Improving the social determinants of health in rural America through Medicaid Section 1115 waivers

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Introduction

Worse health outcomes among rural populations can be partially attributed to the unique social determinants of health (SDOH) they face. Medicaid Section 1115 waivers present states with the ability to create and test novel programs via pilots, delivery system reform, or enhanced benefit packages to improve the health of their state's beneficiaries.[1,2] Recent demonstration programs approved by the Centers for Medicare and Medicaid Services (CMS) highlight the potential for Section 1115 waivers to modify the societal factors associated with diminished health in rural areas.

Background

Rural social determinants of health

SDOH are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[3] While public health professionals have begun adopting the terminology "social drivers" in lieu of "social determinants" to acknowledge the ability for these factors to undergo positive change, SDOH continues to be widely used when describing these conditions. SDOH observed in rural communities include diminished access to transportation and health care services, a higher prevalence of food deserts, unsafe housing conditions, and social isolation.[3,4,5,6]

Rural populations experience worse health outcomes than their urban counterparts, including higher rates of morbidity and mortality associated with preventable conditions such as chronic disease and unintentional injury.[7,8] Socioecological determinants, including a higher prevalence of behavioral risk factors, higher rates of poverty, lower education levels, and fewer personal resources, contribute to these health outcomes.[4,6] These disparities are more pronounced among rural residents who belong to racial and ethnic minority groups.[8,9,10,11]

The opportunity to modify SDOH and their impact on health outcomes relies on providing health care and non-medical services. One study found that SDOH can affect up to 50 percent of county-level variations in health outcomes compared to clinical care, which only impacts 20 percent.[12] There is mounting evidence to support the notion that programs and strategies targeting certain SDOH, including housing, food and nutrition, transportation, social and economic mobility, and social service connections, positively impact health outcomes and reduce health care costs.[13] While improving health is often conceptualized as the treatment of disease, community-based approaches that address the structural causes of disparities and aim to prevent disease are necessary for long-term improvements in health outcomes and equity.[13]

Medicaid and Section 1115 waivers

Medicaid is a joint federal-state public health insurance program that provides health insurance coverage to individuals with limited income and resources. Individuals in rural communities are more likely to rely upon Medicaid for insurance coverage than those in urban areas, and nearly 17 percent of Medicaid beneficiaries – or 14 million people – lived in rural areas in 2022.[14,15,16] More rural residents rely on

Medicaid for health care coverage due to greater rates of poverty and lower participation in the labor force, which results in lower rates of employer-sponsored health insurance.[15,17,18] Further, Medicaid can be critical in filling coverage gaps for rural individuals who are not covered under private insurance.[15,19]

Though federal and state governments jointly fund Medicaid, the programs are administered by the states, which have sole discretion over the optional benefits they cover in their plan. While Medicaid coverage differs by state, federal regulations prohibit Medicaid funding from being directed to many non-medical services.[1] However, states may use Section 1115 waivers, also known as 1115 demonstration projects, to implement initiatives that amend their plan and waive specific Medicaid Act provisions.[20] Approval of 1115 waivers is contingent on the initiative being deemed "likely to assist in promoting the objectives of the Medicaid Act" by the Secretary of the Department of Health and Human Services.[20] Additionally, waivers must be budget neutral to the federal government, undergo public notice and comment, and comply with periodic reporting and evaluations.[1] The requirement that Section 1115 waivers be budget neutral is intended to stymie excess federal spending. Financial constraints can hinder demonstration programs that increase health equity among marginalized populations.[50] These communities, which have experienced historic disinvestment, may require additional spending to achieve equitable health outcomes.[51]

In 2021, CMS issued guidance outlining opportunities for states to cover "housing-related services and supports, non-medical transportation, home-delivered meals, educational services, employment, community integration and social supports, and case management," citing Section 1115 waivers as one strategy to address SDOH or health-related social needs (HRSN).[21] Through care delivery, quality measurement, and coverage of clinically appropriate HRSN interventions, CMS has positioned itself to advance the health equity of Medicaid enrollees, reflecting the agency's 2022 Strategic Plan.[22] In response to the recommendations and guidance from CMS, an increasing number of states have submitted 1115 waivers to expand coverage and access to these services for their beneficiaries.[23]

Considering the high rates of rural residents enrolled in state Medicaid programs and worse health outcomes associated with SDOH, Section 1115 waivers present an exciting opportunity to reduce health inequities in rural America. As the scope of Section 1115 waivers can be tailored to cover specific populations and services, states can develop and test policies that address the unique HRSN of rural residents.[24] However, HRSN demonstration projects are subject to fixed fiscal policies and specific guardrails related to provider reimbursement, monitoring, and evaluation, tempering their potential for innovation by enforcing detailed regulatory requirements.

