



FEBRUARY 2024

State Strategies to Leverage Medicaid Managed Care Contracting for Investments in Health and Housing Alignment

Executive Summary

Health and housing supports and services are critical for many individuals and families to obtain and maintain stable housing in community settings. Most state Medicaid agencies contract with managed care organizations (MCOs) to deliver services to Medicaid beneficiaries. Managed care is a critical option states have to cover housing supports and services and coordinate between health and housing partners.



NATIONAL ACADEMY
FOR STATE HEALTH POLICY

Some states have already implemented innovative strategies with MCOs to deliver housing supports and services. The following are among the many examples discussed in this report:



Ohio requires its MCOs to invest a percentage of their annual after-tax profits to community reinvestment — a key element of the state Medicaid agency’s strategy to addressing housing instability, among other social determinants of health (SDOH) and initiatives for cross-system collaboration.



Arizona requires its MCOs to employ a housing specialist who serves as a liaison to housing partners to align data systems and better coordinate resources to address an enrollee’s unmet housing needs.



Nevada requires its MCOs to strengthen care coordination for individuals experiencing housing instability by prioritizing enrollees experiencing homelessness for case management, designating a specific clinician or case manager to ensure continuity of services for enrollees experiencing homelessness, and submitting an annual population health strategy to the state Medicaid agency to plan for addressing enrollee SDOH needs.



California supported planning efforts through its housing and homelessness incentive program (HHIP) and leverages the CalAIM Incentive Payment Program (IPP) to encourage MCOs to build necessary infrastructure and capacity so they can provide additional housing supports and services.

When considering these policy changes, it is important to acknowledge the need to coordinate MCO housing strategies with other housing initiatives across the state, such as those financed through Medicaid or federal grant programs. Given the diversity of approaches across states, it is our hope that this resource can be helpful for states seeking to learn from one another.

Introduction

A growing number of states are covering [housing-related services under Medicaid](#), including pre-tenancy and tenancy sustaining services. Many states leverage their contracts with managed care organizations (MCOs) to support housing-related interventions. Regardless of whether a state has pursued an [1115 waiver or other Medicaid authority](#), Medicaid MCOs can be important players in developing partnerships and coordinating resources to deliver housing supports and services.

The goal of this report is to highlight examples of how state Medicaid programs are leveraging their managed care contracts and policies to pursue health and housing alignment and address the housing needs of beneficiaries. This resource highlights the requirements and incentives Medicaid agencies can apply in Medicaid MCO contracts to improve availability of housing resources, identify and address individuals’ housing

needs, and leverage data to support planning, implementation, and evaluation of housing efforts. Additionally, we highlight how states are paying MCOs for housing-related services and also offering financial incentives to deliver these services.

Examples of Health and Housing Services and Supports





Aligning Health and Housing Supports and Services

For decades, state leaders have pursued a variety of strategies to align affordable housing, rental assistance, and supportive services to assist individuals in finding and maintaining stable housing. The health care sector is increasingly investing in supportive housing solutions, recognizing the [evidence that stable housing has positive impact on one’s health and well-being](#). Successful approaches require aligning resources and [coordinating across health, behavioral health, human services, and housing sectors](#).

When we say “health and housing supports and services,” we refer to services that help individuals obtain and maintain stable housing in community settings. This might include case management, pre-tenancy or tenancy services (such as housing search, applications, deposits, and/or modifications), referrals to social supports (such as employment or nutrition resources), and physical and behavioral health services. This is not a comprehensive list of the services that might be offered — please visit the [U.S. Interagency Council on Homelessness](#) website for additional information.

Leveraging Managed Care to Expand Housing Resources and Formalize Partnerships

Recognizing that many systems must come together to effectively coordinate health and housing services, states are requiring MCOs to collaborate closely with housing system partners who have extensive experience in this work. Several states have language in their contracts that require or encourage MCOs to invest in housing systems, with specific requirements to invest in community-identified priorities or collaborate with certain housing partners.

Participate in Community Planning

A handful of states require or incentivize MCOs to support identification of resources and assets in the community they serve. For instance, **Oregon** requires its MCOs (called coordinated care organizations or CCOs) to work closely with communities to support housing-related planning efforts. Since 2012, Oregon has fostered partnerships between its CCOs and community-based organizations (CBOs) to reduce health inequities by addressing both individual CCO enrollees' and community social needs. In 2020, Oregon launched [CCO 2.0](#), which built on several policies that were already in place in the 1.0 phase intended to strengthen CCO/CBO partnerships.

