Approaches to covering health-related social needs services through Medicaid

Advantages and disadvantages

HPIO Health-Related Social Needs Workgroup – September 16, 2024

Feedback consolidated from all small groups

DISCUSSION 1: For each approach, what advantages did you identify? What disadvantages?

Medicaid funding approach	Advantages:	Disadvantages:

Value-added services	• Easy to implement
	  ○ Within the control of the MCOs
	  ○ Does not need CMS approval
	• Very flexible, especially compared to waivers.
	• Does not require state funding
	• Once one MCO adopts it, usually others follow.
	• Simplest and fastest short term but varies greatly across MCOs
		• Hard to advocate for within the MCO
		  ○ Funding comes from the MCO's administrative costs
		  ○ The decision to offer value-added services usually comes from the national MCO leadership, with for-profit venders driving decisions.
		  ○ State public policy change sounds easier to Adrienne (United Healthcare).
		• Causes churn between plans
		  ○ Cash benefits are the only things that plan enrollees actually go for.
		• Little political will to make robust
		• Difficult for consumer to navigate
		  ○ Low usage. Not a lot of communication with members on how to take advantage of offerings.
		  ○ Communication about the benefits is difficult; influenced by the brokers
		• May overwhelm the navigation network (211, AAA)
		• Services are offered plan by plan, not statewide
		  ○ This doesn't work well for CBOs who have different eligibility criteria not based on insurance plan. (Amy H: We were approached by some plans to do this with a food medicine program. We can't do that as a CBO because

		we're going to serve everyone equally. For us, as a foodbank, we cannot make this different for one person than another.) • Who determines which services add value? • There are no minimum standards for value-added services

Community reinvestment	• Provides grants to communities/community-based organizations, which can be a sliver of hope.
	  o Funding impacts at the community-level, not just Medicaid beneficiaries
	  o Because these are community grants and not service reimbursements, MCOs can fund things that cannot be covered by other Medicaid approaches.
	  o Not as stringent as other forms of state funding
	• Politically appealing because it's seen as the MCOs "giving back"
	• Easy implementation for the state
	• There is already a framework in place with a wide range of services
	• Collective implementation by the MCOs (needs to be strategic)
	  o Can still be shaped. Brand new. Opportunity to do some advocacy
	• Purpose and amount are very suitable for supporting infrastructure and pilot or capacity building that could lead to statewide policy change
	  o Making investments into data and legal infrastructure
	  o Useful for building resources to deliver services, not services themselves (all applicants are resource depleted)
	  o Also works for pilots and small projects. Can be used to fill gaps.
	  o Use community reinvestment to build the evidence to then apply for an 1115 waiver or other funding.
		• Not a sustainable funding source
		  o $7 million is not going to go very far for actually meeting the needs of communities
		  o It's a grant, so if the priorities shift, community-based organizations are out of luck
		  o The profit of health plans varies from year to year, so CBOs can't bank on these dollars. They're essentially one-time funds and not ongoing.
		  o There is currently no time limit on the funding, so it's not clear when another opportunity will come and how long the community reinvestment grant needs to last (one year? Three?).
		• Cannot be used to reimburse for services.
		• Deciding who will receive the funding is a very long process
		• New lever in Ohio and ODM is still defining what their guardrails are (not yet strategic)
		  o ODM can just bring in new guidance and the MCOs have to follow that.
		  o Not clear how dollars are decided
		  o Funding focus has been on two Ohio counties; can be more widely dispersed
		  o Not statewide right now, so not sure how it would be rolled out. Could lead to uneven distribution across the state leading to big disparities.
		• Bigger organizations are more skilled with proposal writing, which makes it more likely for them to win the

	• Easiest option to pursue short term	grant for community reinvestment, hence creating further disparities and imbalances across the state.

In lieu of services and settings (ILOS)	• Has happened in other states
	  o Medically tailored meals have improved outcomes and are good for the community
	  o Using Medicaid dollars to help with this could lower healthcare expenses
	  o Lessons learned from MyCare, doula benefits, and BH housing
	  ▪ Vast majority of doula providers are not under a provider agreement right now
	  o Leveraging potential from CMS/other states doing it now
	• Encourages collaboration between CBOs and hospitals allowing CBOs to do more holistic case management
	• Flexible
	  o Can be done at the state level or individual plans can do it with individual providers/specific services
	• May be most feasible
	  o Does not require a waiver
	  o No legislative involvement
	  o Funded by the medical portion of the capitation rate, so there is political will from the MCOs to implement
	• Can be used to support service provision in the short term
		• Requires approval from CMS
		• Would not be consistent across the plans
		• Currently ODH is resistant to waivers
		• Less long term
		  o Has to be reviewed more often
		• Can use medical dollars once
		• Rigidity would be hard for CBOs

Home- and community-based services waiver	• Often funded by the medical portion of the capitation rate
	  ○ If we can get some of these put into the medical portion, less state dollars we would have to put forward, and the better long-term sustainability
	• Flexible; Can set the services/population you're requesting
	• Ohio has had experience with this approach
	• Can expand access to current waivers
	  ○ Level of care and financial eligibility
		• Ultimately, costs more to the state
		  ○ Has to be cost neutral/cost effective
		• We do not have enough capacity to meet the needs through the waivers
		• Have to apply to CMS for a waiver
		• Restricted to the people who need that level of care
		• ODH is resistant to waivers currently

1115 waiver	• Often funded by the medical portion of the capitation rate
	• Can target certain populations
	  ○ Bridging people who are frequent users of ERs/hospitals into housing
	• Increased FFP – more federal dollars in the state; "it's the cash cow"
	• Experimental and pilot
	  ○ This is appropriate given where we are at the hospital level in proving the impact of programs
		• No political will to implement this on the department side
		  ○ Legislators get involved
		  ▪ Do not need to have it approved by the legislature but they are going to be very hands on, making it difficult
		• While pilot programs have value, a larger collective impact initiative would be better
		  ○ Partners are reluctant to build capacity for pilots because they will end
		  ○ Need to prove it works, but they are reticent to expand their services
		• ODM is the barrier
		• ODH is resistant to waivers currently

State Plan Amendment	• Funded by the medical portion of the capitation rate
	• Statewide
	• Capacity building
	• May be the most feasible approach because it can be put into the state budget
		• Can only be for services that CMS says can be covered
		  ○ Because it can only cover care coordination and not the housing or nutrition services, does not seem "worth it"
		  ○ Roundabout way to get to food and housing
		• Complicated to figure it out from the actual, tangible resources
		• In MyCare, care coordination is required

CHIP Health Services Initiative	• Often funded by the medical portion of the capitation rate • Potential, but process unclear • While consistency across administrations for group VIII and ABD has been difficult, the kids have been relatively consistent • Is it possible to help the whole family or rope the parents in as well?	• Restricted to children • Need more information on the parameters since CHIP in Ohio is very narrow.

DISCUSSION 2: Initial prioritization

1. Which approaches have the most pros?
2. Which approaches have the most cons?
3. Which approaches would you recommend Ohio pursue in the short term (1-2 years)? In the long term (3-5 years?)

Summary: Overall, most groups discussed that, in the short term, ILOS and community reinvestment should be implemented seeing as they are the most feasible options with significant advantages. In the long term, groups believe that the 1115 waiver is going to be the most effective but is not politically feasible in the current environment.