Analysis

HRSN Waiver Framework overview

The CMS Health-Related Social Needs Waiver Framework was created to elucidate how the agency will evaluate state proposals that target HRSN.[25] The framework describes the services eligible for coverage, service delivery guidelines, fiscal policies, and related requirements, such as monitoring and evaluation procedures.

Existing programs

Several 1115 demonstrations – including North Carolina's Healthy Opportunities Pilots (HOP), Washington's Accountable Communities of Health (ACH), and California's CalAIM – target high-need enrollees and seek to improve their health through social services [appendix].[26,27,28,29] Though each state waiver offers unique provisions, these programs all address HRSN by providing non-medical benefits to beneficiaries. Despite these demonstrations being relatively new, evidence suggests that they are

achieving positive outcomes. While most waivers do not explicitly target rural beneficiaries, the services provided through these demonstrations can reach rural residents in states that extend HRSN services to their Medicaid enrollees through Section 1115 waivers.

Initiated in 2022, HOP is a five-year program that provides HRSN assistance to high-need managed care enrollees identified as having special health and social risk factors. As of May 2023, the pilot program has delivered 76,582 food, housing, transportation, and interpersonal safety services to 10,234 enrollees.[30] Services provided include healthy food boxes or meals, housing safety inspections and repairs, payment for non-medical transportation, and home visiting services. Another demonstration program in North Carolina, the North Carolina Medicaid Reform Demonstration, created financial incentives that tied the health and socioeconomic outcomes of the pilot services to value-based payments.[21,31]

In the midpoint evaluation of Washington's ACH program, advancement of health systems capacity and care delivery, development of cross-sector relationships along the care continuum, and progress towards implementing strategies focusing on health equity were observed, among other successes.[32]

The CalAIM program adopts a whole-person care approach by integrating their state Medicaid program, Medi-Cal, with nonmedical social services. Under this demonstration, California launched the Providing Access and Transforming Health Initiative to increase the capacity and infrastructure of community-based organizations, public hospitals, and other partners to implement HRSN services successfully.[28,33]

The latest HRSN waiver approvals

In 2022, CMS approved and renewed innovative 1115 waivers in Arkansas, Arizona, Oregon, and Massachusetts to improve the care and coverage of their state's beneficiaries.[1,34] While each state's waiver covers a unique set of services and supports, these waivers generally addressed housing insecurity and food access for beneficiaries who meet specific health and social criteria.[1,34] In all four states, the Section 1115 waivers provide housing-related services and case management, outreach, and education to improve coordination across the health care continuum.[29,34]

The Arkansas Health and Opportunity for Me (ARHOME) program utilizes Medicaid dollars to purchase private health insurance for Medicaid beneficiaries and provides care coordination to specified populations.[35] Within the ARHOME waiver, there are Life360 HOME programs that tailor the provision of services to specific populations. For example, the Rural Life360 HOME program provides intensive support services to individuals living in rural areas of the state who have received a serious mental illness or substance use disorder diagnosis.[36] The waiver in Arkansas supports housing deposits, one-time transition and moving costs, pre-tenancy and tenancy-sustaining services, and housing transition navigation services. As the poorest rural communities, which are most likely to be served by Medicaid, experience the most significant challenges related to housing affordability and substandard conditions, these supports may be instrumental in improving rural health.[37]

Arizona's Health Care Cost Containment System (AHCCCS) provides comparable housing support.[38] However, it includes additional services such as medically necessary home accessibility modifications and remediation services, utility costs, and post-transition rent/temporary housing for up to six months. Structural dangers that lead to unintentional injury and death can be present in homes, with poisonings and falls being the second and third leading cause of unintentional injury in nonmetro areas, respectively.[39,40] The 2016 American Community Survey conducted by the Housing Assistance Council estimates that 30 percent of rural housing units have at least one essential element, such as indoor plumbing, that is not fully functioning.[40] Therefore, a reduction in unintentional injuries and environmental

hazards associated with substandard housing may be achieved with AHCCS model, which has the potential to improve health outcomes for rural populations.

Another component of AHCCCS, the Targeted Investments 2.0 Program, provides financial incentives to providers to address HRSN for targeted populations.[53] Incentive payments are given to provider organizations that meet certain benchmarks, such as implementing culturally and linguistically appropriate services standards and achieving outcome metrics, to support the development of infrastructure and care coordination services for patients.[53,54] This program has the potential to improve health equity among rural residents by encouraging providers to adopt a whole-person care approach to address the breadth of factors that can contribute to worse health outcomes.[53]

The Oregon Health Plan, similar to AHCCCS, will provide eligible populations with up to six months of rent and temporary housing. Statutory and regulatory limitations on using Medicaid dollars for non-institutional room and board have restricted the provision of such services up until this point.[41]

The MassHealth demonstration program provides transportation for HRSN services regarding tenancy and nutrition in Massachusetts.[29] Low-income rural residents are disproportionately impacted by food insecurity and have lower access rates to personal vehicles, resulting in a greater reliance on public transportation.[42] Additionally, food insecurity can drive poor health outcomes and contribute to higher rates of obesity and chronic disease.[43] Under the MassHealth waiver, certain beneficiaries will be eligible for medically-tailored food prescriptions and meal deliveries for up to six months.

