

A Brighter Future for Ohio's Medicaid Managed Care Program

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OPLC
Ohio Poverty Law Center

Executive Summary

The Ohio Department of Medicaid's new managed care contract, if fully implemented and funded, has the potential to significantly improve access to necessary health care services for low-income Ohioans.

The Medicaid program is critical for ensuring that more than three million Ohioans can access health services that are necessary for their full participation in society. The majority of these individuals' health care services are authorized and paid for by private managed care organizations.

This report highlights many of the current contract's systemic failures that legal aid attorneys have sought to address for years, recommendations about how to fix them, and how the new contract takes positive steps to address those concerns.

As a result of these systemic issues, it can be difficult for Medicaid recipients with complex needs to navigate the Medicaid program without the assistance of an attorney who specializes in Medicaid law and a health care provider who is dedicated to ensuring they receive care. Ohio's Medicaid program needed to be fixed, and the proposed changes are necessary to improve access to care and health outcomes.

The report focuses on four issues:

- Grievances and appeals processes—The formal system that plans must implement to respond to and adjudicate complaints from members, particularly when coverage for a service is rejected.
- Services for children—Screening, outreach, and specialized services that children are eligible for that extend beyond what would be offered to an adult.
- Care coordination—A managed care plan's obligation to actively work with their members to help them navigate the health care system and access services they need.
- Social determinants of health and legal services—Non-medical causes of poor health outcomes, such as homelessness and air quality, that must be addressed to improve health outcomes. Medical-legal partnerships are a proven strategy for addressing social determinants of health.

Collectively, proposed changes in these areas should make it significantly easier for low-income Ohioans to access health services without protracted appeals processes.

First, the plans' grievance and appeals systems will be overhauled to make it easier to access and fairer for individuals to navigate. Plans will also have to report collect data on their appeals systems and fix systemic problems that appear.

Second, plans will have to make substantial investments in improving services for children, from routine vaccinations to complex medical care. A key part of these changes will be a requirement to adhere more closely to the expanded standard for what care must be covered for children.

Third, plans will be required to do a better job of proactively reaching out to their members and creating individualized plans for their care. They must also work proactively with community-based organizations that already have relationships with their members.

Lastly, the contract requires plans to make real investments—five percent of their profits—in interventions that address the social determinants of health. Medical-legal partnerships are a proven team-based approach between doctors and lawyers to address the root causes of adverse health outcomes where a lawyer's intervention is critical.

A Brighter Future for Ohio's Medicaid Managed Care Program

Introduction

The Ohio Department of Medicaid's new model managed care contract has the potential to make strides toward addressing many of the systemic concerns identified by legal aid attorneys about Ohio's managed care program since the last procurement eight years ago. The Medicaid program is critical for ensuring that more than three million Ohioans can access health services that are necessary for their full participation in society. The majority of these individuals' health care services are authorized and paid for by private managed care organizations.

If fully implemented and enforced, the new managed care plan contracts ought to result in a Medicaid program that is substantially fairer and easier for low-income Ohioans to navigate, particularly for vulnerable children and those in need of specialized services.

Throughout the state, legal aid offices provide civil legal representation to low-income Ohioans. Each legal aid has a health and public benefits practice group that specializes in assisting low-income Ohioans in obtaining income supports and health services for which they are eligible.

When vulnerable Ohioans need access to health care, the process can be complicated well before they enter a doctor's office. First, they must submit an application for Medicaid to the County Department of Job and Family Services. The application and re-application processes for Medicaid can be surprisingly complex and require the applicant to produce multiple documents verifying their eligibility. If a county agency makes a mistake when processing an application, there is a formal "state hearing" process for applicants to appeal the denial.

Once an application is approved and an individual is assigned to a managed care plan (MCP), there is no guarantee that they will receive the health services they need. Medicaid pays for "medically necessary" services, some of which need to be pre-approved by the MCP. And in some areas of the state, particularly rural areas, it can be extremely difficult to find a provider that accepts Medicaid.