To support planning efforts and understand the resource landscape, Oregon's CCOs are required to conduct a community health assessment, develop and implement a community health improvement plan, and establish a [community advisory council](#) (CAC). As part of CCO 2.0, the current contract also requires that social drivers of health and equity (SDOH-E) partners and organizations be included in the development of both the assessment and improvement plan. An SDOH-E partner is an entity, including a CBO, that "delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO's service area" (p. 264, Exhibit K of [2024 CCO Contract](#)). Payment for these efforts is discussed further in the section titled "Paying MCOs to Address Housing Challenges."

Invest Profits into Housing Resources

Several states require Medicaid MCOs to reinvest a portion of their revenues directly into the communities being served and/or into specific programs. Many MCOs are leveraging this opportunity to identify top community priorities and, in some cases, invest directly in housing resources. For example:



The **Ohio** Department of Medicaid (ODM) requires MCOs to contribute 3 percent of their annual after-tax profits to community reinvestment, and the percentage of contributions must increase by 1 percent each subsequent year until it reaches 5 percent. Community reinvestment initiatives began in 2023 based on the first annual period from January to December 2023. MCOs must prioritize community reinvestment opportunities generated from community partners and use available population health data (e.g., opportunity index data) and consider existing local community health assessments to develop its community reinvestment plan. Additionally, MCOs are required to collaborate with other MCOs and evaluate the impact of community reinvestment efforts (p. 137 of [Provider Agreement](#)). Community reinvestment is a key activity within ODM's [Population Health Approach](#), which focuses on addressing housing instability, among other social determinants of health (SDOH) and initiatives for cross-system collaboration.



In **Mississippi's** draft contract for its next Managed Care Request for Qualifications, the state requires MCOs to devote at least a half percent of capitation payments to SDOH projects and work with CBO partners to develop and administer those initiatives (p. 215 of [2021 Coordinated Care Model contract](#)). The draft contract's SDOH strategy refers to homeless shelters and CBOs addressing housing needs as examples of partners in this work. The contract has not yet been implemented.



Through **Oregon's** [SHARE initiative](#) (Supporting Health for All through REinvestment), coordinated care organizations (CCOs) must [spend a portion of their net income](#) on SDOH-E efforts in their community. Investments with community SDOH-E partners must be based on priorities in the CCO's current community health improvement plan, include a role for the CCO's community advisory council (CAC) in CCO spending decisions, fit into one of four domains (economic stability, neighborhood and built environment, education, and social and community health), and address the Oregon Health Authority-designated statewide priority (which is currently housing-related services and supports) (p. 273, Exhibit K of [2024 CCO Contract](#)). An [example of such an investment](#) from the Oregon Health Authority includes "investing in low-income housing units with wraparound supports on site."

Dedicate Resources to Maintain Relationships with Housing Partners

Many states require MCOs to develop written agreements or regular touch points with housing providers or other housing partners. A handful of states require or incentivize partnerships with certain types of entities. The most prescriptive contracts require MCOs to form partnerships with specific entities or require an MCO to employ someone whose position is dedicated to collaborating with housing partners.



Arizona requires MCOs to employ a housing specialist or community liaison who serves as an expert on housing resources within an MCO's service area and coordinates with housing partners and other systems to address an enrollee's unmet housing needs. Arizona housing specialists are required to partner with provider networks' support staff (e.g., case managers) to provide education and support to enrollees in accessing their independent living housing options (the contract lists specific housing programs). Additionally, the housing specialist is the MCO's liaison to the state Medicaid agency's quarterly Housing Coordination Meetings and other ad hoc housing workgroups and initiatives. They are also the liaison to the Continuum of Care (CoC, i.e., local entities that coordinate a community's homelessness response and receive funding from the U.S. Department of Housing and Urban Development) in the MCO's service area, must attend relevant CoC meetings, and participate in coordinated entry and the [Homeless Management Information System](#) (HMIS, see more details in the following section). The contract further specifies that MCOs must ensure that the housing specialist is familiar with certain standards and practices related to permanent supportive housing (PSH), including state and federal Fair Housing laws and the fundamentals of Housing First and the Substance Abuse and Mental Health Services Administration (SAMHSA) PSH program, among other practices (p. 123 of [ACC contract](#)).



