HEALTH RELATED SOCIAL NEEDS

An Emerging Opportunity for Behavioral Health

NATIONAL COUNCIL *for* Mental Wellbeing

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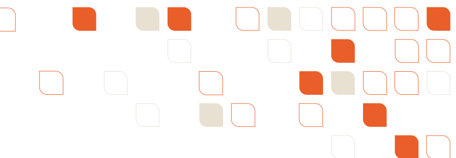
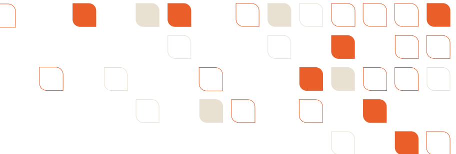


Abbreviations Used in This Brief

HRSN	health related social need
SDOH	social determinant of health
BHO	behavioral health organization
CCBHC	Certified Community Behavioral Health Clinic
CMS	Centers for Medicaid and Medicare Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SMA	state Medicaid agencies
CMCS	Center of Medicaid and CHIP Services
SUD	substance use disorder
SNAP	Supplemental Nutrition Assistance Program
BMI	body mass index
AHCCS	Arizona Health Care Cost Containment System

CSP	community support program
FSP	flexible services program
OHA	Oregon Health Authority
CCO	coordinated care organizations
FCS	foundational community supports
HMIS	homeless management information systems
CBO	community-based organization
SSO	social service organization
TPA	third-party administrator
MCO	managed care organization
TCM	targeted case management
CARF	Commission on Accreditation of Rehabilitation Facilities
CP	community partner
SWIG	Social Services Integration Workgroup



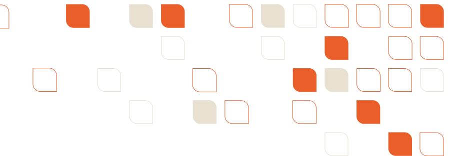
Summary

Health related social needs (HRSN) represent difficult conditions, such as food insecurity, housing instability, unemployment and lack of reliable transportation, that often contribute to poor health. Such conditions are also major drivers of health disparities across demographic groups (Tsai, 2023). An individual's HRSNs are directly related to underlying social determinants of health (SDOH). SDOHs may include conditions in their community and conditions of their daily life, including "economic policies and systems, social norms, social policies, and political systems" (World Health Organization, n.d.).

Behavioral health organizations (BHO), including Certified Community Behavioral Health Clinics (CCBHC), often provide services such as tenancy and nutritional supports that address HRNSs for individuals with behavioral health needs. Recent efforts by the Centers for Medicare and Medicaid Services (CMS) to offer services that address HRSNs can leverage current BHO and CCBHC efforts. This includes:

- Requiring CCBHCs to meet Substance Abuse and Mental Health Services Administration (SAMHSA) requirements, offer services such as comprehensive evaluations that address SDOHs, and ensure individuals receive Medicaid Targeted Case Management.
- Meeting current requirements by payers and accreditation organizations, such as the Commission of Rehabilitation Facilities, to have BHOs include approaches to address HRSNs in their strategic planning efforts, performance measurement and services delivery.
- Ensuring CCBHCs meet their requirements regarding Designated Collaborative Organization if they decide to partner for facilitating access to services to support HRSNs versus providing them directly.
- Aligning current CCBHC and BHO reporting efforts with state Medicaid agencies' (SMA) required outcomes measures for services to address HRSN and Medicaid Health Homes.
- Providing a consistent source of funding (e.g., Medicaid) for sustaining efforts to provide services to support HRSNs.

However, BHOs and CCBHCs will face new and existing issues if they choose to provide services to support HRSNs, including ongoing workforce and capacity issues, potential siloing of case management to facilitate access to services that address HRSNs, and the administrative burden of setting up new reporting processes.



