Lutheran Services in America®

POLICY BRIEF

December 2025

How Partnerships Strengthen Services: Opportunities for Faith-Based Organizations in a Shifting Medicaid Landscape

How faith-based social service organizations in Lutheran Services in America's nationwide network continue to leverage partnerships with Medicaid and managed-care organizations to improve the health and wellbeing of children and families.

Key Takeaways

- Despite federal policy changes to Medicaid, social service organizations can strengthen integrated care to the populations they serve by partnering with Medicaid and Medicaid managed-care organizations.
- Opportunities exist to expand strategic partnerships between social service organizations and MCOs including through identifying state Medicaid policies and managed care contract requirements.
- Social service organizations can leverage existing and future state Medicaid program innovations to support their outreach for care coordination services related to health-related social needs (HRSN).

Key Opportunities

1. State Medicaid programs increasingly require HRSN-related screening and assessment of Medicaid beneficiaries.
2. States are using Medicaid waivers and contracts to require MCOs to collaborate with social service providers in order to coordinate care around HRSNs.
3. States are adopting integrated care models that facilitate screening of and treatment for physical health, behavioral health and HRSNs.
4. States continue to test value-based payment arrangements to improve patient outcomes and reduce healthcare costs. As part of this effort, many states are requiring MCOs to engage in performance improvement projects to measure the impact of addressing HRSNs on health and health disparities.

Background

Addressing non-medical drivers of health—referred to here as health-related social needs (HRSNs) such as housing and nutrition—can improve health outcomes and lower health care costs.

In states with Medicaid managed-care organizations (MCOs),[1] the recognition of the importance of HRSNs has resulted in MCOs forming strong partnerships with social service providers and Medicaid (via state agencies) to better address both the health needs and health-related social needs of patients.[2, 3, 4]

So, despite a shifting federal landscape regarding Medicaid policy and financing, a number of key opportunities still exist to build on and/or expand these partnerships between social service providers, Medicaid and Medicaid managed-care organizations.

As part of Lutheran Services in America's (LSA) Strengthening Families Initiative,[5] LSA partnered with researchers at The George Washington University (GWU) to analyze 16 state Medicaid programs to identify opportunities for collaboration between social service providers and Medicaid managed-care organizations. Documents reviewed for this analysis include:[1]

- Master agreements/contracts between state Medicaid offices, Medicaid managed-care organizations and accountable care organization plans
- Existing Section 1115 waivers related to HRSNs
- Community health-worker state plan amendments
- In lieu of service guidance documents:
    - CHIP state plan amendments, and
    - Managed care external quality reviews

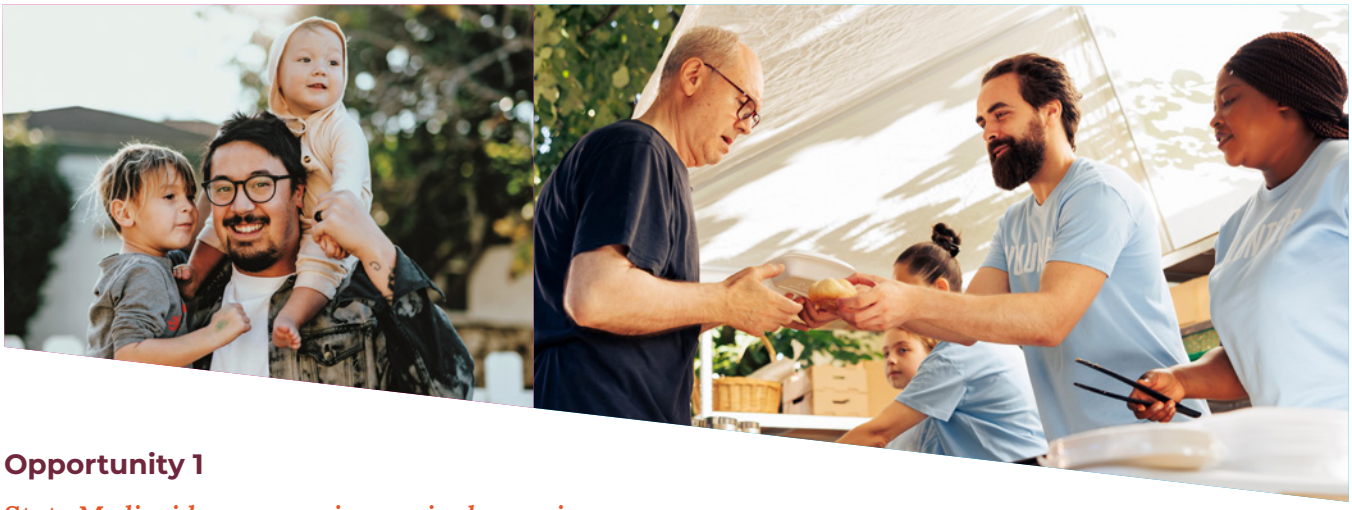
States with Medicaid MCOs were selected for analysis based on case studies of LSA member organizations, as well as innovative Medicaid policies identified through a literature review. In addition, three fee-for-service (FFS) Medicaid states were included in order to provide information outside the managed care context regarding how states are incorporating social service organizations into Medicaid to help address HRSNs.