California requires MCOs to develop a robust provider network to deliver Community Supports (which includes housing services and supports, as outlined in the next section), and MCOs must enter into subcontractor or network provider agreements with these providers. MCOs are also required to partner to ensure that Community Supports providers have sufficient capacity to receive referrals and to support Community Supports providers in accessing systems and processes that allow them to obtain and document MCO enrollees' information and notify MCOs when a referral has been fulfilled (p. 227, Exhibit A, Attachment 22, Provisions 20-21 of [Medi-Cal Managed Care contract](#)). MCOs are not required to provide community supports but are strongly encouraged to do so by the state Medicaid agency. Payment

for Community Supports is discussed in the section titled “Paying MCOs to Address Housing Challenges.”



Pennsylvania requires its Physical Health MCOs to incorporate community-based organizations into value-based payment arrangements to address SDOH (p. 158 of [2023 HealthChoices Agreement](#)). The MCO contract specifies certain percentages of capitation revenues that must be spent on CBOs addressing SDOH domains such as housing.

Using Managed Care to Identify and Address Individuals’ Housing Needs

In addition to encouraging investments in community infrastructure to strengthen health and housing systems, state Medicaid agencies are uniquely positioned to leverage their contractual relationship with MCOs to improve coordination of health and housing resources for their individual enrollees. Many states leverage their Medicaid managed care contracts to ensure that MCOs screen their enrollees for housing instability and document housing needs, refer individuals and coordinate care with community resources, and reimburse for the provision of housing-related supportive services. States may choose to update contracts to include efforts to identify and address SDOH more broadly, embed these efforts into care coordination/care management requirements, or coordinate with an existing state program to address individual enrollees’ housing needs. States may also encourage MCOs to voluntarily cover a range of services through value-added and in-lieu-of services provisions.

Leverage SDOH Screening and Referral Requirements

In recent years, some states have moved to leverage their MCO contracts to screen and refer for SDOH broadly. These states require MCOs to establish policies to identify and address health-related social needs, screen enrollees for specific social risk factors, and refer enrollees or otherwise partner with state or community initiatives to address social needs, including housing. States require these elements to different degrees — for instance, within SDOH screening requirements. The most prescriptive contract provisions require MCOs to use a specific screening tool or closed-loop referral system (North Carolina requires use of [NCCARE360](#)), use specific SDOH questions in the MCO’s screening tool (e.g., Hawaii, Iowa, and North Carolina), or use a tool that has been approved by the state (e.g., Arizona).

Washington, DC requires MCOs to assess each enrollee to identify social factors; establish policies to identify and comprehensively address SDOH; and screen and address SDOH through community referrals, peer navigation support, or other strategies. Contracts also require MCOs to use DC information systems and tools to screen for SDOH and participate in DC initiatives that promote opportunities to collaboratively or independently address SDOH (p. 223 of [Amerigroup Contract](#)).

Leverage Care Coordination Requirements

Similarly, some states are incorporating requirements to screen individuals for housing instability and refer those with unmet needs to community agencies that deliver housing services into care coordination or care management provisions of their MCO contracts. For example, **Nevada** leverages three requirements to strengthen care coordination for individuals experiencing housing instability:

- “Members in Supportive Housing” and “Homeless/Transient Status” are listed as priority conditions for case management, which ensures that all MCOs must provide case management to enrollees fitting these description (p. 159, [2022 Molina Managed Care Contract](#)).
- MCOs are responsible for designating a specific clinician or case manager to ensure continuity of services for enrollees with special needs, which includes “homeless members” (p. 132, [2022 Molina Managed Care Contract](#)).
- As part of the state’s population health care management contract provisions, Nevada requires MCOs to submit a Population Health Annual Strategy to the state Medicaid agency. The strategy must include a description of the MCO’s screening process for SDOH, the process to address identified SDOH needs, and how enrollee SDOH needs, as well as cultural, ethnic, and racial factors, are incorporated into risk stratification algorithms (p. 136, [2022 Molina Managed Care Contract](#)).

Coordinate with an Existing State Housing Program

Louisiana’s Medicaid agency instructs MCOs to augment the state’s centralized [Permanent Supportive Housing \(PSH\) Program](#). The PSH program is jointly administered by the Louisiana Department of Health (LDH) and Louisiana’s state-level housing authority, which is located within the state’s housing finance corporation. Louisiana requires MCOs to work with the PSH program by identifying and providing outreach to eligible individuals/households with disabilities, assisting MCO enrollees with applying to the program, and working with the state’s PSH program staff to ensure an adequate and qualified network of PSH program providers. The state’s contracts require MCOs to contract with providers that meet a specific set of PSH program requirements and that are approved by the LDH PSH program director (p. 210 of [MCO Manual](#)). Additionally,

MCOs must employ a housing specialist responsible for connecting individuals to appropriate housing resources, including referring people to the MCO's PSH liaison for application to the Louisiana PSH program (p. 20 of [MCO Manual](#)).

