Innovation Center.[9] In addition, some states are beginning to explore systematic ways of connecting their Medicaid-funded work on social determinants with related work led by public health or social service agencies. In the months and years ahead, it will be important to build on this growing collaboration, as well as to continue to expand the evidence base on which social interventions are effective in improving health outcomes.

Legal and Regulatory Authorities for Medicaid Coverage of Social Supports

In this section, the paper describes the legal and regulatory authorities available to cover social support services. It also highlights new flexibility available to states to provide social support services—that were historically available only to beneficiaries in home and community-based waiver programs (e.g., selected housing and employment-related services)—to a broader array of beneficiaries. The legal and regulatory analysis that follows is designed to serve as a guide for states, but CMS ultimately must approve any state plan amendments or waivers that use Medicaid funds to cover services aimed at the social and economic factors that affect health. Unless otherwise noted, any statutory references in this and succeeding sections are to Title XIX of the Social Security Act.

In general, there are three routes to covering services in Medicaid that help to address social factors that affect health: state plan amendments, waivers, and managed care and alternative payment models.

State Plan Amendments

State Plan Amendments (SPAs) can be used when the Medicaid statute directly allows for coverage of a particular service or activity. These generally are the simplest and easiest way for states to secure funding for an activity or service. When it comes to facilitating access to social support services, there are several SPA-based options available to states:

- Case management and targeted case management. Case management services under Section 1905(a)(19) and targeted case management (TCM) services under Section 1915(g)(1)[10] are optional benefits in Medicaid. They allow states to use Medicaid to pay for the costs associated with helping beneficiaries gain access to needed medical, social, and educational services, as well as to other services such as housing and transportation. Case managers can conduct an assessment of a beneficiary's needs; develop a care plan to secure medical, social, educational, and other supports; refer the individual to such services and assist in scheduling appointments; and provide monitoring and follow-up support to the beneficiary and others. TCM consists of the same services as case management, but states are not obligated to provide it on a statewide basis or to provide it to all groups of Medicaid beneficiaries.[11] These features make TCM an ideal vehicle for providing case man-

agement to a targeted population in Medicaid, such as those beneficiaries who are high utilizers of care or who were recently homeless.

Notably, federal law imposes a number of requirements on how case management and TCM benefits are deployed, including that beneficiaries cannot be obligated to use case management services and, if they do opt to use them, must have free choice of providers.[12] States must also develop a care plan for individuals, meet record-keeping requirements, and ensure that Medicaid is not financing costs more appropriately borne by other social programs. These and other requirements reflect historic concern among some federal policymakers that states used case management to shift the cost of other social service programs onto Medicaid.[13]

- "Preventive" and "rehabilitative" services. States have the option to include "preventive" services and "rehabilitative" services in their benefit packages. In the context of Medicaid, these terms are defined broadly, creating the opportunity for states to use them to cover an array of services and to rely on "community health workers" or "peer specialists" to provide some of these services. Specifically, Section 1905(a)(13) allows states to furnish "any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." The language is notable for several reasons:

    - Broad array of providers. By referencing services recommended by a physician or licensed provider—rather than actually provided by such a professional—the law gives states the flexibility to use peer specialists, community health workers, and other kinds of workers to provide medical and remedial services, even if they are not licensed medical providers. Increasingly, these workers are being used to help beneficiaries navigate the medical system; sustain recovery from a mental health or substance use disorder; establish and pursue personal goals; adopt lifestyle changes; and connect with community-based organizations that offer social support services.

    - Broad array of settings. The language offers states unique flexibility to provide services in an array of settings, including in a person's home or work environment rather than only in a hospital, primary care practice, or other clinical setting.

    - Scope of services. The language allows for a broad range of services to be covered. Over the years, states have relied on this language (often referred to as the "rehab option" found in regulations at 42 CFR §440.130(d)), to cover "traditional" physical rehabilitative services, such as occupational therapy and speech therapy. States have also relied on these regulations to cover a range of behavioral health services, such as mental health and substance use disor-

der treatment services, including individual and group therapy, peer support services, behavior modification, intensive outpatient services, and Assertive Community Treatment. States may also be able to use this authority to cover psychosocial rehabilitation, social skills development, independent living skills instruction, some limited employment support, and housing-related services or components of these services. Notably, to be covered as a rehabilitative service, the service would have to be related to reducing physical or mental disability and restoring a beneficiary to his or her best possible functional level. This is an area where early consultation with CMS could be helpful.

