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Community Investments in West Virginia through Medicaid Managed Care

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Medicaid managed care plans work to improve both the clinical and non-clinical factors that contribute to the health and wellbeing of Medicaid members and their communities. These plans are well situated to improve the whole health of individuals, making them an important partner in investing in under-resourced communities.

Background

Social Drivers of Health (SDOH), also referred to as Health-Related Social Needs (HRSNs), are the conditions in the environments where people are born, live, learn, work, socialize, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH contribute to 70-80 percent of a person's modifiable contributors to health and clinical outcomes (clinical care contributes 20 percent) and have a large impact on disparities and health equity.[1]

From 2017 to 2019, U.S. health systems invested over $2.5 billion in programs targeting SDOH factors.[2] These investments are leading to changes in how healthcare professionals deliver care to under-resourced communities, as they consider the array of social services available and the ways in which addressing SDOH factors may lead to improvements in health and wellbeing as well as significant cost savings.

Social Drivers of Health

Medicaid Managed Care and SDOH Initiatives

Many people enrolled in Medicaid programs may face barriers related to SDOH, and there is substantial evidence that indicates that these barriers can lead to poorer health outcomes for individuals and therefore higher healthcare costs.[3] Medicaid managed care enrollment accounts for over two-thirds of all Medicaid membership nationally, and therefore Medicaid health plans are an important partner and mechanism to address members' SDOH needs.[4]

How Health Plans Address SDOH Needs

- Screening for SDOH
- Referring to social services
- Tracking the outcome of referrals
- Partnering with community-based organizations
- Offering value-added benefits that help address SDOH
- Investing in community resources
- Employing nontraditonal healthcare workers
- Using SDOH data to inform decision making

SDOH and the Medicaid Medical Loss Ratio

There are various pathways to enhance SDOH activity and investments through Medicaid managed care contracts, including refining how state Medicaid agencies calculate a Medical Loss Ratio (MLR). Federal Medicaid statute requires that capitation payments made by states to Medicaid health plans are actuarially sound. The MLR is a component of rate setting meant to ensure that health plans directly spend Medicaid payments on care for Medicaid members.

MLR Calculation. The MLR numerator is the sum of health plan spending on incurred claims and activities that improve healthcare quality.[5] Administrative expenses (e.g., provider contracting, member services, utilization review, claims processing), and profit cannot be included in the numerator. The denominator includes premium revenue minus taxes and fees.

MLR Standards. Where required by states, health plans must meet minimum MLR standards of 85 percent or higher. As of 2020, 25 states require Medicaid health plans to reimburse them if they do not meet the 85 percent MLR requirement.[6] This means that at least 85 percent of the premium (less taxes/fees) must be spent on providing healthcare services and supports and/or improving quality of healthcare for Medicaid enrollees.

Improving quality of healthcare, as defined by federal statute, includes activities that meet the following requirements:

- Increase the likelihood of desired health outcomes.
- Directed toward individual members or toward specific subpopulations.
- Grounded in evidence-based medicine.
- Primarily fall into one of five categories:
  - Improve health outcomes,
  - Prevent hospital readmissions,
  - Improve patient safety,
  - Promote health and wellness, or
  - Enhance the use of health care data.[5]

Managed Care Contracts. West Virginia is one example of how a state Medicaid program can amend its contracts to encourage managed care plans to invest in and promote more SDOH activities and community investments.

In January 2021, West Virginia's Bureau for Medical Services (BMS) modified its Medicaid managed care contracts to allow health plans to develop strategies to address SDOH that meet the criteria to improve healthcare quality and include the spending on those strategies in the MLR numerator.

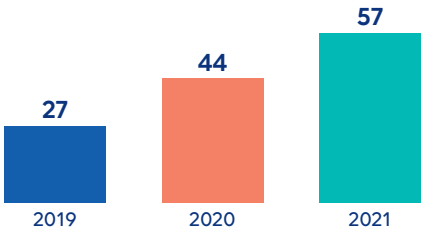
Strategies permitted under the contract language would "enhance integrated physical and behavioral health care, active local involvement, and focus on enrollees and family through proactive case management activities that support enrollees living in their homes and community, increase enrollees' self-sufficiency, and address SDOH needs."[7]

As mentioned, this contract amendment allows SDOH strategies that are broader than only serving a health plan's members, thereby promoting community-level impact.

