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Community Health Benefit (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 172, #11]

CURRENT LAW

The medical assistance program (MA), also known as Medicaid, pays certified health care providers for primary, preventive, acute, and long-term care services they provide to enrollees. These providers include individual practitioners as well as hospitals, nursing homes, and local governmental entities such as county human services departments and school districts. MA enrollees are entitled to receive covered, medically necessary services furnished by these providers. Eligibility for MA is based on meeting financial and/or disability status criteria.

The state receives federal matching funds for services meeting the requirements under Title XIX of the Social Security Act. The federal medical assistance percentage (FMAP), which is the matching rate for eligible expenditures, is determined under a formula based on each state's per capita personal income in relation to the national average. Currently, Wisconsin's FMAP is approximately 59% to 60%. The federal government provides 50% FMAP for a state Medicaid administrative costs.

Federal law lists MA services that states are required to fund under their MA programs, as well as services that states may choose to fund, at their option, under their MA programs. These federally-defined services are commonly referred to as state plan services, since states indicate in their state MA plans which of the optional services their MA programs will cover. Examples of mandatory state plan services include physician services, inpatient and outpatient hospital services and nursing home services. Examples of optional state plan services include dental services, and physical therapy.

In addition to funding state plan services, states may fund other services not defined in federal law. However, states that choose to fund such services must seek waivers of federal law to enable them to receive federal MA matching funds to support these services. Many of the

services Wisconsin's MA program provides under its long-term care programs are "waiver services," since the state receives federal MA matching funds to support the services by entering into negotiated waiver agreements with the federal Centers for Medicare and Medicaid Services. Examples of Wisconsin's current long-term care waiver services include services provided by assisted living facilities, vocational services, and respite care.

GOVERNOR

Provide $45,000,000 ($22,500,000 GPR and $22,500,000 FED) in 2020-21 to fund a new MA benefit, subject to federal approval, for nonmedical services that contribute to the determinants of health. Direct DHS to determine which specific nonmedical services that contribute to the determinants of health would be included as an MA benefit, and require the Department to seek any necessary plan amendment or request any waiver of federal Medicaid law to implement this benefit.

Specify that DHS is not required to provide these services as a benefit if the federal Department of Health and Human Services (DHHS) does not provide federal financial participation for these services.

DISCUSSION POINTS

1. According to the Executive Budget Book, the proposed community health benefit would consist of nonmedical services, including "housing referrals, nutritional mentoring, stress management, transportation services and other services that would positively impact an individual's economic and social condition."

2. The administration's community health benefit proposal is intended to address what are commonly known as the social determinants of health. Health care providers and health policy experts have increasingly recognized that a person's social and economic environment has a significant impact on his or her health outcomes, independent of any underlying physical or mental conditions.

3. As an example, the Massachusetts Medical Society notes that health determinants are shaped by the distribution of money, power, and resources at global, national, and local levels. Subsequently, these social circumstances create societal stratification and are responsible for health inequities among different groups of people based on social and economic class, gender, and ethnicity, which in turn contribute to negative health outcomes including obesity, heart disease, diabetes, and depression.

4. With the increasing recognition of the importance of the social determinants of health, some have advocated a more aggressive approach to using nonmedical social services as a way of improving population health and reducing costs for public healthcare programs, including Medicaid.

5. The total healthcare costs associated with any group, including those covered under medical assistance, is heavily influenced by the particularly high costs associated with a small number of individuals with serious illness or chronic conditions. According to an analysis of national

healthcare expenditure data (the Peterson-Kaiser Health System Tracker), the costliest 5% of individuals account for 50% of all health system costs. In many cases, the high costs associated with these individuals will not be influenced by social interventions, since they are associated with intensive clinical interventions for serious illness or trauma. In some cases, however, the high costs may be mitigated or avoided with "upstream" interventions that target social determinants of health.