Introduction and purpose

In the past, the Center for Medicaid and CHIP Services (CMCS) approved SMAs to implement various approaches to addressing SDOH factors (Costello, 2021); they have identified addressing HRSNs as a key Medicaid priority (Tsai, 2023). A major focus of HRSN efforts by CMCS and SMAs is providing new Medicaid services to individuals with behavioral health conditions, including individuals with serious mental illness, families of youth with serious emotional disturbances and individuals with a substance use disorder (SUD). To that end, CMS has created an opportunity for SMAs to offer services to address HRSNs through a Medicaid 1115 Demonstration Waiver (HRSN Demonstrations). Under section 1115 of the Social Security Act, CMS can waive certain federal requirements so that states can test new or existing ways to deliver and pay for health care services in Medicaid to the extent that the HRSN Demonstration will likely promote the objectives of the Medicaid program (CMS, n.d.).

This brief provides information in support of the case for considering Medicaid funded services for HRSNs in a BHO's approach, including CCBHCs for delivering services. BHOs are nonprofit or for-profit agencies that deliver mental health and/or substance use treatment services to individuals in their geographic region, including individuals with serious mental illness, who can benefit from various HRSN services. CCBHCs are specially designated organizations that provide a comprehensive range of mental health and substance use services (SAMHSA, n.d.). CCBHCs serve anyone who walks through the door, regardless of their diagnosis, insurance status or ability to pay for services. More information on CCBHCs can be found by visiting the National Council's CCBHC Success Center.

This brief is intended to help BHOs and CCBHCs operating in states with an approved or pending 1115 Demonstrations by summarizing findings regarding CMCS-approved approaches to addressing HRSNs. It concludes with opportunities and issues to consider if their SMA seeks to offer Medicaid reimbursable services to address HRSNs.

This brief was developed by reviewing the most up-to-date information from four states with approved HRSN Demonstration applications: Arizona, Massachusetts, Oregon and Washington. Interviews were conducted with National Council provider associations and SMAs in these states to understand their state-specific programs to offer services to address HRSNs, as well as opportunities and issues for BHOs and CCBHCs. As discussed later in this brief, these services include care coordination, tenancy supports and nutrition-sustaining supports.

Case for HRSN Services for individuals with behavioral health conditions

Within SDOH, socioeconomic factors such as poverty, employment and education have the largest impact on health outcomes (American Academy of Family Physicians, 2022). Adults and children with behavioral health conditions and their caregivers are at high risk of poor health outcomes and could benefit from HRSN services. Mental illness is an independent risk factor for worse overall health status and higher rates of physical illness and premature death (Osborn, 2001; Lawrence et al., 2013; Kilbourne et al., 2009). Additionally, individuals from different racial and ethnic backgrounds and individuals in rural areas experience disparities related to access and utilization of mental health services, diagnoses, and outcomes (American Psychological Association, n.d.; Morales et al., 2020).

For instance:

Poor housing or lack of housing is predictive of depression and anxiety.

Poor diet increases various physical ailments, notably heart disease, stroke and Type 2 diabetes, which in turn can worsen an individual's mental illness.

Adults living in poverty, including many individuals with a significant behavioral health condition, are at a higher risk of adverse health effects from obesity, smoking, substance use and chronic stress.

Clinical care, including formal treatment and supports may impact only 20% of various health outcomes, while HRSN services can potentially positively impact 50% (Whitman, et al., 2022).

Impact of HRSNs on health and other outcomes

The availability of services and supports to address HRSNs, such as housing and nutritional assistance, can positively impact an individual's physical and behavioral health. For instance, studies show compelling evidence of the benefits of "housing first" interventions, which provide supportive housing to individuals with chronic health conditions (including behavioral health conditions). Housing first has shown improved health outcomes and reduced health care costs, especially for inpatient, emergency department and long-term care utilization (Whitman et al., 2022).

Efforts to improve food access through healthy food environments and public benefit programs such as Medicaid can lower health care costs and improve health outcomes (Whitman et al., 2022). Programs providing food assistance, such as the Supplemental Nutrition Assistance Program (SNAP), have been associated with lower health care costs, lower health care utilization and improved health outcomes (Carlsen & Llobrera, 2022). For instance, individuals receiving home-delivered meals had greater improvements in anxiety and self-rated health and reduced rates of hospitalizations and falls (Tsega et. al., 2019; Center for Health Law and Policy Innovation, 2020). Some services to address HRSNs include prescriptions for meals, which has been found to decrease Hemoglobin A1C (HbA1c) levels (Whitman et al., 2022).