The **Washington** Health Care Authority (HCA) requires MCOs to coordinate with its [Foundational Community Supports](#) (FCS) program for supportive housing or supportive employment. The HCA contracts with Amerigroup to be the sole third party administrator for FCS. In this arrangement, Amerigroup authorizes individuals for FCS supportive housing or supportive employment services, selects and contracts with providers, and reimburses providers for services. HCA's contracts with MCOs require MCOs to coordinate with and refer enrollees to Amerigroup, as the contracted third party administrator, for supportive housing and supported employment (p. 282 of [Integrated Managed Care Contract](#)).

Cover a Broader Range of Services

Outside of or in addition to using waivers or state plan amendments, state Medicaid agencies have two other avenues to cover housing-related supportive services specific to managed care. MCOs may voluntarily cover “value-added services,” which are services outside the Medicaid benefits package that improve health outcomes and/or reduce costs by reducing the need for more expensive care. These services are provided at the discretion of MCOs and are not included in capitation rates, but they can be included in the numerator of the medical loss ratio if it is part of a quality initiative. In-lieu-of services (ILOS) are another avenue for MCOs to voluntarily cover additional services that are cost-effective substitutes to services covered under the state plan. In a recent [letter to state Medicaid directors](#), the Centers for Medicare & Medicaid Services highlighted the potential for ILOS to address unmet health-related social needs (HRSNs) and established a policy framework for ILOS. Several states are already leveraging value-added services and ILOS through their MCO contracts. For instance:



In **Washington, DC**, the contracts define value-added services and state that MCOs must submit all proposed value-added benefits for review and approval prior to implementation in a format as determined by the Medicaid agency. Further, the contract specifies that an MCO that operates a community facility must at minimum provide support and resources to enrollees identified as homeless or facing housing instability (p. 64 of [Amerigroup contract](#)).



Through the state's [administrative rules and 1115 waiver](#), **Oregon** permits each CCO to count spending from its global budget toward [health-related services](#) (HRS), which are non-covered services intended to improve care delivery and overall enrollee and community health and well-being. For example, an MCO may use this authority to [“implement, promote and](#)

[increase wellness and health activities](#),” including paying for a coaching program designed to educate individuals on methods for managing a chronic disease. Oregon implemented financial incentives for CCOs to provide HRS and requires CCOs to ensure a role for the community advisory councils and Tribal Nations in how HRS spending decisions are made. [According to the Oregon Health Authority](#), HRS “are offered as a **supplement** to covered benefits under Oregon’s Medicaid State Plan [while] ILOS are determined to be a medically appropriate and cost-effective **substitute** for a covered benefit under Oregon’s Medicaid State Plan.” Oregon’s contracts additionally list nine ILOS that CCOs may choose, but are not required, to offer to beneficiaries (for instance, community transition services, enhanced case management, and post-hospitalization recuperative care). CCOs must indicate in their Member Handbook which ILOS they offer to CCO enrollees and may add or remove ILOS annually. CCOs can submit an Administrative Notice to the Oregon Health Authority to offer an ILOS not listed in the contract (p. 83 of [2024 CCO Contract Template](#)). Outside of CCO contracts, Oregon Health Authority published a [document comparing CCO spending initiatives](#), which outlines requirements and spending examples for HRS, ILOS, and the SHARE Initiative.



Under the [CalAIM initiative](#), **California** MCOs can cover a menu of 14 ILOS services, or “Community Supports” services on a voluntary basis, including the following related to housing:

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Day habilitation
- Recuperative care
- Short-term post-hospitalization housing

In addition, recuperative care and short-term post-hospitalization housing services are provided through California’s 1115 waiver while the other 12 Community Supports are provided under ILOS authority through the state’s 1915(b) waiver and incorporated into MCO contracts (p. 226 Exhibit A, Attachment 22, Provisions 20-21 of [Medi-Cal Managed Care Contract](#)).