6. As evidence of the impact of the potential impact of nonmedical interventions on health costs, a 2016 study, from the Yale School of Public Health found that "states with a higher ratio of social to health spending (calculated as the sum of social service spending and public health spending divided by the sum of Medicare and Medicaid spending), had significantly better subsequent health outcomes for the following seven measures: adult obesity; asthma; mentally unhealthy days; days with activity limitations; and mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes." Specifically, the researchers found that between 2000 and 2009, the period covered by their data, states with higher ratios of social to health spending had better health outcomes one and two years later compared to states with lower ratios.

7. Medicaid has long provided some nonmedical services to help address health-related needs. For instance, the program provides transportation services to facilitate access to medical appointments. Likewise, for some persons with serious mental illness or substance use disorder, the program covers psychosocial rehabilitation services, which includes several services that are not traditionally provided as part of clinical treatment, but that nevertheless may contribute to improved health. The proposed community health benefit would seek to expand nonmedical services to other dimensions of social and economic needs.

8. The administration points to a new initiative in North Carolina as a potential model for the proposed community health benefit. In October, 2018, the DHHS Centers for Medicare and Medicaid Services (CMS) approved North Carolina's request for a Medicaid demonstration waiver. Among other provisions, the demonstration waiver included authorization for North Carolina to select two to four regions of the state in which to operate a pilot program of enhanced case management and other services focused on housing instability, food insecurity, transportation insecurity, and interpersonal violence and toxic stress. Overall, the goal of the pilot is to improve health outcomes and lower healthcare costs.

9. North Carolina's approved pilot will operate between November 1, 2019, and October 31, 2024, and serve approximately 25,000 to 50,000 beneficiaries. The pilot regions are to be selected based on the regions having specific target populations of high-need Medicaid beneficiaries within their geographic regions.

10. Examples of services offered under North Carolina's pilot include: tenancy support and sustaining services, housing quality and safety improvement, access to legal assistance, support for a security deposit, and post-hospitalization assistance; food support services such as nutrition counseling and education, funding for nutrition provided through food banks for medical conditions, and meal delivery services; non-emergency health related transportation, such as public transit and private services (taxis, ride-sharing) for accessing the pilot services; and transportation, support resources (including assisting individuals to transition out of traumatic situations), access to legal assistance, and child-parent support.

11. The bill would provide DHS broad authority to determine which specific nonmedical services that contribute to the determinants of health would be included as an MA benefit, and require the Department to seek any necessary plan amendment or request any waiver of federal Medicaid law to implement this benefit. The administration indicates that it has not yet determined the specific social determinants to be addressed by this provision. Instead, DHS anticipates working with providers, community members, and other stakeholders to design the benefit and delivery models to effectively address the particular needs of individual communities.

12. DHS indicates that it anticipates implementing the program in multiple pilot locations but that the locations have not yet been selected. DHS further indicates that the anticipated target population would be non-disabled, non-elderly adults and families in Medicaid.

13. The bill would provide $45,000,000 ($22,500,000 GPR and $22,500,000 FED) in 2020-21 to fund the services identified by DHS. This estimate assumes that approximately 12,500 individuals would be served on a monthly basis, at an average cost of $300 per person per month. However, DHS would not be required to provide these services as a benefit if DHHS does not provide federal financial participation for these services.

14. The funding provided by the bill is based on the assumption that community health benefit services would be eligible for the MA administrative FMAP of 50%, rather than the standard FMAP applicable to Medicaid benefits. However, DHS indicates that if CMS classifies some, or all, of the benefits offered under this provision as benefits, eligible for a higher FMAP, the Department would be able to offer more service options or serve more people without increasing the GPR funding.

15. If the Committee approves the creation of the community health benefit, it could adopt the Governor's recommended funding, with the 50% administrative FMAP assumption, on the grounds that this level of GPR funding would provide sufficient resources to administer the benefit even if CMS does not approve the program activities as a covered benefit eligible for a higher FMAP [Alternative 1].