- Habilitation services. States have the option under home and community-based services (HCBS) waivers authorized under Section 1915(c) and Section 1915(i) (a provision of the Social Security Act that allows states to provide HCBS waivers to Medicaid-eligible individuals even if they do not require an institutional level of care) to provide "habilitation services" to targeted populations, such as people with mental illness. These are services "designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings."[14] As such, they can include a broad array of activities related to social support services and social factors that affect health, such as employment-related services (e.g., interpersonal skills training, assistance with prospective employers). Unlike state plan rehabilitative services, these services can be used to help someone attain or maintain function; they are not limited to cases in which someone is recovering from a condition.

- Health Home services. States have the option under Section 1945 to establish "Health Homes" in order to provide expansive care coordination and management for beneficiaries with intensive needs. Health Homes are designed to provide personal and family-centered care that takes into account and responds to an individual's social, emotional, physical, and behavioral needs. Created by the Affordable Care Act (ACA), the option provides states with eight quarters of 90% federal match funding[15] to establish Health Homes for beneficiaries who have two or more chronic conditions; one chronic condition, and a risk of acquiring a second one; or one serious and persistent mental health condition.[16] (In states, that have chosen to expand Medicaid, Health Home services provided to newly eligible adults will be subject to an enhanced federal match on an ongoing basis.) In choosing which conditions and geographies a Health Home will cover, states have the flexibility to design Health Homes for their beneficiaries who are at highest risk from both a health status and cost perspective. Among other responsibilities, Health Homes are expected to "coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services."

Note that states now have the flexibility to target state plan services as discussed above to any group of Medicaid beneficiaries whereas historically they have been obligated to provide any benefit to all categorically needy beneficiaries under Medicaid's "comparability" requirement. Specifically, they now have two mechanisms to do so without violating Medicaid's statewide or comparability requirements:

- 1915(i) option. The Section 1915(i) option allows states to provide any HCBS waiver to any group of Medicaid beneficiaries even if the beneficiaries do not require an institutional level of care. Moreover, while states cannot set numerical limits on how many people they will serve, they can target the services to defined groups. For example, to date, habilitation services often have been viewed as a benefit only for people with disabilities in a Section 1915(c) HCBS waiver. However, states can now use habilitation services to provide these benefits to a broader array of beneficiaries as a result of regulations issued in the aftermath of the ACA.[17]

- Alternative benefit plan option. States have broad flexibility to set up alternative benefit plans (ABPs) for targeted groups of beneficiaries. These ABPs must include all essential health benefits, including habilitative services and devices that meet a minimum standard linked to commercial plans, but states also have the flexibility to include additional habilitative services (relying on the Medicaid definition of such services[18] used in HCBS waivers) or other services that traditionally have been provided only to people in HCBS waivers and the 1915(i) program.[19] States adding such services to an ABP would need to include needs-based criteria for the population receiving services that could be included in a 1915(i), provide person-centered planning, and meet the HCBS settings criteria.

Waivers

The Medicaid statute creates a number of waiver opportunities, including Section 1115 waivers and 1915(c) HCBS waivers, which provide states with additional flexibility to facilitate access to social supports.

- Section 1115 demonstration program waivers. Under Section 1115, the Department of Health and Human Services (HHS) has broad flexibility to waive many provisions of the Medicaid statute in the interest of pursuing demonstrations that further the purposes of the Medicaid program. Increasingly, states are using 1115 waiver demonstrations to test new approaches to delivery system reform that include connecting people to social services and, to some extent, allow for flexible funding of social services that directly affect health. Section 1115 waivers offer by far the most flexible vehicle for using Medicaid to integrate social determinants of health into the care delivery system, but the process of securing a Medicaid 1115 waiver can be lengthy. The state must also provide assurances that the waiver is budget neutral.

- Home and community-based services waivers. The HCBS waivers available to states under Section 1915(c) are well-known, long-standing ways to provide a broader array

of services to beneficiaries who otherwise would require institutionalized care. HCBS waivers authorize coverage of a range of medical and nonmedical services to address long-term care needs in a home and community-based setting, including many of the housing-related, habilitation, peer support, and care management services that are needed to address social, emotional, and economic issues. In fact, they directly mirror the services that states now can cover through a state plan amendment under Section 1915(i), although the HCBS waiver option is widely viewed as giving states more flexibility to limit enrollment.