Predictability of funding for HRSN services

Services and activities to address HRSNs are currently funded through a variety of disconnected, unpredictable and finite resources. In many instances, CCBHCs or BHOs that provide HRSN services rely on state or local general revenues or other discretionary funding. These providers often depend on other sources (e.g., grants or targeted fundraising activities) to underwrite their HRSN efforts. Individuals served by these providers may be on waiting lists for local housing (even when eligible for federal housing programs) or rely on in-kind resources (e.g., food pantries) for nutritional supports. These resources historically have been underfunded and were further strained due to the COVID pandemic. The availability of Medicaid funding to underwrite services to address HRSNs provides more stable and consistent funding than the state or local grants and provider-sponsored activities that are currently necessary to generate revenue for these services.

In addition to providing a more predictable revenue stream, CMCS has noted that "research shows that increasing Medicaid payments to providers improves beneficiaries' access to health care services and the quality of care received." To maintain and/or improve access to quality care for enrollees, CMCS is requiring states with an approved HRSN Demonstration to maintain base Medicaid payment rates of at least 80% of Medicare rates for behavioral health providers and increase any rates that are below this level (Guth, 2022).

Outcomes for CCBHCs and BHOs

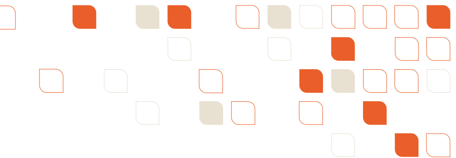
In some instances, participation in the state HRSN initiative aligns with various CCBHC and BHO reporting requirements. CCBHCs and BHOs have different reporting requirements based on federal and state law or regulation. CCBHCs in Section 223 CCBHC Medicaid Demonstration states and awarded SAMHSA discretionary CCBHC-Expansion grants must collect and annually report various quality measures. One such measure is screening for SDOH, which is a broader concept but often aligns with HRSNs. CCBHC Demonstration states must report other quality measures for all Medicaid enrollees in the CCBHCs. A relevant measure that is related to HRSNs includes HbA1c control for individuals with diabetes.

Required Measures for CCBHC Clinics

- **Time to Services**
- **Depression Remission at Six Months**
- **Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling**
- **Screening for Social Drivers of Health (SDOH)**

CCBHCs and BHOs are also participating in various SMA Health Home Programs focusing on individuals with serious mental illness and/or other chronic conditions. Nineteen states participate in the Health Home Program. Providers of Health Home services are required to report quality measures to the SMA as a condition for receiving payment. Relevant measures include the rate of assessment for body mass index for adults and controlling high blood pressure.

The Health Home Program was created by the Affordable Care Act to coordinate care for people with Medicaid who have chronic conditions. Health Home providers operate under a "whole-person" philosophy, integrating and coordinating all primary, acute, behavioral health, and long term services and supports to treat the whole person.



Summary of findings

As one would expect, there are similarities and differences across states in the approaches taken to developing their HRSN Demonstration applications, in both key features and implementation strategies. First, all of the states reviewed had previous experience funding HRSN services. Arizona's Health Care Cost Containment System (AHCCCS) has financed pre-tenancy and housing supports (including rental subsidies) for many years with a braid of Medicaid and substantial state funds and has contracted with a statewide housing administrator since 2021 to administer rent payments and perform day-to-day housing operations for the AHCCCS Housing Program. Massachusetts MassHealth began paying for community support programs (CSP) for people experiencing chronic homelessness in 2006 and originally initiated its Flexible Services Program (FSP) in 2020 through a Medicaid 1115 waiver. Since 2012, Oregon Health Authority (OHA) has used a Section 1115 waiver to encourage its coordinated care organizations (CCOs) to spend funds on "health-related services" through partnerships with community-based groups. Through this effort, CCOs have already developed some provider networks, partnerships and expertise in case coordination, food services and supports, and housing services. In 2018, Washington State launched Foundational Community Supports (FCS), funding supportive housing and supported employment through a 1115 Demonstration.