Using Data and Performance Measurement to Guide MCO Efforts to Meet Housing Needs

Data sharing and reporting are critical components of planning, implementing, and evaluating interventions to address housing needs. Sharing data between MCOs and housing entities can assist states with ensuring that they are aware of and effectively coordinating with existing housing resources across the state and are targeting populations that would most benefit from certain housing supports. MCO reporting requirements can help states determine whether MCOs are meeting the obligations of their contract, assess whether the housing investment is producing desired results, and identify potential program improvements.

Leverage CoC Partnerships and HMIS Connections

MCOs that partner with housing entities and share aggregate-level data with their state Medicaid agency can assist the state with identifying populations that would most benefit from targeted housing interventions, identifying existing housing resources across the state, and evaluating efforts to address housing needs. These partnerships among MCOs and housing partners are critical to using a data-informed approach when aligning affordable housing, rental assistance, and supportive services.

A state Medicaid agency may require that MCOs collaborate with key holders of housing-related data, particularly the [Continuum of Care for the Homeless \(CoC\)](#). CoCs govern the [Homeless Management Information Systems \(HMIS\)](#), used to collect client-level data and data on the provision of housing and services by CoC agencies. Several states include provisions in their Medicaid MCO contracts that encourage MCOs to access HMIS data to support planning efforts for homelessness response in their community. For example:



Arizona's Medicaid agency (Arizona Health Care Cost Containment System, or AHCCCS) requires MCOs support this effort by ensuring key program and operational staff participate in the planning and implementation of data-sharing structure and protocols in HMIS in all three Housing and Urban Development (HUD)-recognized Homeless CoCs in the state. Additionally, MCOs must cover any agency or user fees associated with HMIS usage. This provision in particular may be instrumental in facilitating coordination of health and housing-related services if, for instance, MCOs pay for the HMIS license fee for local behavioral health providers (p. 109 of [ACC contract](#)).



California's Medicaid agency encourages MCOs to build partnerships and connect to HMIS data to support planning efforts through the [housing and homelessness incentive program \(HHIP\)](#). Although MCOs are not directly required to access HMIS, they are required to provide an aggregate landscape analysis “utilizing relevant data from the HMIS, [point-in-time](#) (PIT) homelessness counts, and other local needs assessments” in HHIP. In this guidance, the state clarifies that an MCO that “does not have the current data capabilities ... must provide an estimate based on PIT counts and describe what they need to achieve the connectivity to HMIS or other local data sources to report this information in the future” (p. 4 of [All Plan Letter](#)).

Utilize Data Sources to Identify Target Populations

State Medicaid agencies can also leverage contracts to require that MCOs use specific methods to identify target populations that would most benefit from services (such as case management or a targeted housing intervention) and determine if an enrollee meets criteria for certain initiatives. For instance:



Under **Tennessee's** Population Health Program, MCOs must evaluate their entire enrolled population and identify enrollees for specific cohorts according to risk, rather than disease-specific categories. To do this, MCOs must “utilize a combination of predictive modeling utilizing claims data, CSMD [Controlled Substance Monitoring Database] data, pharmacy data, and laboratory results, supplemented by referrals, UM [utilization management] data, and/or health risk assessment results to stratify the member population into cohorts.” Social needs data such as housing status must be incorporated into enrollee risk stratification, and MCOs must re-stratify the enrollee population on at least a quarterly basis (p. [121 of MCO Statewide Contract](#)).



Hawaii's Community Integrated Services (CIS) program for beneficiaries who are unhoused or at-risk of homelessness, and with chronic or complex health needs, requires MCOs to use multiple methods to identify targeted populations that would most benefit from the initiative. The CIS program aims to coordinate enrollee health care services and social supports, as well as establish connections to primary care, behavioral health and substance use services, specialists, hospitals, homeless service agencies, and other community resources. The contract specifies several data sources that health plans must consider in their analytic methodology to identify target populations that would most benefit from participating in the CIS program. The contract sets the expectation that health plans identify and gain access to data on enrollees shared across Hawaii's Department of Health and Behavioral Health agencies and other state partners. These sources include:

- Claims data and history
- Case conferences
- Real-time data from hospital notifications, pharmacy utilization data, and other sources to identify MCO enrollees who are accessing services but are not engaged in primary care
- Health screening, assessment tools, and enrollee surveys
- Social risk factor (SRF) tools that are approved by the Department of Human Services. SRFs refer to an enrollee’s social and economic barriers to health, such as housing instability or food insecurity.
- The Homeless Management Information System for Hawaii

(p. 19 of [Health Plan Manual; CIS Implementation Updated Guidelines](#))

Leverage Reporting for Program Evaluation

State Medicaid programs can use reporting requirements to ensure that MCOs are submitting information and data that allow the state to assess contract compliance and the impact of housing-related requirements. Oregon and Arizona offer examples of how states approach MCO reporting and use MCO reports to advance housing-related goals.