All these issues form the basis for complex legal disputes that can take years to resolve—making access to legal services critical and the perspective of legal services attorneys important when reforming the Medicaid system to make it easier to navigate. Legal aid attorneys who practice in this area participate in a statewide taskforce that meets on an ongoing basis to discuss systemic issues with public benefits programs, with Medicaid taking up a significant portion of their work given its complexity.

In July 2019, the taskforce drafted multiple recommendations in response to the Ohio Department of Medicaid's (ODM) first Request for Information (RFI) regarding how it could improve its managed care program. The taskforce recommendations focused on four main issues of concern:

1. failures in the plans' grievance and appeals systems
2. inadequate services for children
3. lack of meaningful care coordination; and
4. the need to promote medical-legal partnerships in order to achieve better outcomes.

This report provides a brief overview of each issue and shows how the proposed new contracts ought to improve access to services for Medicaid recipients.

ISSUE: Grievances and Appeals

A hallmark of public benefits law is that individuals who are eligible for assistance have a constitutionally protected right to that assistance that cannot be denied arbitrarily. Over the past half-century, a robust body of federal law developed that created a formal appeals process for settling disputes between Medicaid recipients and the state over whether services will be provided and paid for. What emerged is known as the "state hearing process," which is a semi-formal process administered by ODM. It includes many of the same due process protections as a typical trial, such as notice requirements and the right to examine and respond to evidence and to appeal adverse decisions.

Managed care adds a further level of complexity to the appeals process. Typically, individuals must go through a MCP's internal appeals process if they are denied services before they can turn to the state hearing process.¹ While the statute governing these plan-level hearings gives individuals many of the same rights as the state hearing, in practice the plans' processes are extremely hard to navigate or seemingly non-existent.

These dysfunctional or nonexistent processes stand in stark contrast to the state hearing process, in which the Bureau of State Hearings sends a self-mailer with the notice of action, which allows the individual to easily let the state know that they want to appeal. There are also multiple ways to request a hearing, including by telephone, email, or through an online portal.

¹ O.A.C 5160-26-08.4

Furthermore, individuals in state hearings are more easily able to access medical records and reasoning that was used in making a determination to deny services or coverage, and hearings are in front of a Medicaid representative who has the authority to make a different determination.

In plan level appeals, legal aid attorneys repeatedly find that individuals are unable to adequately access the grievance and appeal system because it is confusing and overly cumbersome. It is challenging to access information, including medical records, or to talk to anyone about a request for medical care/prior authorization. For example, one plan's notice referred enrollees to a general customer service that was a labyrinth phone tree with long wait times. The notice also said appeals can be submitted by a "tell us" link. The link redirected the user to an "about us" page, which did not actually have a "tell us" link and included only a general P.O. Box and indirect phone information.

Taskforce Recommendation: Each MCP should be required to create a comprehensive grievance and appeals process that mirrors the state's administrative appeals process for other public assistance programs. Each MCP should be required to routinely report on its appeals outcomes to identify systemic issues.

HOW THE NEW CONTRACT HELPS

The proposed contract states that MCPs must:

- appoint a grievance and appeals director,
- develop and implement written policies and procedures that ensure the MCP's compliance with the state hearing provisions,

REAL IMPACT

"Jessica" is a seventeen-year-old girl who needs constant medical assistance throughout the day due to her autism, developmental delays, Tourette syndrome, and urinary incontinence. She received consistent home nursing support for years until her plan arbitrarily cut her hours in half. The plan's reason for reducing home care hours was that she had not been hospitalized or gone to the emergency room, despite the fact that her doctor's medical opinion was that reducing her hours would put her safety at risk. Her legal aid attorney spent almost a year unsuccessfully trying to work within the plan's appeals system to overturn the decision, which only resulted in the plan approving a temporary 10-day renewal of her services. When her attorney tried to appeal that decision, the plan absurdly argued that she had never 'officially' asked for an appeal in the first place. Her attorney eventually prevailed at a state hearing.

- include the participation of individuals authorized by the MCP to require corrective action in the MCP's grievance and appeal processes,
- use the Ohio Department of Medicaid standardized appeal form to document member appeals,
- keep records of grievances, appeals, and state hearings documenting MCP performance of all state and federal requirements (e.g., timely acknowledgment, continuation of benefits when applicable), and
- conduct root cause analysis of authorization denials and appeals and develop a targeted plan to decrease inappropriate denials and ensure ease of appeal of medical necessity denials.