Across the waivers, there are strong similarities in covered services, as indicated in Table 1:

Table 1: HRSN Demonstrations: Waiver Authorized Services

SERVICES	Ariz.	Mass.	Ore.	Wash.
Case Management, Outreach and Education	X	X	X	X
Case Management	X	X		X
Outreach	X			
Housing Supports	X	X	X	X
Pre-tenancy Services and Supports		X	X	
Tenancy Sustaining Services and Supports		X	X	
Temporary Housing/Rental Assistance	X		X	X
Transitional Housing/Enhanced Shelter	X			
One-time Transition and Move-in Expenses	X	X	X	X
Home Modifications and Remediations	X	X		X

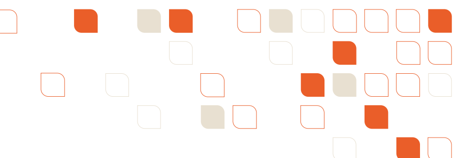


Table 1: HRSN Demonstrations: Waiver Authorized Services

SERVICES	Ariz.	Mass.	Ore.	Wash.
Nutrition Supports		X	X	X
Nutritional Counseling and Education		X	X	X
Home-delivered Meals		X	X	X
Medically Tailored or Nutritionally Appropriate Prescriptions		X	X	X
Cooking Supplies		X		
Transportation	X	X		X

Massachusetts and Washington, which have experience with financing housing supports such as assistance finding and maintaining housing, rely on existing service requirements. Massachusetts also requires CSP providers to use the Homeless Management Information System (HMIS) to document homeless status. However, several of the states are instituting service requirements that align Medicaid delivery system for HRSN-related activities with the homeless delivery system. For example, Arizona will require outreach providers to have connections to the local continuums of care and follow their best practices for outreach; transitional housing providers will utilize the HMIS and will meet its data standards; and various HRSN providers must follow the housing first model and harm reduction approach. In Oregon, pre-tenancy and housing navigation services are expected to facilitate enrollment in the local continuum of care's coordinated entry system.

States vary in their approach to developing provider qualifications for services that address HRSNs. Two states, Arizona and Massachusetts, rely on existing organizational licensure and workforce classifications for current Medicaid-enrolled providers. Arizona will also be creating new licensure standards for a provider type that will be covered by Medicaid. Massachusetts currently has standard provider qualifications for specialized CSP services and will be developing standards for FSP providers. Two other states have fewer specific requirements for current HRSN service providers and for community-based organizations (CBO) that will be newly enrolled in Medicaid. Oregon, for example, has created contractual expectations for these types of providers to "demonstrate the capacity and experience to provide HRSN services by having knowledge of the principles, methods and procedures" of the specific services they want to provide. For FCS, Washington State has general contractual expectations but gives preference to providers that have demonstrated capacity as evidenced by two years' experience with supportive housing (or coordination of independent living services) or that are licensed/certified in supportive housing by the Division of Behavioral Health and Recovery. Because Washington also contracts with individual practitioners, they require the individual to have a bachelor's degree in a related field with one year of experience in supportive housing or independent living, and be licensed or certified as dictated by the service.

To prioritize high-need Medicaid beneficiaries for HRSN services, states are using a variety of criteria, such as clinical/health needs, social risk factors, residential care transitions and child welfare involvement, to define the target population. All states include a behavioral health need and "homelessness or at risk of homelessness" as a criterion. States are also applying these criteria in different ways, with some identifying a few specific populations as eligible, and others listing a broader covered population but also requiring evidence of clinical need and social risk factors. Examples of target population in states with Demonstration waivers are included in Table 2.

Table 2: HRSN Demonstrations: Beneficiary Eligibility Criteria

ELIGIBILITY CRITERIA	STATE			
	Ariz.	Mass.	Ore.	Wash.
Homeless or At Risk of Homelessness	X	X	X	X
Presence of an Assessed Health Need (e.g., behavioral health, activities of daily living/ instrumental activities of daily living, high-risk pregnancy)		X		X
Designation of Serious Mental Illness	X			
Clinical Risk Factors (e.g., complex behavioral health, developmental disabilities, interpersonal violence, chronic health condition)			X	
Social Risk Factors (e.g., food insecurity, need for housing services)		X	X	
Child Welfare Involvement			X	
Institutional/Congregate/Foster Care Discharges			X	X
Correctional Facility Releases	X	X		
Score on a Specific Risk Assessment Instrument				X