Managed Care and Alternative Payment Models

Under Medicaid managed care arrangements, state Medicaid agencies pay managed care organizations (MCOs) a capitated rate to cover a defined set of services. MCOs are obligated to cover case management and any other social support services that are built into the state's benefit package and the MCO contract. MCOs may determine to cover additional social services—i.e., those not covered under the MCO contract—in order to reduce the cost and improve the quality of care. For social services that are not included in the contract, MCOs may cover them via two different pathways:

- In-lieu-of services are *services* or *settings* that are not covered in a state plan or an MCO contract but are a medically appropriate, cost-effective alternative to a service that is covered. MCOs may offer these services to their enrollees, provided the state has authorized the alternative in its contract with the MCO. For example, if an MCO only had inpatient hospital services covered under its contract, it could choose to offer to move an enrollee to a skilled nursing facility for recovery after an inpatient stay—instead of keeping the enrollee in the hospital during recovery. The costs and utilization of in-lieu-of services are taken into account in calculating the medical portion of managed care capitation rates.

- Value-added services are services that are not, and generally cannot be, included in the state plan or under the managed care contract, but that an MCO can elect to provide to improve the quality of care and/or reduce costs. For example, an MCO might elect to provide supportive housing for a beneficiary with severe mental illness who otherwise would cycle between hospital stays and homelessness. The costs of the value-added services may be included in the administrative portion of the managed care capitation rates; however, if the value-added services are activities that improve health care quality under 45 CFR §158.150, they may be included as a "medical" (rather than an administrative) cost for rate-setting purposes.

The costs of both in-lieu-of and value-added services may be included in the numerator when calculating the plan's medical loss ratio (MLR). In other words, they count as medical, not administrative, costs for MLR purposes.[20]

The opportunities and incentives that support the use of capitation dollars to underwrite the cost of social services in Medicaid managed care is replicated in a wide range of alternative payment

methodologies, including bundled payments for episodes of care and risk-sharing with accountable care organizations for defined populations. And in both cases, the capitated nature of the payment and the opportunity to share savings opens the door to more flexibility in how Medicaid funds are used and to new partnerships among providers, plans, and social services organizations.

Medicaid's Role in Specific Social Support Services

This section discusses specific social support and other services that Medicaid may cover in four major areas: linkages to noncovered social services; housing services; employment services; and peer support services. For each major category of services, we offer examples of how states are currently choosing to cover these services through Medicaid.

Linkages to Noncovered Social Services

States have a number of ways to help low-income Medicaid beneficiaries connect with social services, such as the Supplemental Nutrition Assistance Program (SNAP) and other food supports, rental assistance, child care, legal assistance, and help with high utility bills. Increasingly, states and managed care organizations are recognizing that making such connections is an efficient use of Medicaid dollars, allowing low-income beneficiaries to access important social services that can improve their lives and potentially reduce health care expenditures. For example, ensuring that a beneficiary with diabetes is enrolled in SNAP and knows where to go for an emergency supply of food if groceries run out before the next SNAP payment may help prevent the spike in hospitalizations that can occur when people face food shortages.

States can readily use the case management state plan option to provide case management services to finance the cost of linking beneficiaries to needed medical, social, educational, and other services and supports. Using this authority, states have developed systems for assessing the social support needs of beneficiaries; identifying and tracking community-based resources, including through increasingly sophisticated online tools; developing a plan for connecting beneficiaries to resources; scheduling appointments and prompting beneficiaries to attend them; and assisting with filling out applications and gathering appropriate documentation. States have the flexibility to determine the qualifications of case managers (though any requirements must reasonably relate to the provision of case management services and be specified in the state plan amendment), including whether to allow non-licensed individuals (e.g., community health workers) to serve as case managers as long as they receive appropriate training and oversight. If a state wants to target case management services to a selected group (e.g., high-need beneficiaries), it can do so via the targeted case management option or by establishing a Health Home for the targeted group.

State Examples

- Oregon's 1115 demonstration waiver required the creation of Coordinated Care Organizations (CCOs), which in turn were required to train at least 300 community health workers across the state. The goal has already been reached, reflecting that

CCOs have found significant value in using community health workers to connect beneficiaries to social services. Often residing in the same areas as the beneficiaries that they serve, the workers use this first-hand knowledge of the community to connect beneficiaries to social support services.

- Colorado has established regional organizations, known as Regional Care Collaborative Organizations (RCCOs) that are charged with coordinating and improving care for the majority of Medicaid beneficiaries in the state. RCCOs are paid a per member per month (PMPM) fee for the care management and coordination services and primary care practice transformation. RCCO responsibilities include helping beneficiaries navigate their various appointments and medication reconciliation, as well as referring beneficiaries to social service programs and working with local agencies to address food deserts and other community issues. The state links a share of the PMPM payments to a RCCO's ability to meet key performance indicators (e.g., level of patient engagement, well-child visits, postpartum visits, and emergency department utilization).