While it is unknown how these contract provisions will be implemented and how strongly they will be enforced, the model language contained in the proposed contract clearly addresses some of the major concerns of the legal aid community. The language signals that MCPs will be required to implement more formalized appeals processes, approved by ODM, that comply with the rules that govern state hearings. They will be required to report monthly on their compliance with those rules and use that data to address systemic problems. Furthermore, the contract ensures that appeal hearings will be meaningful by requiring someone with decision-making authority to participate on behalf of the MCP.

If implemented faithfully, these provisions will substantially improve low-income Ohioans' ability to access the services they are entitled to without facing bureaucratic processes that are difficult to navigate without the help of legal services.

ISSUE: Services for Children

The primary Medicaid program for children is the Early Screening, Diagnostic, and Treatment (EPSDT) benefit. It is designed to provide comprehensive and preventive health care services for children under age 21. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.² MCPs are not just required to cover the expansive list of services included in the EPSDT benefit, but they have an affirmative duty to inform families of their eligibility and arrange for the provision of screening services and corrective treatments. These requirements are particularly important

² Medicaid.gov, Early and Periodic Screening, Diagnostic, and Treatment, <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html> (last visited 1/12/2021).

for issues like screening for lead poisoning³ or providing immunizations at age-appropriate intervals, which Ohio has historically failed to do. The legal aid community has advocated for years that MCPs do a better job of providing these services to children.

The EPSDT benefit is designed to be flexible and cover a wider range of services than is available to the adult population. The definition of what services are “medically necessary” for the purposes of the EPSDT benefit is different than the definition of medically necessary for the adult population. However, MCPs do not always distinguish between the two definitions which results in protracted disputes between recipients and the MCPs over whether a particular service should be covered.

Taskforce Recommendation: MCPs should be held accountable for applying the EPSDT medical necessity standard. The contract should set forth the specific responsibilities of plans, contracting providers, and the state agency, for conducting outreach and informing enrollees and their families about EPSDT services.

HOW THE NEW CONTRACT HELPS

The proposed contract makes several major changes that, if fully implemented, ought to significantly enhance access to services for children.



REAL IMPACT

Since July 2017, the Legal Aid Society of Columbus alone has had approximately 200 cases regarding EPSDT-related home and community-based care issues. The following is an example of a typical case where a high-needs child is arbitrarily denied the amount of care they need multiple times despite being overturned in a state hearing:

“Andy” is a 7-year-old with cerebral palsy and epilepsy who needed substantial home health care support to help him with activities of daily living. However, the plan arbitrarily denied 10 of the hours that were needed per week. The Legal Aid Society of Columbus was able to successfully appeal the reduction in hours and the young boy was able to receive the supports he needed for 60-days. However, the plan continued to deny the child the full number of hours he needed every 60 days and his attorney had to appeal the decision multiple times, despite there being no change in his circumstances.

³ Chloe Jen, The Center for Community Solutions, *Improving Lead Screening in Ohio: Lifelong Significance for Children* (June 1, 2020), <https://www.communitysolutions.com/research/improving-lead-screening-ohio-lifelong-significance-children/>

First, ODM intends to create a specialized managed care program for youth with complex behavioral health and multi-system needs. This program is intended to specialize in serving children with some of the most complicated and expensive health needs, which has created situations where parents must relinquish custody of their children to the state for them to receive in-patient services. This program will hopefully be better at providing services to children with the most complicated issues and creating capacity to serve children with less complicated but still severe needs.

Regarding EPSDT, the contract makes several changes that should ensure more robust access to services for children.