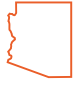
Three of the four states use non-provider organizations to determine eligibility and authorize services. Arizona and Washington State use a third-party administrator (TPA) for all Medicaid beneficiaries, while Oregon uses a TPA for beneficiaries receiving Fee for Service (FFS) benefits and their CCOs for managed care enrollees. In Massachusetts, Accountable Care Organizations (ACO) determine eligibility for FSP and also the services the beneficiary will receive; for specialized CSP services, while Medicaid is not funding a TPA, one provider is currently serving as an informal TPA for other smaller agencies that have the skills to provide the services but lack the administrative capacity to contract with and bill Medicaid.

An accountable care organization (ACO) is a health care organization that ties provider reimbursements to quality metrics and reductions in the cost of care.

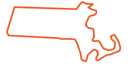
Once eligibility is determined, in three of the four states HRSN providers conduct an assessment, determine service goals and match those goals to the services to be provided. An exception is Massachusetts FSP, for which ACOs create the plan with members and navigate the member to a social service organization (SSO) for plan implementation. In Oregon, the CCO or TPA conducts care management for all individuals approved for HRSN services, including developing the person-centered service plan and referring the member to a HRSN provider for the approved services.

From the descriptions of the eligibility determination system and care planning processes, it is clear that states with HRSN waivers have added components to their Medicaid delivery system (Table 1). While all four states have managed care systems (some in place for decades and others for shorter periods of time), Managed Care Organizations (MCO) have varying degrees of involvement with HRSN providers. For example:

A Managed Care Organization (MCO) is a health care delivery system organized to manage cost, utilization and quality.



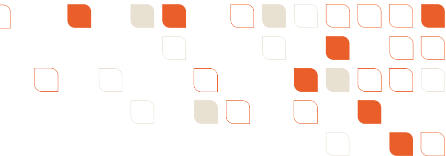
Arizona limits the MCO's role to ensuring care coordination occurs between the member's health home and the providers that offer HRSN interventions; a program administrator will hold the contracts with new Medicaid providers that are CBOs.



Massachusetts has multiple types of MCOs; each manages the specialized CSP benefit, but only ACOs are in charge of the FSP.

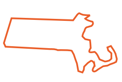
Oregon's CCOs administer the HRSN benefit for managed care enrollees, but a TPA oversees the FFS benefit.

In Washington State, a TPA has responsibility for both the managed and FFS HRSN benefit; the state has added a regionally based network of nine community hubs that are operated by Washington's Accountable Communities of Health (ACH) to provide service coordination and referral for all individuals receiving HRSN services.



In planning and implementing their HRSN Demonstration, states have used a variety of methods to engage stakeholders in the design and development process, including pre-existing advisory groups specifically tailored to their HRSN initiatives.

Arizona sought broad-based input on the waiver through virtual and in-person meetings and webinars; feedback was incorporated into their HRSN Protocol, a CMS-required document.



Massachusetts is reestablishing a Social Services Integration Workgroup (SSIWG) through which it expects stakeholders to provide input on the transition of FSP into ACO managed care as well as on provider qualifications.

Oregon has focused its stakeholder efforts on CCOs and CBOs, with numerous "all comer" webinars.

Washington State is relying on the ACH to get feedback on waiver implementation.

Opportunities for providers

The services and approaches discussed in the previous section provide opportunities for CCBHCs and BHOs in states electing to cover services to address HRSNs. For CCBHCs, the approaches set forth in the four states align well with required SAMHSA services standards, such as:

- Requiring comprehensive evaluations that include any relevant social supports, SDOHs, and health related social needs such as housing, vocational services and social supports. (4.d.1)
- Including key health indicators and health risks when undertaking screening and monitoring activities. (4.g.1)
- Ensuring targeted case management (TCM) activities assist individuals in sustaining recovery and gaining access to housing and other services. In addition, CCBHCs' TCM activities focus on populations consistent with several states' HRSN approaches, including individuals transitioning from inpatient and residential settings or experiencing homelessness.