Challenges

While Section 1115 waivers can be implemented in states that have not expanded Medicaid and can provide services to populations not covered under the state plan, increasing the number of beneficiaries who qualify for coverage under Medicaid could improve health outcomes for more individuals. Rural communities in states that expanded Medicaid have higher insurance coverage rates than rural residents in non-expansion states.[14] When individuals gain access to health insurance coverage, they can experience improved health outcomes.[44] Addressing SDOH can also lower health care utilization and costs for Medicaid and CHIP programs by enabling beneficiaries to access timely, appropriate care.[45] Further, Medicaid expansion has resulted in cost savings and improved financial performance for rural hospitals, state and local governments, and individuals.[44,45] While providing HRSN to rural communities can greatly improve health outcomes, ensuring underlying needs regarding coverage and access are met is critical.

Solutions to address the health needs of certain populations must be rooted in accurate and complete data to be effective. CMS collects information from the states on their Medicaid and CHIP beneficiaries through the Transformation Medicaid Statistical Information Systems (T-MSIS) database and repackages it into a user-friendly format to facilitate its use in health services research.[46] According to the Government Accountability Office, the completeness and accuracy of T-MSIS data do not meet CMS standards, despite improvements over the past decade and initiatives to improve the data submitted by states.[47] This data, which includes information on beneficiary eligibility, enrollment, utilization, cost, and payment, among other measures, is essential for CMS to ensure beneficiaries can access care and providers are paid for their services.[47]

In addition to collecting data that accurately represents state Medicaid beneficiaries, states must understand the specific challenges that beneficiaries face when accessing health care services. States should facilitate and convene meetings with community stakeholders and solicit their feedback as they develop new 1115 demonstration programs. Involving community members can improve health equity and ensure that the programs developed adequately address rural beneficiaries' needs.[48]

Despite the passage of these 1115 waivers, which attempt to increase access to services under Medicaid, demonstration programs can also be used to waive benefits under federal requirements, which may impede access to care. For example, four states implemented waivers to remove non-emergency medical transportation (NEMT) as a benefit.[13] Rural communities have fewer methods of transportation to utilize and often rely upon taxis or mileage reimbursement to friends and relatives who drive them to their appointments.[49] In Texas, officials reported that up to 30 percent of mileage reimbursement was for NEMT usage in rural areas, compared to 10 percent in urban areas.[49] Therefore, demonstration programs that remove benefits could disproportionately affect rural residents and their access to health care services, worsening their health outcomes.

Policy recommendations

- NRHA urges all states to expand access to Medicaid. The gains in coverage associated with the expansion of benefits and eligible populations under Medicaid will improve access to care in rural areas and enhance the financial stability of rural hospitals and health care providers.[52]
- NRHA recommends states collaborate with CMS to standardize data collection and sharing procedures. Increased investments in data collection and reporting on SDOH will allow states to identify the needs of rural beneficiaries and develop data-driven, cross-sector solutions using 1115 waivers.
- NRHA encourages state Medicaid programs to partner with other state, tribal, and local agencies to identify the needs of vulnerable populations and improve care coordination for Medicaid beneficiaries.
- NRHA endorses the incorporation of value-based payment models that encourage the delivery of high-quality care. Demonstration projects can leverage incentive payments for positive health and socioeconomic outcomes that result from 1115 waiver program services.
- NRHA encourages states to engage rural communities and stakeholders in developing, implementing, monitoring, and evaluating their demonstration projects to improve health equity.
- NRHA recommends that states negotiate with NEMT companies to expand operations in areas with a low capacity and encourage states to adopt mileage reimbursement for volunteer drivers.[49]

Recommended actions

- To signal federal support for state Medicaid expansion under the Affordable Care Act, NRHA recommends that the House of Representatives agree to H.Res.122, Expressing support for States to expand Medicaid under the Affordable Care Act to close the Medicaid coverage gap.
- NRHA supports H.R.3004, the Affordable Care Coverage Expansion and Support for States (ACCESS) Act, which would amend the Social Security Act and establish a federal Medicaid program for certain low-income populations.
- NRHA urges support for H.R.31, Cover Outstanding Vulnerable Expansion-eligible Residents Now (COVER Now) Act, which will establish a demonstration program allowing local governments in states that have not expanded Medicaid to furnish health services to the Medicaid expansion population.
- To expand coverage and access to home and community-based services under Medicaid, Congress should pass H.R.1493, HCBS Access Act. Within this bill, NEMT services, housing support, necessary home modifications, and assistive technology, among other services, could be covered.

