APPENDIX TO REINVESTMENT PARTNERS' SUBMISSION

RFI NO. 30-190336

Reinvestment Partners works with people, places, and policy to create just and healthy communities. We have a 25-year history as an advocacy and community development organization. We are a vendor to health insurers and health providers, offering non-medical interventions for improved health outcomes and health care savings in the areas of food and housing.

Reinvestment Partners (RP) respectfully submits these additional comments in response to the North Carolina Department of Health and Human Services (DHHS) Request for Information No. 30-190336 Healthy Opportunities Pilots. Reinvestment Partners submitted responses to the specific questions in the RFI in the format provided and also submitted Cost Estimate Worksheets for two of our programs. However, we also have feedback on the Healthy Opportunities Pilots that does not fit within the framework of the RFI response provided. Therefore, we respectfully submit these additional comments for consideration.

RP is excited about the focus on social drivers of health and DHHS' willingness to commit resources to address non-medical drivers of health. While we appreciate this innovative opportunity to pay for non-medical services related to health outcomes for Medicaid enrollees living in selected communities, RP has additional feedback on the following topics:

- Capacity at community based organizations
- Reliance on referrals to community based organizations without sufficient resources
- Pricing framework for non-medical health intervention services

Capacity at Community Based Organizations

As a community based organization engaged at the intersection of community development and health, RP is excited to participate in the provision of non-medical services for health outcomes. RP is a relatively well-resourced, high capacity community based organization. Yet, we still struggle to find funding to build organizational capacity. We are happy to see that the Pilots will include funding to build capacity and infrastructure to support community based organizations. We agree with the DHHS philosophy that non-medical health interventions and programs should be scalable, replicable, and cost effective. However, those priorities mean that many community based organizations, particularly in rural areas, will be left out. Community based human service organizations are focused on running programs and serving people – it will take significant effort to become compliant with health laws, adjust to new billing and reimbursement requirements, and institute additional health outcomes based measurements.

If the result of the Pilots is that larger higher capacity community organizations become intermediaries or are asked to expand programming into additional counties, these organizations will also need additional resources at the administrative levels or potentially for additional office space to take on additional responsibility. We recommend that DHHS meet with community based organizations to better understand what the capacity building needs are.

Reliance on Referrals

Similarly, although the rhetoric has been to provide Medicaid dollars for services with health outcomes, the actual approved pilot services are relatively limited in scope, providing funding and reimbursement codes for case management but less so for programs and direct services. For example, in housing there are service categories for helping with housing applications, counseling, developing a housing support plan, training on education on tenant rights, but nothing in regard to paying for actual housing. While supportive services and housing counseling can be effective tools, if there is a limited supply of quality affordable housing, it will have limited impact.

Similarly, the services allowed include referrals for legal assistance in both housing and interpersonal violence domains. However, Medicaid is not proposing to actually cover any legal services, just the referral to legal services. A referral to legal services is meaningless if there are no resources to provide legal representation. The actual referral can be as simple as filling out a web request or making a phone call and would take approximately 10-15 minutes. So, the proposal is to pay for the case manager's time to make the referral.

Legal Aid budgets and staff have been shrinking due to budget cuts. Legal Aid does not have resources to handle an influx of clients referred through the health system unless the health system provides funding for that representation. It will result in higher demand with the same supply, which will result in waitlists and frustration. Given that the Pilots are designed to encourage innovation, we recommend more flexibility in the funding of services.

Pricing Framework

DHHS is soliciting feedback on a fee or pricing schedule for programs addressing social drivers of health with health outcomes. RP submitted two cost worksheets, but the DHHS framework is based on funding for traditional human service organizations and we are concerned that the model is too narrow and will exclude other funding frameworks that might be better suited to some programs or organizations. In addition, in providing a narrow framework, the cost estimate worksheets will not allow for innovation in pricing models. RP is working toward to getting our programs in the in-lieu of services bucket as part of the medical cost of services rather than the administrative cost. For some of our programs the traditional funding model does not work.

<u>Food</u>

Our flagship initiative is a fruit and vegetable prescription program that is scalable across the state and can be tailored for population needs and individual health outcomes. The participants receive $40/month that can be spent on fruits and vegetables at retail grocery partners. Eligible patients can be determined by the PHPs based on particular diet-related health conditions, but RP suggests that eligibility be focused on those recommended to receive dietary or nutritional counseling as part of their medical services. The funds are loaded monthly onto the participant's prescription payment card and are automatically drawn down every time the participant purchases eligible fruits or vegetables with the card. The program is unique in its partnership with major grocery retailers and the participant choice in which fruits and vegetables to buy.