Community Investment: Response to HIV Outbreak

During the COVID-19 pandemic and the ongoing opioid epidemic, new cases of Human Immunodeficiency Virus (HIV) and Hepatitis C infections surged throughout West Virginia, especially in the areas surrounding Charleston, located in Kanawha County. The county averaged 16 new HIV cases per year between 2014 to 2018.[8] In 2019, the number of cases began to increase with the county averaging 43 new cases per year between 2019 to 2021.[9]

Figure 1
New HIV Cases—Kanawha County, WV



The Centers for Disease Control and Prevention (CDC) and state and local public health departments in West Virginia recommended several strategies to address the outbreak, including increasing HIV and Hepatitis C testing and preexposure prophylaxis (PrEP) access and expanding mobile services to increase access to comprehensive harm reduction services.[10]

State officials discussed with multiple stakeholders, including BMS, the immediate need to address the increase in the incidence of positive HIV diagnoses. Many SDOH factors can exacerbate health disparities for individuals living with HIV/AIDS. For example, one study found that among all people using the Emergency Department, patients with HIV reported significantly higher levels of food insecurity and housing insecurity than patients without an HIV diagnosis.[11]

UniCare Health Plan of West Virginia

UniCare Health Plan of West Virginia, an Elevance Health affiliated Medicaid health plan, in partnership with BMS, worked to address the HIV outbreak in the Charleston area. UniCare leveraged the new MLR contract changes to support and collaborate with community partners—increasing access to clinical and nonclinical services for both treatment and prevention for these individuals.

One initiative that UniCare supported in 2021, facilitated by the MLR contract changes, was West Virginia Health Right—a free and charitable clinic offering HIV services in Charleston. Through a $1 million investment from UniCare, they launched a new mobile medical unit and a CommUNITY Wellness Center at their West Side Clinic.

Mobile Medical Unit. The mobile medical unit launched in July 2021 and provides individuals at-risk for HIV and/or Hepatitis C with access to health screenings such as HIV and Hepatitis C testing, PrEP medication, recovery assistance, community-based services, and more.

Since July 2021, shortly after UniCare's investment, through September 2022, the mobile unit has tested 1,244 individuals for HIV and Hepatitis C. Eight individuals identified through testing as newly HIV-positive began medication the same day as diagnosis and were transported to the Charleston Area Medical Center (CAMC) Ryan White Program. Thirty patients were re-established with CAMC's Ryan White Program.

Mobile Medical Unit
Additional Impact and Services Provided

139
people were provided Narcan and training on how to use Narcan

46
people were screened for sexually transmitted infections

652
people were referred to the West Side Clinic for follow-up care

CommUNITY Wellness Center. The wellness center opened in March 2022 and features behavioral health offices, health education and training space, childcare, a teaching kitchen, and an on-site gym.

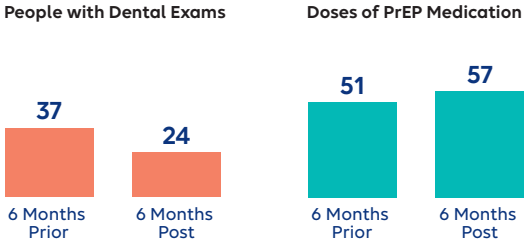
The wellness center has served over 900 people from March 2022 through September 2022. With the wellness center engaging new people to visit the Clinic, it has likely contributed to the increased utilization of services that the Clinic offers. For example, after the wellness center opened, the number of primary care encounters almost doubled from previous months—demonstrating the extended reach and additional services stemming from the UniCare investment. Figures 2 and 3 highlight the services in use at the Clinic six months before and after the opening of the wellness center.

Figure 2

Primary and Behavioral Health Care: Six Months Before and After the Wellness Center Opening

Figure 3

Other Clinic Utilization: Six Months Before and After the Wellness Center Opening



Policy Recommendations

There are several options for state and federal policymakers to consider that would leverage MLR requirements for increased investment in SDOH-related activities. These include:

State Contracts. State Medicaid programs can make changes to their managed care contract language, like West Virginia did, to encourage community investment in SDOH.

State MLR Reimbursement. States electing to apply a minimum MLR of 85 percent could allow health plans to reinvest any required MLR reimbursement into the community instead of paying it back to the state.

Federal MLR Regulations. The Centers for Medicare & Medicaid Services (CMS) can make an explicit change to Medicaid MLR regulations to allow inclusion of expenses for SDOH-related activities in the numerator of the MLR calculation.[5] Previous guidance from CMS has been unclear on the inclusion of SDOH-related expenses in the MLR numerator.

Conclusion

UniCare, in collaboration with state officials and agencies, focused recent community investments on addressing increases in HIV and Hepatitis C diagnoses in the Charleston area. At the same time, the MLR contract changes allowed UniCare to maximize this investment to respond to individual and community needs.

Other Medicaid programs can replicate West Virginia's example by using data, partnerships, and evidence-based strategies to identify and address the needs of under-resourced communities. Explicitly allowing costs related to SDOH-related initiatives in the MLR numerator would help eliminate a significant barrier for managed care plans to invest in whole health, improve health outcomes, and reduce the long-term costs of medical care for both members and their communities.

Endnotes

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