- The plan must hire an EPSDT/Maternal Child Health Manager. The primary functions of the EPSDT/Maternal Child Health Manager are to ensure children receive all EPSDT services, identify and coordinate assistance, interface with community partners and pregnancy-related services coordinators, and participate in EPSDT and maternal child quality and performance improvement efforts.
- The plan must require the use of ODM-developed, standardized developmental screening tools, track EPSDT screenings to ensure screenings are completed for members, and ensure that members with identified needs through the screening are linked to medically necessary services.
- The MCP must develop and implement written policies and procedures describing the MCP's responsibility to inform members and providers about EPSDT and to provide the full range of EPSDT services, including services that are not otherwise included in the basic benefit package.
- In order to improve access to and delivery of services, the MCP must support and encourage providers to deliver services in a school-based setting.
- The contract defines medical necessity for EPSDT to include all mandatory and optional medically necessary services (including treatment) . . . in excess of state Medicaid plan limits applicable to adults.

This is a snapshot of many changes made throughout the contract that put a heavy focus on improving children's access to health care. The most telling change is the fact that each MCP will be required to have a senior-level administrator that is responsible for ensuring that the MCP succeeds in administering the EPSDT benefit. This change, combined with explicit obligations for planning for outreach to eligible children, and a much stronger medical necessity definition should lead to substantial improvements in outcomes for children across the program.

ISSUE: Care Coordination

The health care delivery and insurance systems are complex to navigate as are the multiple social service systems that affect health outcomes. This is especially true for low-income Ohioans with busy lives. Even when Medicaid covers particular services, oftentimes individuals are unable to take advantage of those services because of administrative or logistical barriers, such as transportation or prior approval requirements. Effective care coordination can help reduce barriers to receiving care. The provisions in the MCP contract related to care management services are especially important.

MCPs are required to provide care coordination/care management services to their members. In theory, care coordination is “a strategy to deliberately organize and support an individual with addressing needs to achieve better health outcomes.” Despite the requirement that MCPs provide quality care management, the legal aid community has had significant challenges in meaningfully connecting clients with their MCP’s care coordination/care management teams. Oftentimes, legal aid attorneys find themselves informally serving the role of care coordinator for their clients—helping them find providers and overcoming the various logistical barriers to accessing care.

In many instances, care coordination functionally does not exist. Many individuals with complex health conditions never hear from their plan as they struggle to obtain services. ODM’s 2018 External Quality Review Technical Report confirms that the legal aid community’s experiences are reflective of systemic issues with case management. The report found that every MCP, except for one, performed poorly on member satisfaction surveys with regard to care coordination for adults.⁴

Low-income individuals typically have hectic lives that make it difficult for them to maintain contact even with social service providers, such as legal aid attorneys or social workers, with whom they have a pre-existing, trusting relationship. These problems are even more difficult to overcome when the care manager is housed within an MCP, has no personal relationship with the client, and is not employed by a trusted community-based organization with whom the client has a relationship.

⁴ Ohio Department of Medicaid, State Fiscal Year 2018 External Quality Review Technical Report at 6-11 (April 2019), <https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/External-Quality-Review-Technical-Report-2018.pdf>.

REAL IMPACT

Adison is a 16-year-old boy who was born with a rare muscular disorder that severely impairs nearly all his motor functions and requires him to use a specialized wheelchair. Adison refuses to let these challenges limit his ability to stay active with his friends and family. He loves to read, play videogames, power soccer, and spend time outside with his friends and family. He is a quick learner and has an even quicker sense of humor.

As Adison grew during his teenage years, he needed a new powered wheelchair. With almost no mobility, he needed a custom powerchair that he could control with his head and chin that also had the ability to adjust his position, with capabilities to feed himself, and allow him to control other basic daily functions and engage in activities. Without such a wheelchair, he would have been bed-ridden in pain, unable to move, and at risk of developing numerous other complications.

Adison's physical therapist, Christina, is an expert on medical equipment for children with conditions like Adison's. In the fall of 2019, Adison's managed care plan denied a request to cover his specialized wheelchair. Without having met Adison, the plan representative denied the request because they disagreed that it was medically necessary. Christina appealed the decision and provided extensive medical documentation about Adison's condition and was denied again. After the second denial, Christina and Adison's parents requested a state hearing with the Department of Medicaid with help from Advocates for Basic Legal Equality (ABLE), a legal aid organization that serves northwest Ohio.