- In 2015, Michigan updated its Medicaid managed care contract to require MCOs to use community health workers or peer specialists to serve enrollees with significant behavioral health issues or complex physical comorbidities. The activities they are expected to engage in include arranging for "social services (such as housing and heating assistance) and surrounding support services."[21] The MCOs will be required to maintain a ratio of one community health worker per 20,000 enrollees.

- Maine first implemented a Health Home in 2013 targeting beneficiaries statewide with a variety of chronic illnesses.[22] In 2014, the state implemented an additional Health Home SPA targeting adults with serious mental illnesses and children with serious emotional disturbances.[23] Primary care practices are the foundation of the Health Home provider teams and provide basic care coordination, case management, and family supports for enrolled beneficiaries. However, depending on the severity and type of diagnosis, Health Home beneficiaries may also receive care from community mental health providers or Community Care Teams (CCTs). CCTs are locally based care managers who provide more intensive care management for high-needs patients (generally determined to be the highest utilizing or most costly patients). As discussed previously, the state received 90% federal match funding for Health Home services for the first eight quarters of each Health Home SPA.

- California covers targeted case management in specific counties for Medicaid beneficiaries deemed to be in jeopardy of negative health or psychosocial outcomes. Qualifying circumstances include having a history of family violence or sexual abuse, being illiterate, or experiencing unstable housing.[24] The state does not require that the care managers delivering this service to have a college degree, as long as they have completed an approved training program and have significant relevant experience.

Community Health Workers

Community Health Workers (CHWs) are beginning to play a greater role in Medicaid delivery systems across the country. While states have the discretion to fully define the role of CHWs, in general, these providers are community members who have received training and certification, but are not licensed. CHWs often serve as care coordinators, providing care management services and linkages to noncovered services. As of January 1, 2014, they have also been able to provide preventive benefit services—as defined in 1905(a)(13)—as these services no longer need to be provided, only recommended, by a physician or licensed provider. States have included CHWs in state plan amendments, MCO contacts, 1115 demonstrations, and Health Home initiatives.

Services	Authorities
• Assessing the needs of beneficiaries • Identifying and tracking community-based resources, including through use of online tools • Developing plans for connecting beneficiaries to resources • Scheduling appointments for beneficiaries and promoting attendance • Assisting in gathering documentation and filling out applications	*State Plan:* 1905(a)(19) – optional case management 1915(g)(1) – targeted case management 1915(i) – case management services 1945 – Health Homes *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population) 1915(b)(3) – managed care

Housing Services

A large and growing body of research indicates that stable housing can help to reduce health care costs, particularly for high-risk individuals with mental health issues, substance use disorders, or a history of homelessness. While Medicaid cannot pay for room and board, it can finance a range of services that support beneficiaries in finding and staying in housing. As recently clarified in a June 2015 Informational Bulletin from CMS,[25] various Medicaid authorities can cover the following kinds of housing-related services or components of these services:

- Transition services are activities that help a beneficiary transitioning from institutional living or homelessness find and secure appropriate community-based housing, such as by identifying barriers to retaining housing, developing housing support and crisis plans, evaluating the safety and move-in readiness of a housing environment, and assisting with housing applications.
- Sustaining services are activities that support a beneficiary's ability to maintain a sustainable housing situation, including providing environmental modifications, iden-

tifying and intervening when negative behaviors occur, providing education and training on appropriate tenant behaviors, assisting in resolving housing-related disputes, and linking a beneficiary to other needed resources and supports for maintaining a stable environment.

- Housing-related collaborative activities include working with state and local partners to advocate for and develop additional housing resources.[26]

The June 2015 CMS bulletin was designed to describe services that can be covered for beneficiaries with disabilities via HCBS waivers and other means. It, however, serves as a useful guide for Medicaid beneficiaries more generally. As discussed above, states now have broad flexibility to add such services to the benefits package of other Medicaid beneficiaries who are not part of waivers.

When a beneficiary is leaving an institution, a state can even assist with "community transition services" that are necessary to enable a person to establish a household, such as "rent and utility deposits, first month's rent and utilities, bedding, [and] basic kitchen supplies." Unlike other housing-related services, however, these are available only to individuals transitioning to the community after a stay in an institution and only under 1915(c) waiver authority.