BHOs have many of the same opportunities as CCBHCs. State Medicaid and behavioral health authorities embed similar requirements for screening, assessments and case management. Various accrediting organizations such as the Commission on Accreditation of Rehabilitation Facilities (CARF) require behavioral health providers to include SDOHs in their strategic planning efforts, performance measurement, assessment (including crisis assessments) and plan development (CARF, 2022).

The interviews with various providers and provider associations identified many BHOs (including CCBHCs) that are already providing HRSN activities, especially pre-tenancy and tenancy supports. These organizations often rely on various strategies discussed above to underwrite these efforts. While not a panacea, Medicaid financing would provide a more predictable funding source.

A crucial decision for CCBHCs and BHOs will be whether to "build" or "partner" in the delivery of HRSN services. While it is likely that many organizations are providing these services, others are not. For instance, in Massachusetts, 28% of behavioral health providers are community partners (CP) with ACOs and 11% provide FSP. CPs are community-based entities that work with ACOs and MCOs to provide care management and coordination to certain Medicaid enrollees with behavioral health needs. Yet, individuals with behavioral health issues served by other behavioral health providers that are not CPs or offering FSP services may also benefit from services to address HRSNs. Access to these services will be provided either directly by CCBHCs or BHOs or through partnerships with other local providers.

There is a cascade of questions CCBHCs and BHOs should consider when making this decision:

- *Are you currently providing state services to address HRSNs?*
- *If not, do you want to develop the capacity to offer at least one of the services proposed in your state's HRSN Demonstration?*
- *Is the HRSN approach consistent with the direction of the agency's governance?*
- *What is the percentage of individuals in your organization who are Medicaid enrolled and meet the SMA's eligibility criteria for your state's HRSN Demonstration?*
- *Do you have or can you recruit the staff needed to offer HRSN services consistent with state requirements?*
- *How much effort will your agency have to put into technology infrastructure to bill for and document HRSN services?*
- *Are there local providers that currently offer HRSN services?*
- *Do you have relationships with these providers? Are they willing to serve individuals you serve?*
- *Is the current partnership sufficient? What would need to change?*

An important statutory provision allows CCBHCs to develop partnerships with various entities (depending on the population they serve), including homeless shelters and housing agencies.

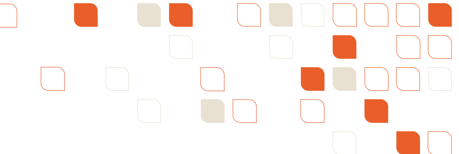
Reimbursement rates will be a major driver in a BHO's or CCBHC's decision to build or partner. While rates have not been developed for most state HRSN initiatives, provider associations raised concerns regarding the sufficiency of rates and whether their members have a true handle on the costs of various services that are currently paid through other funding streams and not using a fee schedule. Getting a better sense of costs for rendering HRSN services will be helpful in determining whether to become a Medicaid provider for such services.

Another consideration is ensuring provider input on the design and implementation of their state's HRSN Demonstration activities. It is well known that over the past decade, CMS has required SMAs to provide an opportunity for public comment and greater transparency of section 1115 Demonstration projects (including renewal of previously approved 1115 waivers) such as HRSNs. Providers report they have participated in these opportunities — but for second-generation 1115s that have added services to address HRSNs (usually through the CMS amendment process), states may not have had as robust a stakeholder process. As discussed earlier, Massachusetts is engaging stakeholders by re-establishing a Social Services Integration Workgroup (SWIG) to assist the Secretary of Health and Human Services' efforts to better integrate social services into the HRSN Demonstration. The SWIG will be responsible for:

- Best practices for operationalizing the transition of FSP into a managed care structure.
- Determining service categories of, and member eligibility for, HRSN services that support the goals of improved health outcomes, reduced health disparities and reduced cost.
- Determining how best to support robust data collection, analysis and evaluation of HRSN referrals and resulting impact of services.
- Inclusion of priority populations for equitable access and outcomes in services, such as children and pregnant/postpartum individuals.
- Improving connections to HRSN services, including member identification, linkage to services, integration of health care and social services and continuous quality improvement (Massachusetts Clean Water Trust, n.d.).