At no point during this process did the managed care plan ever ask to meet with Adison, his doctors, or his family to learn more about his condition. In fact, Christina could not recall a time in which she was contacted by a Medicaid care coordinator about any of her patients' unique needs. Desperate, Christina loaned her private practice's spare chair for Adison to use. Without it, he would have spent the year trapped in bed and unable to move or in constant pain in a medically inappropriate chair.

After a year of fighting with the help of a dedicated physical therapist and multiple legal services attorneys, the Department of Medicaid overruled the managed care plan and Adison received his wheelchair just before Christmas. He chose the colors red and green to celebrate.

Without assistance from a crusading physical therapist or legal aid attorneys, it is likely that Adison never would have gotten the services he needed. The new contract, if implemented fully, will put increased demands on MCPs to proactively reach out to families like the Adison's and proactively plan to meet their needs. When mistakes are made, the reformed grievance and appeals process should make it easier for families to reverse inappropriate denials without a year of intensive advocacy.

Taskforce Recommendation: ODM should overhaul the care coordination benefit and its enforcement to ensure members receive meaningful, individualized, care planning and assistance accessing services from their plan. ODM should consider delegating care management services to other community-based organizations for other populations who face significant barriers to engaging with the MCPs care management teams.

HOW THE NEW CONTRACT HELPS

There are a lot of questions about how managed care plans will address the new obligations to implement a “high performing care coordination program.” MCPs must submit their plan for care coordination to ODM for approval. However, the proposed contract makes a clear commitment to overhauling existing care coordination services to be more responsive to the needs of members. The specific requirements for the program span twenty pages.

Taken as a whole, the requirements show a clear commitment to providing higher quality care coordination services by requiring MCPs to provide varying levels of support for members based on their individual needs; create person-centered care plans; encouraging MCPs to respect and coordinate with community-based organizations that have pre-existing relationships with members; and integrate care coordination services into the MCP’s larger commitment to addressing population health issues throughout their member base.

The following are the Department’s “Guiding Principles” for the new care coordination program:

- Care coordination identifies and addresses physical, behavioral, and psychosocial needs of members.
- Care coordination supports member goals and choices through a person-centered, trauma-informed, and culturally attuned approach.
- Care coordination provides care continuity while honoring member experience and choice.
- The MCP preserves existing care relationships between members and local [Care Coordination Entities (CCEs)].
- The MCP leverages the strengths of CCEs, the OhioRISE Plan, and CMEs by supporting and developing partnerships with CCEs, the OhioRISE Plan, and CMEs.
- The MCP establishes clear communication and delineation of roles and responsibilities of various entities throughout the care coordination process to minimize the duplication of services and streamline service delivery.
- The MCP implements systems capable of efficiently receiving, providing, and exchanging the data and information necessary to effectively coordinate the care of members who are served by multiple entities.

Like the requirements for EPSDT, the model contract works to ensure that these principles are adhered to by requiring each MCP to hire a senior-level Care Coordination Director whose responsibility it is to “Oversee the day-to-day operational activities of the Care Coordination Program in accordance with state guidelines. The Care Coordination Director is responsible for ensuring the functioning of care coordination activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating).”

The contract’s “General Requirements” for care coordination include:

- The MCP must develop and implement a high performing care coordination program that meets the care coordination requirements...and reflects the guiding principles to optimize the health of the individual members and populations it serves.
- Care coordination, for purposes of the requirements in this Agreement, is used in the broadest sense to encompass the full spectrum of care coordination activities, ranging from short-term assistance to meet care gaps to longer-term, intensive, and holistic care management for members with the most intense needs.
- The MCP's care coordination program must serve as the foundation to ensure that all members have access to quality care coordination, whether the member is receiving care coordination from a care coordination entity (CCE), the OhioRISE Plan, an OhioRISE Plan contracted care management entity (CME), the MCP, or a combination thereof.
- The MCP may delegate any requirement specified in this appendix to a CCE in accordance with the requirements in the subcontractual relationships and delegation section in Appendix A, General Requirements. If the MCP does not enter into a delegated arrangement with the CCE, while the MCP is not required to monitor and oversee the CCE, the MCP is expected to maintain a collaborative relationship and coordinate care with the CCE to meet members' needs. The collaborative and coordinated relationships between the MCP and CCEs do not invoke the delegation requirements in Appendix A, General Requirements.
- The MCP's care coordination program must safeguard confidential information in accordance with the privacy compliance requirements specified in Appendix A, General Requirements

While much is still unknown as to how MCPs will implement these requirements and to what extent they will be enforced by ODM, they represent a clear intent to improve upon the current system by putting the needs of the member first and by leveraging their pre-existing relationships with community-based organizations.