State Examples

- Louisiana is currently providing supportive housing services to individuals with physical or developmental disabilities, serious mental illness, or who are in treatment or recovery from a substance use disorder through the Permanent Supportive Housing (PSH) Program. The program is a partnership between the Louisiana Housing Corporation (LHC) and the state's Department of Health and Hospitals (DHH). In general, LHC is responsible for providing the affordable housing resources and DHH is responsible for providing the transition and sustaining services. The services provided by DHH are reimbursable through the Medicaid program because the department has incorporated PSH services into the state's HCBS waivers.[27]

- Oregon is providing housing supports through its 1115 waiver, which established regional Coordinated Care Organizations (CCOs) that are paid a monthly capitation amount (referred to in Oregon as a global budget). Since they are ultimately responsible for meeting outcome metrics within a capped amount of funding, Oregon has granted CCOs the authority to provide "flexible services" with the full sanction of CMS.[28] Using this authority, CCOs can fund moving expenses, housing improvements (e.g., air conditioners, child safety locks, ramps, vacuums), and temporary housing after hospital stays when they determine it is cost-effective to do so. The flexible services must be health-related, although CCOs have significant discretion to determine which services can contribute to better care and health outcomes. To date, Oregon has found temporary housing after hospital stays and housing improvements to be two of the more important services provided by the CCOs.

- Texas requires its Medicaid managed care organizations participating in its STAR+PLUS program to pay for minor home modifications for beneficiaries to ensure the safety, security, and accessibility of the home.[29] The STAR+PLUS program provides integrated acute care and home and community-based services through managed care to low-income adults with disabilities and beneficiaries in the state's HCBS waivers program.

Services	Authorities
Linkages to housing supports • Assisting in finding appropriate housing • Identifying barriers to sustainable housing Direct provision of housing supports • Assisting in securing appropriate housing • Addressing barriers to sustainable housing • Developing housing supports and a crisis plan • Evaluating and addressing issues with housing safety and move-in readiness • Assisting with housing applications • Providing education and training on appropriate tenant behaviors and assistance resolving housing disputes	Linkages to housing supports *State Plan:* 1905(a)(19) – optional case management 1915(g)(1) – targeted case management 1915(i) – case management services *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population) 1915(b)(3) – managed care Direct provision of housing supports *State Plan:* 1915(i) – habilitation services *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population) 1915(b)(3) – managed care

Employment Services

Most Medicaid beneficiaries are part of working families, but often these families include members who are struggling to keep stable employment. States have the flexibility to provide case management services that connect people to employment resources. As covered earlier in the discussion of linkages to social support services, they can do so as one prong of Medicaid case management or targeted case management. For beneficiaries with disabilities or major barriers to work, states also have gone significantly further and used 1915(i) or HCBS waivers to provide more direct employment-related services such as the following:[30]

- Prevocational services prepare people who would otherwise not work with the skills they need to find and keep a job. These services can include training in effective workplace communication, workplace conduct, workplace safety and mobility, problem-solving techniques, and strategies for staying on-task and following directions. States also can incorporate career planning activities and personal care activities into prevocational services.

- Supported employment services assist individuals who otherwise could not work in obtaining and maintaining employment in a community setting. Jobs obtained through this service should be appropriate for an individual's needs, skills, interests, and work history, if applicable, and can therefore be a competitive or customized position, either in an integrated setting or at the individual's home. The types of services covered under this benefit include job searching and employment planning, assistance with prospective employers and on-boarding processes, ongoing/long-term job coaching support and training (in excess of what is provided to all employees), and other accessible workplace support services.

State Example

- In Maryland, habilitation services are provided through the state's HCBS waiver, called the Community Pathways Waiver, to children and adults with developmental disabilities. Administered by the state's Medicaid office and the Developmental Disabilities Administration, the waiver covers 19 services, including "employment discovery and customization" and "supported employment."[31] Employment discovery and customization is a short-term service (not to exceed six months) intended to help a beneficiary explore employment opportunities and prepare for employment through training and job customization. The state provides "supported employment" services on a longer-term basis, assisting beneficiaries in maintaining jobs in the community, ideally in workplaces where the majority of employees do not have disabilities. The specific activities that Medicaid covers include job coaching, job training, and monitoring and evaluating performance at the workplace.