This issue brief provides an overview of the key opportunities identified in the GWU analysis.

Key Opportunities Identified for Collaboration between Social-Service Providers, Medicaid and Medicaid Managed-Care Organizations

The states reviewed include:

1. Alaska (FFS)
2. California
3. Florida
4. Illinois
5. Kentucky
6. Massachusetts
7. Minnesota
8. Nebraska
9. Ohio
10. Oregon
11. Pennsylvania
12. South Dakota (FFS)
13. Texas
14. Virginia
15. Wisconsin
16. Wyoming (FFS)



Opportunity 1

State Medicaid programs increasingly require HRSN-related screening and assessment of Medicaid beneficiaries.

State-mandated efforts to require HRSN screening by Medicaid MCOs have paved the way for more targeted, patient-centered interventions, such as connecting individuals and families to housing or nutrition support provided through social service organizations. A 2024 survey by KFF (formerly Kaiser Family Foundation) found that 32 of the 40 responding states with Medicaid managed care reported specific MCO requirements for screening of members' social needs.[6] Making HRSN-related services—including screening and assessment—Medicaid-covered benefits across the state, regardless of a beneficiary's MCO, has expanded opportunities for all social service providers to contribute to improving the health and well-being of the communities they serve.

GWU's review found that all 13 states (non FFS) with managed care analyzed for this project had some type of requirement that at least a subset of managed-care members be screened and assessed for HRSNs.[2] For example, Massachusetts and Illinois managed-care contracts require that all new enrollees in managed-care plans be screened for HRSNs.[7, 8] Minnesota's managed-care model contract requires managed-care members who present to emergency departments be screened for HRSNs and connected to case management services.[9] This covered service supports hospitals in partnering with individual and social service providers to assess and follow up on individuals' needs related to housing, behavioral health, transportation, and employment—all of which help reduce avoidable emergency department use in the future.[10]

In other states, screening for social needs is more targeted or limited to specific Medicaid populations, depending on whether it is required through a managed care contract or via a waiver. In Kentucky, for example, under a 1115 waiver approved in July 2024, the state has received approval to extend a limited set of Medicaid covered services to adults in Kentucky state prisons and to youth in youth development centers for 60 days prior to their release. As part of the services, individuals are proactively screened and assessed for HRSNs so that upon release and up to 12 months post release, they can be provided case management services to address their HRSNs and other health needs.[12, 13]

Similarly, in Illinois, a specific 1115 waiver approved in July 2024 focuses on managed-care enrollees who, based on screening or service utilization, are high-risk or high-cost utilizers, including those with HIV, cancer, hypertension or behavioral health concerns.[14] Individuals who fit these criteria are then screened and assessed for HRSN services including tenancy and nutrition support services.

Lutheran Social Services (LSS) of Wisconsin and Upper Michigan: Partnering with MCOs to Deliver Proactive Behavioral Health Solutions

The Healthcare Partnership, launched in 2022 by LSS of Wisconsin and Upper Michigan network providers, offers intensive case management, medication management and referrals to community-based organizations. This program has demonstrated improvements in total cost of care and health outcomes for children and adults, with significant behavioral health conditions assigned to a singular Medicaid MCO. Key data collections areas include: overall program engagement, reduction in acute psychiatric/behavioral health admissions and stays and the use of intensive outpatient services. As with all of LSS's programs, the Healthcare Partnership leverages the organization's significant investment in data analytics and proactive outreach to clients, including via screening and assessment of HRSNs. Specifically, community-based programs utilize a 12-question social determinants of health screening assessment for every individual assessed at intake.