As discussed in more detail under “Paying MCOs to Address Housing Challenges,”

Oregon offers its CCOs financial incentives to provide housing-related services as health-related services (HRS). To administer this policy and promote transparency, MCOs are required to submit [semi-annual reports \(L.621 and L.622\) detailing their spending on HRS](#). Required information includes a description of each service, type of HRS (e.g., housing support services), dollars spent, and measurable outcomes for services. MCOs are also required to report the Medicaid ID number of all MCO enrollees who received more than \$200 of HRS. Oregon has established a review process to ensure all HRS meet Oregon’s definition of an HRS and consistent coding of HRS across MCOs. Once the review process is completed, Oregon analyzes the data to produce:

- Briefs [detailing spending](#) and [services provided](#)
- Calculate the medical loss ratio and performance-based reward incentives (see “MCO Payment” section)

Analysis of the 2022 data found the following:

- Housing was the second highest HRS spending category in 2022 when MCOs spent a total \$10,553,949 on housing.
- The majority of HRS spending on housing was for temporary housing (\$3,950,443), houselessness supports and supplies (\$2,540,125), and rental assistance (\$2,066,331).

Arizona requires MCOs operating under its [AHCCCS Complete Care \(ACC\) Contract](#) to provide permanent supportive housing coordination to eligible MCO enrollees, including “assessment of, coordination with, and supports to, assist members in attaining and maintaining housing as part of their independent living goals and service planning” (p. 108). As part of this coordination, MCOs are required to enter into an agreement with the AHCCCS housing administrator. The housing administrator operates the AHCCCS housing program, which uses state funding to pay for housing for eligible enrollees, who are primarily those with a severe mental illness diagnosis who meet additional eligibility criteria. The roles of each of the contractors and how they should work together to provide housing to eligible enrollees is detailed in a [separate policy document](#), which is regularly updated.

AHCCCS requires each MCO to submit a quarterly supportive housing report, which the agency can use to assess whether MCOs are meeting the performance requirements described above, and support program evaluation. This report includes information about all enrollees who were referred for or requested housing assistance, including those who were referred to a housing program other than that offered by the housing administrator and those who did not qualify for permanent supportive housing coordination. The report includes:

- Information about referrals and their results (if known)
- Information needed to understand whether listed enrollees qualified for permanent supportive housing, including whether the individual was on the MCO’s high-cost needs roster and had a severe mental illness diagnosis, as well as each enrollee’s current housing situation
- Whether the enrollee received any housing navigation or supportive services
- Both the Medicaid and HMIS identification number, which enable the agency to find more information about the enrollee’s medical and housing needs, as well as enrollee health outcomes

Utilize Z Codes

Some states use [ICD-10-CM Z](#) codes, diagnosis codes that enable providers to specify the type of SDOH they identified, in planning and evaluation. However, underutilization of Z codes in practice remains a challenge. Robust uptake will require bidirectional engagement among providers and the state to capitalize on this option. To address this challenge, some states have leveraged their contractual relationships to require MCOs to ensure that providers use Z codes, require that MCOs reimburse providers who submit Z codes, and require that MCOs educate providers on Z codes to promote their use. For example, in Arizona, MCOs must “monitor, promote, and educate providers on the use of SDOH ICD-10 codes. These codes shall be included on claims to support data collection on the HRSN experienced by AHCCCS members” (p. 47 of [ACC Contract](#)).

Paying MCOs to Address Housing Challenges

With the exception of services provided as value-added benefits, state Medicaid agencies pay MCOs for delivering covered services, including housing-related services and supports. Arizona and California offer examples of how states are factoring the cost of providing housing-related services into their capitation rates. Massachusetts offers an example of a cost-based reimbursement model. Finally, California and Oregon offer examples of state use of incentives for delivering these services.

Factor the Cost of Services into the Capitation Rate

Paying MCOs that accept financial risk for provision of services via capitation is fundamental to the MCO model. Indeed, states are required to incorporate the projected cost of any new Medicaid services that MCOs must cover into their capitation rate-setting process. States are also required to consider the effect of in-lieu-of services in the rate-setting process. So, if a state adds housing supports as an MCO covered service, either as a state plan benefit or an ILOS, these services must be factored into the rate setting process. (See the CMS [“2023–2024 Medicaid Managed Care Rate Development Guide”](#) and the [January 2023 state Medicaid letter](#) for more guidance on MCO rate setting.) Below are some examples of how states have approached this issue.