ISSUE: Social Determinants of Health and Legal Services

Since the last procurement process in 2012, there has been a growing recognition that to improve health outcomes and lower costs, Medicaid must address social determinants of health.⁵ Social determinants of health (SDOH) are defined as the “[c]onditions in the places where people live, learn, work, and play” that affect a wide range of health risks and outcomes.⁶ For example, The Health Policy Institute of Ohio (HPIO) has written at least 14 publications since the last procurement process in Ohio that focus on the social determinants of health.⁷ HPIO’s featured publication on the topic, “A New Approach to Reduce Infant Mortality and Achieve Equity,” concludes that the state must do more to address social factors that increase the risk of infants dying, particularly housing instability, employment, and transportation.⁸

Health policy experts have analyzed how states can incentivize contracted plans to make greater investments in non-clinical interventions that address SDOH.⁹

Taskforce Recommendation: ODM should create incentives for MCPs to invest in non-medical interventions to address social determinants of health and create incentives for MCPs to invest in medical-legal partnerships.

The Center for Health Care Strategies December 2018 report, “Addressing Social Determinants of Health via Medicaid Managed Care Contracts and 1115 Demonstrations,” which surveyed states that created requirements in managed care contracts to provide for or encourage activities related to social determinants of health showed that Ohio was an outlier. Ohio’s contract included few requirements related to SDOH. By contrast, 24 states included contractual incentives for MCPs to invest in SDOH-related additional services, and 23 states incentivize MCPs to partner with community-based organizations and social service agencies.

⁵ Karen DeSalvo & Michael O. Leavitt, Health Affairs Blog, *For an Option to Address Social Determinants of Health, Look to Medicaid* (July 8, 2019), <https://www.healthaffairs.org/do/10.1377/hblog20190701.764626/full/>

⁶ World Health Organization, *About Social Determinants of Health*, https://www.who.int/social_determinants/sdh_definition/en/

⁷ Health Policy Institute of Ohio, *Social Determinants of Health*, <https://www.healthpolicyohio.org/social-determinants-of-health/>

⁸ Amy Bush Stevens MSW, MPH, et al., Health Policy Institute of Ohio, *A New Approach to Reduce Infant Mortality and Achieve Equity: Policy Recommendations to Improve Housing, Transportation, Education, and Employment* (December 1, 2017), https://www.healthpolicyohio.org/wp-content/uploads/2018/01/SDOIM_FinalCombined_posted-1.pdf

⁹ Manatt Health, *Medicaid Coverage of Social Interventions: A Road Map for States* (July 2018); National Health Law Program, *Addressing the Social Determinants of Health Through Medicaid Managed Care* (November 2017); Center for Health Care Strategies, *Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations* (December 2018); Institute for Medicaid Innovation, *Innovation and Opportunities to Address Social Determinants of Health in Medicaid Managed Care* (January 2019)

ODM needs to better incentivize MCPs to invest directly in addressing social determinants of health. One strategy for achieving that goal is to invest in Ohio's network of medical-legal partnerships (MLPs).

Over the last decade, legal services organizations have taken on a critical role in health care through collaborations with medical providers. In MLPs, medical facilities and legal services providers partner to address legal issues that negatively impact patient health. Legal advocates train medical personnel to identify health-related SDOH that have a legal remedy. Medical personnel learn new interviewing techniques to ask patients about housing, personal and neighborhood safety, food security, and more. Patients are then assisted by legal advocates to address the underlying conditions that are affecting health.

The medical community has recognized and supports the increased role legal aid can play in improving health outcomes. Both the American Medical Association and the American Academy of Pediatrics encourage medical professionals to seek out and establish relationships with the legal community to better serve patients.