Services	Authorities
All beneficiaries • Linking beneficiaries to job training services Beneficiaries who require additional support to work • Providing training on effective workplace communication, workplace conduct, and workplace safety and mobility • Teaching problem-solving techniques and strategies for staying on-task and following directions • Assisting beneficiaries with career-planning activities (for example, benefits counseling, referral to vocational rehabilitation) • Facilitating interactions between beneficiaries and prospective employers • Assisting with the on-boarding process • Providing ongoing career coaching and training	All beneficiaries *State Plan:* 1905(a)(19) – optional case management 1915(g)(1) – targeted case management 1915(i) – habilitation services *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population) Beneficiaries who require additional support to work *State Plan:* 1905(a) – rehabilitative services (providing training on effective workplace communications, workplace conduct, and workplace safety and mobility) 1915(i) – expanded habilitation services *Waivers:* 1915(c) waivers (only for HCBS population)

Peer Support Services

For many beneficiaries with mental health or substance use disorders, peer support services can be a critical part of their care, particularly when they are in recovery and seeking to prevent a relapse. Unlike clinical care, peer support services generally are aimed at helping individuals cope with social and emotional challenges. They are provided in the community by people who have themselves experienced an illness and are able to support an individual's recovery. Referred to by a number of different titles (e.g., "peer navigators," "health coach," or "promotores de salud"),[32] these nonmedical professionals share important characteristics —such as ethnicity, language, socioeconomic status, or lived experience related to a specific behavioral or physical health condition—with the clients they serve.[33]

Key Elements of Peer Support[34]

Although there are a number of different models and approaches to providing peer support, the Peers for Progress, a program of the American Academy of Family Physicians Foundation, has articulated four key elements of such services:

- Assistance in daily management. Helping individuals translate the recommendations of clinical providers into specific, actionable plans;
- Social and emotional support. Using empathetic listening and encouragement to assist patients in coping with stress and social or emotional barriers and staying motivated to reach identified goals;
- Linkage to clinical care and community resources. Helping individuals recognize when and how to access clinical and social support services, and facilitating such linkages as needed; and
- Ongoing availability of support. Keeping patients engaged through the development of a sustained and flexible long-term supportive relationship.

Peer support services can be covered under a number of different authorities, but most states choose to cover them as a state plan "rehabilitative service" under Section 1905(a)(13). If this authority is chosen, states will need to comply with the requirements in the State Medicaid Director Letter #07-011 issued on August 15, 2007. (States may also use Section 1915(i) or 1915(c) if they are limiting the services to home and community-based services recipients.) Some states also integrate peer support specialists into their Health Homes or 1115 waivers.

State Examples

- Georgia was the first state to cover peer support services in its Medicaid program, beginning in 2001.[35] The state provides peer support to enrollees with serious mental illness under the rehabilitative services option. The peer support specialists, who are trained and certified as peer support providers by the state, receive a fee-for-service payment of between $18.15 and $36.65 per 15-minute increments, depending on the setting and provider certification. A program evaluation conducted by the state's Department of Behavioral Health and Developmental Disabilities found positive outcomes for beneficiaries receiving peer support, as well as annual savings of $5,494 per person in the first three years of the program when peer supports are substituted for participation in a day treatment program.[36]

- When Kansas established Health Homes, it included peer support specialists as required members of the provider teams serving beneficiaries with serious mental illness.[37] The peer support specialists must self-attest to being in active recovery from a mental illness or substance use disorder, receive training and certification from the state, and operate under the supervision of a licensed mental health provider. As paid members of the provider teams, they offer individual support, family support, and referrals to community resources and social services.

- New York chose to add "peer specialists" to its standard list of authorized care team members in the state's Health Home program. In addition, the state's Medicaid Redesign Team's Social Determinants of Health Work Group recently recommended that the state create a certified peer specialist program. In making its recommendation, the work group highlighted that peer support services can be very useful to certain Medicaid beneficiaries, as well as the beneficial effect of creating employment opportunities for those who serve as peer support specialists.[38]

Services	Authorities
• Assisting in daily management • Providing social and emotional support • Linking to clinical care and community resources • Providing a long-term supportive relationship	*State Plan:* 1905(a)(13) – rehabilitative services 1915(i) – habilitation services *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population)

Conclusion

As the evidence continues to mount about the importance of looking beyond clinical interventions to improve the health and health outcomes of low-income populations, states are taking a renewed interest in Medicaid's role in addressing the social and economic challenges faced by beneficiaries. States have significant flexibility under Medicaid law and regulations, and clearly can assist people in securing and using social support services, such as housing programs, SNAP, job training, and other community resources and benefits. To an extent not always recognized, states also may directly provide many employment-related and housing-related services to a broad array of Medicaid beneficiaries, not just the relatively small group of people with disabilities who received these more intensive nonmedical supports in the past. In the context of Medicaid managed care programs, MCOs can take advantage of the in-lieu-of and value-added options to provide services that improve health, even if not explicitly contemplated under the state plan. As states increasingly pursue value-based payments and delivery system reform models that prioritize outcomes and cost-effectiveness, they may find that there are even more ways to use Medicaid to address social issues when it is cost-effective to do so.