Arizona adjusted the 2019 capitation rates for the ACC program for an expected increase in the number of SDOH screenings provided by MCOs. Arizona also adjusted the rate for the addition of Supplemental Security Income/Social Security Disability Insurance Outreach, Access, and Recovery (SOAR) as a Medicaid-reimbursable case management service, billable as procedure code T1016 HK. The HK modifier enables Arizona to review utilization of SOAR services. (SOAR increases access to Social Security disability benefits for people experiencing or at risk of homelessness.) Arizona based its adjustment on the amount paid for the new service and anticipated utilization — finding that neither change would have an across-the-board impact of more than 0.2 percent. (See pp. 31–32 of the [“Contract Year Ending 2019 AHCCCS Complete Care Program Capitation Rate Certification.”](#))



California factored the cost of Community Supports (which includes housing supports, outlined above), and the associated care coordination provided as whole person care, into the [capitation rates paid to MCOs in 2023](#). The adjustment amounts were based on information reported by the MCOs. Only those MCOs that agreed to provide community support services received those adjustments, and the amounts are MCO specific. As discussed below, California is currently offering MCOs incentive payments for building capacity and infrastructure necessary to deliver Community Supports, address homelessness, and for the provision of community support services through

the [Housing and Homelessness Incentive Program \(HHIP\)](#). The Medicaid program reports that these incentive programs have no effect on the capitation rate. (See pp. 40–41 and 83–85 of California’s “[2023 Rate Certification Report](#).”)

Leverage Cost-Based Reimbursement

Massachusetts Medicaid’s major investment in housing-related services is via its flexible services program, which is funded under its 1115 waiver as a [delivery system reform incentive payment program \(DSRIP\)](#). This authority provides the state with much flexibility in program design and payment approach. Flexible services are not Medicaid-covered services, nor are they an entitlement. Rather, the flexible services program offers accountable care organizations (ACOs) a limited amount of funding to test whether they can reduce the total cost of care and improve health outcomes by meeting enrollees’ health-related social needs through targeted evidence-based programs. The overarching ACO payment model creates strong financial incentives for ACOs to fully and effectively invest their flexible services funding. ACOs are paid via prospective capitation payments, but they also share financial risk with the state. Each plan’s performance in containing the total cost of care and achieving quality outcomes governs what amount of savings it may retain or losses it must pay.

ACO payment for the flexible services program is addressed in section 5.2C of the [ACO Contract](#) (begins on p. 361). The state has chosen to target nutrition and housing needs, and ACOs will only be paid for programs that target these needs and meet other criteria defined by the state. Essentially, each year, the Medicaid agency allots each ACO a specific amount of funding for its flexible services program, which varies based on the number of Medicaid beneficiaries enrolled in the plan. Then the agency pays each ACO in four equal quarterly installments calculated based on each ACO’s allotment and approved program budgets. To implement these provisions, the state issued [extensive separate guidance](#) about budget and spending requirements, allowable costs, financial reporting, and other aspects of the program. This guidance is updated annually.

Use Incentive Payments

Most MCOs do not have experience in delivering housing supports. They are likely unfamiliar with the services and providers that deliver them and often are still learning the circumstances under which such services are cost-effective. Many housing services are provided by community-based organizations that are not familiar with the contracting process and do not have existing systems they can use to bill MCOs. As a result, both MCO and housing providers need to make investments in infrastructure and develop new partnerships to enable MCOs to deliver housing-related services. Those states covering housing-related services as in-lieu-of services have the added complication that they cannot require MCOs to cover the service. Some states have established financial incentives to encourage MCOs to make the needed investments.

California: Incentive Payments Outside the Capitation Rate

California has two housing-related incentive payments. One supports the delivery of Community Supports (which include housing services), and the other is for the state's Housing and Homelessness Incentive Program ([HIPP](#)). Both are structured similarly, and both are voluntary for MCOs. California's Medicaid agency provides each MCO that chooses to participate in an incentive payment program with the total amount of funds it could earn through its performance, including performance on a set of metrics that includes both narrative and quantitative measures. The Medicaid agency establishes benchmarks for performance on each measure for each reporting period. To meet the benchmarks, MCOs need to improve their performance in each reporting period. Participating MCOs receive a set number of points for each benchmark they achieve, and the amount of the incentive payment each MCO receives is dependent on the number of points each earns. The Medicaid agency does not direct how MCOs spend the incentives they earn and does not require MCOs to share the earnings with providers. However, the agency anticipates that to earn the incentives MCOs will need to invest in partnerships with relevant providers. Some of the specifics of each program are detailed below.