16. Alternatively, the Committee could approve funding at the same overall level, but based on the presumption that CMS would classify the activities in the Department's waiver as benefits for MA recipients. In this case, the standard FMAP of 59.55% in 2020-21 would apply to these services. Relative to the bill, GPR funding could therefore be reduced by $4,297,500 GPR and FED funding increased by $4,297,500 to reflect the higher FMAP for the same total expenditure of $45,000,000 (but totals of $18,202,500 GPR and $26,797,500 FED) [Alternative 2]. However, if the Committee chooses this option and the state does not receive the standard FMAP application to services, less total funding would be available to support community health benefits.

17. As noted above, the administration has not yet determined many elements of the proposed community health benefit, including what types of nonmedical services that would be offered, how the services would be delivered, what types of MA beneficiaries would be targeted, and what region or regions the program would operate in. Without more knowledge of the basic parameters of the proposed benefit, it is difficult to evaluate to what extent it might achieve its stated goals of addressing the social determinants of health. This, in turn, may make it difficult for the Committee to make a decision on whether to provide funding for the benefit.

18. On the one hand, the Committee could determine that the state should explore further the potential benefits for improved health outcomes and lower costs by providing certain targeted nonmedical services through the MA program. But the Committee may feel that more information is needed before agreeing to provide funding for this purpose. As such, another alternative would be to authorize DHS to seek a demonstration waiver to implement a community health benefit, but without providing additional funding for such a benefit. Under this alternative, DHS would fund the benefit within existing resources as the Department deems necessary and appropriate, or request additional funding during the following biennial budget if a waiver is approved and after developing a more detailed program for implementation [Alternative 3].

19. While the state Medicaid program does not currently have a specific community health benefit, there are a number of other state, federal, and local programs available to Wisconsin families and individuals with low income aimed at addressing certain social health determinants. For example FoodShare and the Women, Infants, and Children (WIC) program are intended to address food insecurity; local housing authorities are intended to help people obtain federal Section 8 housing assistance; and the homeless case services to homeless families by grant recipients such as homeless shelters.

Furthermore, the Department has developed policies in the existing contracts with health maintenance organizations (HMOs) that are intended to encourage the HMOs to address social determinants of health as part of an overall care management model. For instance, the HMOs must establish partnerships and maintain effective working relationships with key social service and community-based agencies to ensure the social determinants of health (for example, housing instability, low health literacy, chronic stress, traumatic life events, and other social factors) are identified and addressed.

The Committee may therefore feel that a new benefit is not necessary since state, local, and federal governments already administer and fund programs intended to target the social determinants of health, making this provision redundant. As such, the Committee may wish to delete the provision [Alternative 4].

ALTERNATIVES

1. Approve the Governor's recommendation to provide $45,000,000 in 2020-21 ($22,500,000 GPR and $22,500,000 FED, based on an assumed 50% FMAP applicable to Medicaid administrative costs) to fund a new MA benefit for nonmedical services that contribute to the determinants of health and to require the Department seek federal approval for the benefit.

ALT 1	Change to Base	Change to Bill
GPR	$22,500,000	$0
FED	22,500,000	0
Total	$45,000,000	$0

2. Modify the Governor's recommendation by reducing funding by $4,297,500 GPR and

by providing a corresponding FED increase in 2020-21, reflecting the assumption that the proposed benefit would be classified as a Medicaid benefit and, therefore, would be eligible for the state's FMAP applicable for Medicaid benefits.

ALT 2	Change to Base	Change to Bill
GPR	$18,202,500	- $4,297,500
FED	26,797,500	4,297,500
Total	$45,000,000	$0

3. Approve the Governor's recommendation to create an MA benefit for nonmedical services that contribute to the determinants of health, and to require DHS to seek a waiver to get federal approval for these activities, but delete funding provided for this benefit. Under this alternative, the Department could seek funding in a future biennial budget if federal approval is obtained.

ALT 3	Change to Base	Change to Bill
GPR	$0	- $22,500,000
FED	0	- 22,500,000
Total	$0	- $45,000,000

4. Take no action.

ALT 4	Change to Base	Change to Bill
GPR	$0	- $22,500,000
FED	0	- 22,500,000
Total	$0	- $45,000,000

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