The organizations saw encouraging results when comparing the 12 months pre-enrollment to 12 months post-enrollment. Behavioral health inpatient admissions decreased by 16.67%, while utilization of intensive outpatient/partial hospitalization programs increased by 132.39%.

This shift toward less intensive levels of care is a positive indicator of improved service alignment and early intervention.

With the understanding that the state Medicaid program is requiring MCOs to screen members for HRSNs—especially seniors, the disabled and those with behavioral conditions—LSS is positioned to expand its partnership services to additional MCOs in the Healthcare Partnership. LSS brings significant expertise in care coordination for individuals with mental health and substance use disorders, as well as those with disabilities. LSS also provides housing assistance and skills-building services across multiple populations.

Opportunity 2

States are using Medicaid waivers and contracts to require MCOs to collaborate with social service providers in order to coordinate care around HRSNs.

While screening for HRSNs is essential, it is equally important to ensure that individuals with HRSNs receive adequate support to navigate services. According to KFF's survey, 31 responding states with Medicaid-managed care required MCOs, via their managed-care contracts, to provide enrollees with referrals to social services.[15] Among the 13 states that GWU reviewed with Medicaid-managed care, all 13 states required that MCOs coordinate care with social service organizations to address member social needs.

For example, GWU found that in Illinois, MCOs are required to provide care management to all enrollees who accept or request it. State-mandated MCO care-management programs must assess members' social health in addition to physical and behavioral health. In addition, interdisciplinary care teams must include care coordinators who connect MCO enrollees with community and social service providers to address their HRSNs.[16]

In Florida, MCO contracts similarly stipulate that each MCO will contract with at least three community-based organizations in each region that the plan services.[17] In addition, MCOs must establish community partnerships to provide services and supports for the HRSNs of MCO enrollees including case referrals, case planning, program development, information sharing and management, community awareness, group services and more. Through these partnerships, MCO-contracted providers are expected to refer enrollees to these community-based organizations, and follow-up to ensure enrollee's receipt of services from the organization using a closed-loop referral system. Importantly, these partnerships are designed to address various state-identified priority areas including birth outcomes, mental health of children and adolescents and HRSNs, which can include partnerships with vocational training and job placement organizations, literacy-focused organizations or intimate partner violence specialty organizations, among others.[18]

GWU's analysis also found that such innovations in Medicaid are not limited to states with managed care. For instance, Alaska, an FFS state, operates a voluntary program called the Alaska Medicaid Coordinated Care Initiative. Through this initiative, the state contracts with a private entity, Comagine Health, to provide case-management services for Medicaid beneficiaries, including HRSNs navigation services such as appointment scheduling, medication education, transportation or housing assistance.[19] Comagine Health also provides individuals with referrals to social service organizations to address social needs and proactively reduce

reliance on hospital emergency rooms as the health system's first point of contact.[20]

Similarly, in Wyoming, another FFS state, the state Medicaid program's Health Management Program helps enrollees with food and transportation needs by assigning a nurse case manager.[21] In California, via a state plan amendment approved in July 2022, and in Kentucky via a state plan amendment approved in March 2023, community health-worker services are covered under benefits, presenting opportunities for MCOs to contract and partner with community health workers (CHWs).[22, 23]

In Kentucky, for example, CHW-reimbursable services include health system navigation, resource coordination; health promotion and education are covered Medicaid services. Community-based organizations and health systems that have partnered with CHWs in the state, particularly in rural areas, have seen numerous programmatic successes, including in screening and coordinating health and HRSN-related care services.[24]

Lutheran Services Florida Health System (LSFHS): Strengthening Community Partnerships to Meet Medicaid's Evolving Priorities

Lutheran Services Florida Health Systems coordinates robust and comprehensive services to individuals across approximately one-third of Florida. While LSFHS manages an integrated network of roughly 100 provider organizations and is one of seven managing entities that has contracted with the state's Department of Children and Families (DCF), the organization's partnerships with the state's Medicaid program or Medicaid-managed care organizations provide an even greater opportunity to better align and strengthen amid ongoing policy and programmatic developments in the state.