Table 1. Summary of Coverage Opportunities

Services	Authorities
Social Services Linkages to noncovered social services • Assessing the needs of beneficiaries • Identifying and tracking community-based resources, including through use of online tools • Developing plans for connecting beneficiaries to resources • Scheduling appointments for beneficiaries and promoting attendance • Assisting in gathering documentation and filling out applications	*State Plan:* 1905(a)(19) – optional case management 1915(g)(1) – targeted case management 1915(i) – case management services 1945 – Health Homes *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population) 1915(b)(3) – managed care
Housing Services Linkages to housing supports • Assisting in finding appropriate housing • Identifying barriers to sustainable housing Direct provision of housing supports • Assisting in securing appropriate housing • Addressing barriers to sustainable housing • Developing housing supports and a crisis plan • Evaluating and addressing issues with housing safety and move-in readiness • Assisting with housing applications • Providing education and training on appropriate tenant behaviors and assistance resolving housing disputes	Linkages to housing supports *State Plan:* 1905(a)(19) – optional case management 1915(g)(1) – targeted case management 1915(i) – case management services *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population) 1915(b)(3) – managed care Direct provision of housing supports *State Plan:* 1915(i) – habilitation services *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population) 1915(b)(3) – managed care

Services	Authorities
Employment Services All beneficiaries • Linking beneficiaries to job training services Beneficiaries who require additional support to work • Providing training on effective workplace communication, workplace conduct, and workplace safety and mobility • Teaching problem-solving techniques and strategies for staying on-task and following directions • Assisting beneficiaries with career-planning activities (for example, benefits counseling, referral to vocational rehabilitation) • Facilitating interactions between beneficiaries and prospective employers • Assisting with the on-boarding process • Providing ongoing career coaching and training	All beneficiaries *State Plan:* 1905(a)(19) – optional case management 1915(g)(1) – targeted case management 1915(i) – habilitation services *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population) Beneficiaries who require additional support to work *State Plan:* 1905(a) – rehabilitative services (providing training on effective workplace communications, workplace conduct, and workplace safety and mobility) 1915(i) – expanded habilitation services *Waivers:* 1915(c) waivers (only for HCBS population)
Peer Support Services Direct provision of peer supports • Assisting in daily management • Providing social and emotional support • Linking to clinical care and community resources • Providing a long-term supportive relationship	*State Plan:* 1905(a)(13) – rehabilitative services 1915(i) – habilitation services *Waivers:* 1115 waivers 1915(c) waivers (only for HCBS population)

Notes

[1] See, for example: Clary, A. and Riley, T. Braiding & Blending Funding Streams to Meet the Health-Related Social Needs of Low-Income Persons: Considerations for State Health Policymakers. National Academy for State Health Policy. February 2016. (Accessed June 20, 2016: http://www.nashp.org/wp-content/uploads/2016/02/Jean.pdf.)

[2] See, for example: Crawford, M. and Houston, R. State Payment and Financing Models to Promote Health and Social Service Integration. Center for Health Care Strategies, Inc. February 2015. (Accessed June 20, 2016: http://www.chcs.org/media/Medicaid_-Soc-Service-Financing_022515_2_Final.pdf)

[3] See note 1 above.

[4] See note 2 above.

[5] Booske, B.C., Athens, J.K., Kindig, D.A., et al. Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Population Health Institute. February 2010. (Accessed June 20, 2016: https://uwphi.pophealth.wisc.edu/publications/other/different-perspectives-for-assigning-weights-to-determinants-of-health.pdf.)

[6] Bachrach, D., Pfister, H., Wallis, K. and Lipson, M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund. May 2014. (Accessed June 20, 2016: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/may/1749_bachrach_addressing_patients_social_needs_v2.pdf.)

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[8] Bradley, E. and Taylor, L. The American Health Care Paradox: Why Spending More Is Getting Us Less. New York, NY: PublicAffairs, 2013.