Each legal aid organization in Ohio has helped to create and supports at least one MLP. Each of these partnerships focuses on improving health outcomes for specific vulnerable populations, such as children, pregnant women, formerly incarcerated individuals, seniors, and those in addiction or behavioral health treatment. Partners include the state's premier children's hospitals, Federally Qualified Health



REAL IMPACT

Medical-Legal Partnership (MLP) Success: Cincinnati Children's Hospital Medical Center (CCHMC) and the Legal Aid Society of Greater Cincinnati have operated a medical-legal partnership together for many years. The MLP trains doctors, residents, and other staff on how to identify environmental factors in a patient's life that may be the basis for legal intervention. For example, in the summer of 2010, three CCHMC doctors referred multiple asthma patients to their legal partners. These patients had been told by their landlord that they would be evicted if they used air conditioning units. Air conditioning is an important treatment for people with asthma. The attorneys discovered that each family lived in a building owned by the same landlord and that there were multiple other issues, such as pests or mold. The landlord owned 19 similar buildings with 700 units throughout the city. The MLP successfully advocated for multiple improvements to the buildings and eventually they were sold to a local nonprofit that received a large grant to continue improving the buildings.

Centers, large public health systems, and more. Some partnerships were created recently, to address current issues like Ohio's opioid crisis, while others have been active for well over a decade.

Through our MLPs, legal aid attorneys prevent evictions and improve housing conditions, help victims of domestic and sexual violence and their children get safe, ensure families get Supplemental Nutrition Assistance Program, Medicaid, Ohio Works First, and other essential benefits, advocate against unjust suspensions and expulsions that would remove children from school, seal criminal records to allow for increased employment opportunities, ensure kinship caregivers get custody and supportive benefits for the child victims of the opioid crisis, and ensure that workers get paid the minimum wage. These interventions, and the many more achieved by legal advocates, produce beneficial outcomes like improved well-being, reduced stress, decreased use of the emergency department, and reduced health care costs.

HOW THE NEW CONTRACT HELPS

Creating and implementing strategies to address population health and social determinants of health is at the center of the new managed care contract. MCPs applying for contracts were required to submit an 85-page description of "how the Applicant will identify and address the social determinants of health (SDOH) affecting its membership in the context of the Applicant's population health management strategy."

At the core of this strategy will be each MCP's Community Reinvestment Plan. The MCP must contribute three percent of its annual profits to community reinvestment. The MCP must increase the percentage of the MCP's contributions by one percent each subsequent year, for a maximum of five percent of the MCP's annual profits. The MCP must submit its Community Reinvestment Plan each year to ODM for approval.

The plans must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities. The services may not be already covered by Medicaid and MCPs are encouraged to work collaboratively with other MCPs in the region to maximize the collective impact of community reinvestment funding.

Five percent of a MCP's annual profits would translate into millions of dollars of needed investment every year into interventions like housing, food, and other supports that directly impact social determinants of health in low-income communities.

MCP Community Reinvestment Plans create a perfect opportunity for MCPs to support Ohio's medical-legal partnerships. The work of MLPs inherently addresses the goals of the

reinvestment plans while also assisting MCPs in meeting their larger obligations to provide enhanced care coordination, improve access to services for children with complex needs, and continually improve their processes to arrange person-centered care.

Conclusion

There are many unknowns about how the portions of the proposed contract discussed in this report, and many other changes beyond our scope, will be implemented and enforced. However, there is clearly an aspiration towards addressing many of the barriers legal aid organizations have struggled to help their clients overcome. We are particularly encouraged by the stronger grievance and appeals section of the contract and stronger requirements around how MCPs apply the concept of “medical necessity” when approving or denying services. Improved care coordination and financial support for community-based organizations and medical-legal partnerships will improve access to services and address social determinants of health. With proper resources to implement and enforce this contract, Ohio is poised to substantially improve the health of its Medicaid population.



The Ohio Poverty Law Center’s mission is to reduce poverty and increase justice by protecting and expanding the legal rights of Ohioans living, working and raising their families in poverty. We partner with Ohio’s legal aid programs who provide free civil legal services to low-income Ohioans.

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