Under new managed-care contracts started this year and running through 2030, Medicaid-managed care organizations are specifically required to establish and maintain partnerships with community-based organizations to address HRSNs through case management and referral. These partnerships are also required to focus on at least one priority area to include either improved birth outcomes, pediatric behavioral health or health-related social needs, including financial literacy or housing. The state also has operated an 1115 waiver, since 2019, that offers behavioral health services and supporting housing assistance for individuals 21 and older with serious mental illness and/or substance use disorder and incorporates care coordination, peer support and mobile crisis management. Currently, the pilot serves two regions in the state with four participating MCOs.

Similarly, LSFHS manages robust care coordination program for high utilizers of behavioral health care that connects their behavioral health needs with primary care, housing, education and other health and HRSN services. This program, paid through DCF, reimburses outreach, crisis support, case management and supportive housing, and prioritizes improving transitions of care, decreasing avoidable hospitalizations and homelessness and increasing access to community-based services.

The similarly aligned initiatives present a promising opportunity for LSFHS to become even more involved within the Medicaid system and to partner with more Medicaid managed-care organizations as they continue to extend their reach in Florida.

Opportunity 3

States have adopted integrated care models that facilitate screening of and treatment for physical health, behavioral health and HRSNs.

Increasingly, states are adopting models of care that integrate physical health, behavioral health and services addressing HRSNs in their Medicaid programs.[25] For example, states are using Certified Community Behavioral Health Clinics (CCBHCs) to provide comprehensive access to behavioral health services including 24/7 crisis response, medication-assisted treatment and targeted care management.[26] CCBCHCs are integrated with primary care and they also screen and address HRSNs for the individuals they treat. In 2024, for example, 91% of CCBHCs engaged in activities to help clients find or maintain stable housing.[27, 28]

GWU's review identified various forms of integrated care models within Medicaid that address physical health, behavioral health and HRSNs. Among the thirteen states with Medicaid-managed care, all are using integrated care models that address HRSNs. For example, Kentucky, via an 1115 waiver approved December 12, 2024, has launched a recuperative care or medical respite services pilot program that provides integrated medical, behavioral and HRSN service supports to those individuals experiencing or at risk of homelessness, including those with serious mental illness.[29, 30] Recuperative care services give these individuals clean and safe environments while providing them access to medical and behavioral health services. These services are intended to improve health outcomes and reduce unnecessary hospital admissions or readmissions.[31]

A similar program exists in Florida. Through an 1115 waiver, a pilot program in two regions in the state utilizes four participating MCOs to provide services to Medicaid beneficiaries who have a severe mental illness or substance use disorder and who are or at risk of being homeless, including mobile crisis management, peer support, transitional housing and tenancy sustaining services.[32]

Lutheran Social Services of Northern California: Building a Stronger Medi-Cal System Through Local Partnerships and Innovation

LSS of Northern California was one of the first social service organizations in the state to partner with Medicaid MCOs under the CalAIM Medicaid Transformation program created through a Medicaid 1115 waiver. The program is part of a broad transformation of Medi-Cal, California's Medicaid program, to create a more coordinated, person-centered health system. LSS increases access to integrated community-based behavioral health services by leveraging their longstanding connections in the 10 counties they serve through partnerships with Medi-Cal MCOs. LSS also offers enhanced care management, and community supports including coordination with medical and other social service providers while providing housing navigation and tenancy supports, all of which are reimbursable through MCOs thanks to the CalAIM program.

Another Medicaid 1115 waiver in California called the Behavioral Health Community-Based Organized Networks of Care and Treatment (BH-CONNECT) demonstration presents LSS with further opportunities to provide needed services to the Medi-Cal community and expand their already successful partnerships with MCOs. BH-CONNECT makes transitional rent coverage a new CalAIM community supports benefit starting in July 2025 and injects $1.9 billion in additional federal and state funding to expand community-based services, including those already provided by LSS, with the hopes of reducing emergency department visits and hospitalizations. The demonstration will support behavioral health workforce investments and provide dedicated funding to provide children and youth with specialty mental health services. The program will also cover community health worker services. Additionally, managed care plans statewide will be required to have County Child Welfare Liaisons to oversee, deliver and coordinate care while Centers of Excellence will provide training and technical assistance to delivery systems and providers.