[9] Accountable Health Communities Model. Centers for Medicare & Medicaid Services Web site. May 18, 2016. (Accessed June 20, 2016: https://innovation.cms.gov/initiatives/AHCM.)

[10] All section references refer to sections of the Social Security Act.

[11] See 42 CFR §440.169(b) which clarifies that the statewideness (i.e., that services must be available throughout the state) and comparability requirements that typically apply to Medicaid benefits are waived with respect to TCM. Note, however, that TCM no longer is the only way to provide case management services to a subset of beneficiaries. States also can target case management services using the flexibility available to them under Section 1915(i) or by creating an alternative benefits package that includes case management services for a targeted group of beneficiaries.

[12] An exception is that a state can require people with developmental disabilities or chronic mental illness to use specified case managers if the state determines it is necessary to ensure that they are served by qualified providers.

[13] After extensive controversy emerged in the early 2000s over the appropriate use of case management services and the Bush administration issued guidance limiting it, Congress included a provision in the Deficit Reduction Act of 2005 requiring issuance of an interim final rule and imposing some limits on case management. Several provisions of the resulting rule were subject to a congressionally mandated moratorium through July 1, 2009. A few days prior to the expiration of the moratorium, the Obama administration rescinded selected provisions of the interim final rule that were considered too restrictive of state activities and interests. The rescissions included a requirement for the use of a single case manager and for use of a payment methodology that required case managers to bill based on 15-minute increments. (Accessed June 20, 2016: https://www.gpo.gov/fdsys/pkg/FR-2009-06-30/pdf/E9-15345.pdf.)

[14] By law and regulation, the definition excludes (i) special education and related services (as such terms are defined in Section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401)) that otherwise are available to the individual through a local educational agency; and (ii) vocational rehabilitation services that otherwise are available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

[15] For states that expand Medicaid, the enhanced Medicaid matching rate available for newly eligible adults is available to finance the cost of their services—including those provided through a Health Home—in perpetuity. The enhanced matching rate currently is set at 100%, and it will be reduced gradually over time before stabilizing at 90% in 2020.

[16] The current list of eligible chronic conditions includes mental health conditions, substance use disorders, asthma, diabetes, heart disease, and obesity (BMI>25).

[17] Note, however, that, in some instances, the description of the benefit itself may contain some limits on who can receive it. For example, prevocational services (considered part of expanded habilitation services) are for individuals who otherwise are not expected to be able to join the general workforce or participate in a transitional sheltered workshop within one year. 42 CFR §440.180(c)(2)(I).

[18] As CMS noted in the final rule on essential health benefits in alternative benefit plans released on July 15, 2013, there is an existing definition in Medicaid of habilitative services under 1915(c) and 1915(i), but this is not necessarily the same definition as states must use when designing their minimum ABP. See 42214 Federal Register, Volume 78, No. 135, July 15, 2015.

[19] As a result of regulations that CMS issued after passage of the Affordable Care Act, states can provide alternative benefits packages to Medicaid beneficiaries (or to targeted groups or subgroups of beneficiaries) that are supplemented by any of the services available under 1915(i), which, in turn, allows for coverage of the services available under HCBS waivers. 42 CFR §440.360.

[20] See 42 CFR §438.8(e).

[21] Comprehensive Health Care Program for the Michigan Department of Health and Human Services, Request For Proposal No. 007115B0005022.

[22] Centers for Medicare & Medicaid Services. Maine Health Home SPA (#12-004). 1 January 2013. (Accessed June 20, 2016: https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/downloads/me/me-12-004-att.pdf)

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[24] Centers for Medicare & Medicaid Services. CA TCM for Individuals in Jeopardy of Negative Health or Psycho-Social Outcomes State Plan Amendment (#15-029). 7 December 2015. Accessed June, 20, 2016:http://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM%20SPAs/SPA%202015/CA_SPA_15-029.pdf)

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[26] State- and local-level housing related collaborative activities are only covered through Money Follows the Person Rebalancing Demonstration grants at this time.

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[36] Ibid.

[37] Centers for Medicare & Medicaid Services. Kansas Health Home State Plan Amendment. 28 July 2014. (Accessed June 20, 2016: https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/downloads/ks/ks-14-014.pdf.)

[38] New York State Department of Health, Medicaid Redesign Team, Social Determinants of Health Work Group. Final Recommendations. October 2014. (Accessed June 20, 2016: http://www.health.ny.gov/health_care/medicaid/redesign/docs/final_recommendations_11-05-14.pdf)

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Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, and staff.