- H.R.629, the Medicaid Improvement and State Flexibility Act of 2023, will allow for the approval of demonstration projects that utilize electronic benefits transfer cards to purchase primary care services and medications.
- NRHA supports passage of H.R.1066, CARING for Social Determinants Act of 2023, to direct CMS to issue guidance to states on effective strategies to address the SDOH in their Medicaid programs.

Conclusion

The unique SDOH in rural areas often contribute to worse health outcomes. Section 1115 demonstration waivers present an opportunity for states to provide HRSN services to their Medicaid beneficiaries. As Section 1115 waivers can be created to target specific populations and their health challenges, states should develop demonstration projects that recognize the challenges rural Medicaid beneficiaries face and provide them with corresponding HRSN services. Recognizing the disparate health outcomes in rural communities, CMS should continue encouraging states to adopt Section 1115 waivers to improve health equity.

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Appendix

Table 1

Section 1115 Health-Related Social Needs (HRSN) Services Approved for AZ, AR, MA, and OR

In all 4 states, HRSN services must be determined medically appropriate for the individual, based on clinical and social risk factors. See SDOH table of KFF's waiver tracker for more information on each state's waiver.

		HRSN Allowed		
Waiver	**Target Populations**	**Housing Supports**	**Nutrition Supports**	**Other Supports**
Arizona Health Care Cost Containment System	Enrollees who are homeless or at risk of becoming homeless and who meet at least one of a list of specified clinical and social risk criteria (e.g., SMI designation, high- cost high needs chronic health conditions or co-morbidities, or enrolled in AZ's Long Term Care System)	- Post-transition rent/temporary housing (up to 6 months) - Utility costs - Pre-tenancy and tenancy sustaining services - Housing transition navigation services - One-time transition and moving costs - Housing deposits - Medically necessary home accessibility modifications and remediation services		- Case management, outreach, and education, including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees
Arkansas Health and Opportunity for Me (ARHOME)	HRSN services are available to beneficiaries participating in a Life360 HOME, which are based out of eligible hospitals. Eligibility varies by type of HOME and includes individuals with SMI or SUD diagnosis who live in rural areas (Rural Life360 HOME), individuals with high-risk pregnancies and up to 2 years postpartum (Maternal Life360 HOME), and young adults at high-risk for long-term poverty (Success Life360 HOME)	- Pre-tenancy and tenancy sustaining services - Housing transition navigation services - One-time transition and moving costs - Housing deposits	- Nutrition counseling and education, including health meal preparation	- Case management, outreach, and education, including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees
Massachusetts MassHealth	HRSN services will be available to populations who participate in the Flexible Services Program (ACO-enrolled members age 0-64 who meet at least one health needs-based criteria and one risk factor) or in a Specialized Community Supports Program (members who meet criteria related to behavioral health needs and are either: experiencing homelessness, justice-involved and living in the community, or are facing eviction as a result of behavior related to their behavioral health condition). Varying HRSN services are available for each program.	- Pre-tenancy and tenancy sustaining services - Housing transition navigation services - One-time transition and moving costs - Housing deposits - Medically necessary devices to maintain healthy temperatures and clean air - Medically necessary home accessibility modifications	- Nutrition counseling and education - Meals delivered to the home (for up to 6 months) - Medically-tailored food prescriptions (for up to 6 months) - Cooking supplies	- Case management, outreach, and education, including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees - Transportation to HRSN services for tenancy supports and nutrition supports
Oregon Health Plan	Populations eligible for HRSN services are experiencing major life transitions. These include: youth with special health care needs (YSHCN); adults and youth discharged from IMDs; adults and youth released from incarceration; youth involved in child welfare system; individuals transitioning from Medicaid-only to dual eligibility status; individuals who are homeless or at risk of becoming homeless; and individuals with high-risk clinical needs residing in regions experiencing extreme weather events.	- Post-transition rent/temporary housing (up to 6 months) - Utility costs - Pre-tenancy and tenancy sustaining services - Housing transition navigation services - One-time transition and moving costs - Housing deposits - Medically necessary devices to maintain healthy temperatures and clean air - Medically necessary home accessibility modifications	- Nutrition counseling and education - Medically-tailored meals (for up to 6 months) - Fruit and vegetable prescriptions (for up to 6 months) - Meal or pantry stocking	- Case management, outreach, and education, including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees

SOURCE: KFF Section 1115 Waiver Tracker • PNG

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