- The [HIPP](#) operated from January 1, 2022, through December 31 2023, with a total of \$1.288 billion in funding from the [American Rescue Plan Act](#). (See pp. 24–25 of California's approved [Home- and Community-Based Services Spending Plan](#).) Participating MCOs were eligible for four payments. To qualify for payment MCOs had to work together with the local CoC and other MCOs to prepare and submit a joint [local homelessness plan](#) for each county in which the MCO is participating, submit an individual [MCO investment plan](#), and report [required measures](#). (These requirements are summarized in an [all-plan letter](#).)
- The CalAIM Incentive Payment Program (IPP) will operate from January 1, 2022, through June 30, 2024. The 2021–2022 state budget allocated \$1.5 billion for this program. Participating MCOs are eligible for five payments. The IPP is designed to support implementation of multiple aspects of the CalAIM program, including encouraging MCOs to choose to provide community support services. To qualify for payments MCOs have to submit a [needs assessment](#), a [gap-filling plan](#), and required measures. (Note: [Year one measures](#) differed from [year two and three](#) measures.) The number of points that MCOs may earn for performance are allocated across priority areas. Initially, there were three priority areas, one of which was community supports provider capacity building and take-up. This priority was worth at least 30 percent of the available points — and each MCO could choose to allocate more points to performance in this area. (The requirements are summarized in an [all-plan letter](#).)

Oregon: Using the Capitation Rate-Setting Process and Medical Loss Ratio Requirements as Incentives

Oregon uses both its capitation rate-setting process and medical loss ratio (MLR) requirements to create incentives for CCOs (Oregon’s term for MCOs) to offer [health-related services](#) (HRS), which include housing services.

Oregon implemented a performance-based reward (PBR) pool as part of its capitation rate-setting process. The intent of the PBR pool is to “incentivize CCOs to pay for HRS that will improve health and reduce medical cost.” The PBR pool does this by ensuring that the capitation rates paid to CCOs do not decline due to successful investments in HRS — and the resulting reductions in medical costs. Oregon Medicaid created a statewide PBR pool based on the historical spending of its CCOs on HRSs, and each year the state adjusts the amount for [trends in cost](#). The amount in the PBR pool is then allocated to individual CCOs based on their approved HRS spending and all capitation rates paid to that CCO are adjusted based on the CCO’s allocation. (See p. 37 and Appendix K of “[CY23 CCO Program Capitation Rate Development and Certification](#).”)

Under [federal law](#), states must require MCOs to calculate and report an MLR and may require MCOs to meet an MLR of 85 percent or more. (An MLR defines the minimum percent of premiums that an MCO must spend on clinical services and quality improvement.) Oregon has chosen to require its CCOs to maintain an MLR of at least 85 percent; CCOs with an MLR of less than 85 percent are required to pay a portion of their payments back to the state Medicaid agency. To leverage these requirements as an incentive, Oregon defined an HRS service to include only services that count as spending on quality improvement (i.e., the services improve health care quality or are “related to health information technology and meaningful use requirements to improve health care quality”). This approach incentivizes MCOs to spend their payments on HRS because doing so helps them achieve the 85 percent ratio. (See Oregon’s “[Health-Related Services Brief](#).”)

Conclusion

Medicaid MCOs are an important partner in supporting robust permanent supportive housing programs, regardless of whether a state has pursued 1115 or other Medicaid authority. States have a variety of levers to partner with MCOs to advance alignment of affordable housing, rental assistance, and supportive services, and NASHP will continue to support states in this endeavor.

Contributing Authors

Ella Roth and Neva Kaye

Acknowledgements

The authors would like to thank Robin Wagner, Elaine Chhuan, and all the state officials who reviewed this brief for their thoughtful feedback. This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the National Organizations of State and Local Officials as part of a three-year award totaling \$2,632,044 with 0% financed with non-governmental sources. The information, content, and conclusions are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit [HRSA.gov](https://www.hrsa.gov).



Visit nashp.org
for more information.