Opportunity 4

States continue to test value-based payment arrangements to* improve patient outcomes and reduce healthcare costs*. As part of this effort, many states are requiring MCOs to engage in performance improvement projects to measure the impact of addressing HRSNs on health and health disparities.

While many states require Medicaid MCOs to address health-related social needs for the individuals they serve, they need data on patient outcomes to assess effectiveness and build support for further work.

> One way to track the impact of addressing HRSNs, including in regard to health disparities, is through ICD-10-Z codes. These codes flag HRSNs in Medicaid claims alongside physical or behavioral conditions.

Use of these codes in a patient's electronic health records can trigger care coordination services and referrals to SSOs, and help health plans and other organizations evaluate interventions to determine impact on unmet needs and health disparities.[33] As of FY2024, 20 states reported using Z-codes in their Medicaid programs.[34] Combined with mandated performance improvement projects (PIPs), this data helps MCOs deliver quality, outcome-driven care.

Eleven of the 13 states with Medicaid-managed care that were reviewed for this project have implemented a value-based payment arrangement that incentivizes MCOs to account for HRSNs or encourages them to engage with communities to address health disparities. GWU's review found that in Massachusetts, for example, specific language in MCO and Accountable Care Organization contracts encourages the use of Z-codes. Through the state's similar Quality and Equity Incentive Programs (QEIP) for MCOs and ACOs, MCOs and ACOs are financially rewarded by the state with Quality Incentive payments based on the completeness of their HRSN data, screening rates and improvements in access and quality metrics tied to social drivers of health and health disparities.[35, 36]

To meet the goals of the Quality and Equity Incentive Program, one ACO, Berkshire Fallon Health Collaborative (BFHC), began screening for HRSNs in all affiliated primary care practices

in 2023 and expanded HRSN screenings to inpatient settings in 2024.[37] BFHC also placed community health workers in practices to support HRSN screening and follow-up.

Nebraska is another state with a value-based payment arrangement requirement that is incentivizing MCOs to address HRSNs and health disparities. Nebraska's managed care model contract requires MCOs to submit their plans to the state for implementing value-based purchasing agreements with contracted providers. These plans include strategies for "localizing care management, addressing SDOH gaps and addressing health equity" for their members.[38]

UnitedHealthcare (UHC) in Nebraska offers an example of an MCO using these state-required value-based purchasing agreements to address HRSNs and health disparities. Through pilot programs, UHC is contracting with the largest children's hospital in the state, a rural provider, and tribal health provider, and is testing value-based incentives for these providers to improve care on a Healthcare Effectiveness Data and Information Set measure (HEDIS), the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents quality measure. The pilots have seen contracted providers utilize innovative efforts to navigate some of the HRSN challenges that impact HEDIS measures in this area, such as a lack of transportation. Innovations include educating the entire family on healthy living as well as the development of an individualized interactive weight loss application in conjunction with community health workers to gain support among populations of color in North Omaha.[39]

Conclusion

State-led Medicaid initiatives and requirements for managed-care organizations to address health-related social needs are increasingly complex and varied.

Despite the political uncertainty at the federal level—including the withdrawal of federal Medicaid guidance that impacts the ability of states to use waivers and other funds to address HRSNs—most states in GWU's analysis, including those with and without Medicaid managed care, appear to embrace the benefits of HRSNs.[40, 41]

While, at present, no new 1115 waivers are being issued, social service organizations and MCOs should be aware of these initiatives and requirements, as well as the potential for their organizations to partner with Medicaid state agencies and advance HRSNs services and improve health outcomes. Specific strategies on how to build and structure these collaborations will be presented in an upcoming Partnership Playbook, which will be made available early 2026.

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About Lutheran Services in America

Lutheran Services in America is one of the nation's largest national networks of health and human service providers with a mission to cultivate caring communities that advance health and opportunity for all. Our work is rooted in a century-long faith tradition of service in, with, for, and to the community. Through its nationwide network of more than 300 independent faith-based health and human service providers, LSA works in 1,400 communities, Washington, DC and Puerto Rico, and reaches six million people annually: 1 in 50 people in America, in 1,400 communities, with more than 250,000 dedicated employees.

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