Massachusetts recently solicited a request for nominations for the SWIG, specifically members identified as having experience providing FSP or specialized CSP services, community partners and other providers of MassHealth services. The state is focused on engaging existing BHOs as well as SSOs in their planning efforts to promote effective service design and implementation.

The initiation of 1115 Demonstrations to address HRSNs reflects the growing realization that attention to both clinical and social needs must be integrated if the highest cost drivers of health care spending can be tamed. More than half of adult Americans have a chronic illness, and individuals with multiple chronic conditions account for two-thirds of health care costs. Whole-person care that addresses the relationship between chronic illness and SDOH is an important strategy to improve health and reduce costs. Without a whole-person approach, it is unlikely that payers' efforts to hold health systems accountable for total cost of care (TCOC) will be successful. In fact, in its FSP, Massachusetts is "testing whether ACOs can improve health outcomes and reduce TCOC through a targeted evidence-based program that addresses a certain subset of eligible members' HRSNs." BHOs and CBOs that participate in HRSN Demonstrations are likely to be seen as attractive partners for MCOs and ACOs that will increasingly be assuming financial risk for TCOC.



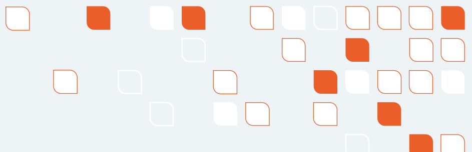
Potential issues

Medicaid coverage for services to address HRSNs presents some challenges for provider associations, BHOs and CCBHCs. Housing, housing supports and nutrition services may be a new concept to SMAs, MCOs, ACOs and the state's actuaries. There have been various lessons learned from efforts to cover services under Medicaid that were previously reimbursed through other federal, state or local resources. The most recent example is SUD services provided in large residential settings that are covered by Medicaid in many states. While some SUD providers had experience with American Society of Addiction Medicine and commercial payers, a substantial percentage had little or no experience participating in Medicaid and struggled during implementation with myriad operational issues, such as negotiating contracts with Medicaid MCOs, having adequate workforce to address new Medicaid standards and building the infrastructure to bill third-party payers, especially Medicaid.

Workforce and capacity issues are another major factor in determining if and how an agency will participate in their state's HRSN program. Providers must focus on existing service delivery obligations while also entertaining new and competing opportunities, such as providing services to address HRSNs or other State Medicaid initiatives. In addition, the workforce in BHOs and CCBHCs that provide Medicaid services may be recruited by ACOs or other organizations resulting in a shortage for BHOs and CCBHCs to provide these services. Delivering HRSN services directly may dictate the need to recruit and hire different personnel.

HRSN approaches may diffuse current care management and care coordination efforts by BHOs and CCBHCs. Developing a new focus for care coordination to facilitate access to services that address HRSNs may not take into account current efforts by BHOs and CCBHCs to perform these functions through assertive community treatment, TCM and community support services. Having a parallel care coordination approach or applying conflict-free case management to proposed care coordination for HRSN may be complicated for behavioral health providers and the individuals they serve.

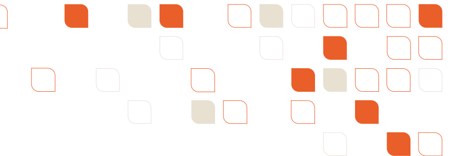
Lastly, standing up new benefits will entail additional administrative burden for providers. Information system changes and regulatory and reporting requirements are just a few examples of new responsibilities that can add to existing provider burden for delivering and being reimbursed for Medicaid services.



Conclusion

Medicaid coverage for services that address HRSNs provides both opportunities and potential challenges for CCBHCs and BHOs.

Providers should pay close attention to their state's HRSN Demonstration submission or amendment to identify services for coverage, eligible service recipients, provider qualifications and more. Providers should also weigh options when deciding whether to provide services to address HRSNs directly or to partner with other local agencies to best meet the needs of service recipients and to promote optimal health outcomes.



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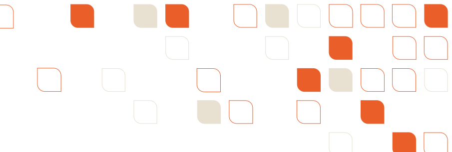

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