RP has already proposed partnering with Medicaid Managed Care Organizations (MCOs) to implement the Fruit and Vegetable Prescription Program to address food insecurity and poor nutrition among

targeted Medicaid patients. We have piloted the program using USDA funding and anticipate using new technology to expand the programming and the number of participating retailers as part of the Healthy Opportunities Pilots. In the Healthy Opportunities Pilots the program will focus on Medicaid patients rather than SNAP recipients. In the Medicaid-funded Fruit and Vegetable Prescription Program, we anticipate using a third-party card vendor that works with multiple grocery retailers and provides additional coupon offers on healthy food. We have based our fee schedule based on preliminary estimates on the cost of that technology based on our discussions with that vendor.

The Fruit and Vegetable Prescription Program has a pricing structure that does not fit into the payment structure proposed by DHHS. However, the pricing structure is simple:

Per client served per month:

- $40 for eligible food (fresh, frozen, or canned fruits and vegetables without any added sugar, salt, or fat)
- $1 for technology
- $4 for indirect costs (10% for administrative, program management, overhead)

The program relies on technology and is easily scalable with an easily understood cost of $45 per participant per month of participation. Therefore, the 10% indirect costs could cover administrative and program management if it reaches enough scale.

Housing

The housing services proposed to be covered mostly fall under the category of case management. However, patients and case managers will still face the challenge in the supply of high quality affordable housing. We applaud the inclusion of home assessments to identify potential health risks within the home (H13) and the corresponding reimbursement for repairs or remediation as necessary (H16).

However, our Breathe Easy at Home asthma intervention program includes the provision of equipment and supplies to reduce in-home environmental triggers of asthma. This kit consists of non-medical equipment used to improve health outcomes. The model is designed to demonstrate the cost effectiveness of identifying and mitigating in-home asthma triggers as a non-medical intervention to improve health outcomes. The goals of the program are to reduce preventable asthma emergency department visits and hospitalizations among high-risk children. In addition, Reinvestment Partners' goal is to design a program that can be replicated across the state through partnerships between health partners and community-based groups that specialize in housing.

RP's Breathe Easy program targets pediatric asthma patients who are most frequently hospitalized for asthma treatments. The hospital or the payor identifies pediatric asthma patients they think would benefit from the program. RP provides the local Healthy Homes Housing Specialist who will conduct home visits, conduct home assessments, provide a Breathe Easy Kit and training on using the kit, and conduct a follow-up home visit.

Reinvestment Partners will provide families with a Healthy Homes Kit that provides tools and equipment to reduce environmental asthma triggers in homes.

- HEPA-filtered upright vacuum cleaner

- Hypoallergenic latex free mattress cover, box spring cover, and pillow covers for the child's room
- Asthma-friendly cleaning supplies
- Non-toxic pest control devices
- Non-toxic, safe products to kill roaches
- HEPA-filtered air purifier for child's room

RP has focused on equipment because these families are more likely to be renters and to move more frequently. The equipment can follow the family. If more extensive home repairs are identified as a critical need, the Housing Specialist refers eligible families to existing home repair programs for more extensive home repair issues when appropriate or to new repair programs focused on repairs for health. The Housing Specialist will assist the family with navigating local home repair assistance programs which can be fragmented and bureaucratic.

For patients with more intensive needs, the hospital system or health provider could provide an asthma educator, community health worker, or visiting nurse to participate in the home visit and reinforce the clinical asthma management plan, review asthma medications, and learn how to detect asthma symptoms.

The cost of the Breathe Easy kit is approximately $600. The in-home visits and follow-up services could be paid for with bundled payments that would pay for the housing specialist, an assistant to accompany the housing specialist on home visits, and administrative support. We estimate that the bundle of services provided outside of the kit would cost nearly $1,400 per family served. The total cost of the program is less than $2,000 to serve one family. However, the cost of a one-night hospitalization for asthma ranges from $3,000-10,000.

Given that DHHS has stated its commitment to replicable and scalable programs, RP developed its Breathe Easy at Home asthma program with the goal of scalability. In order to replicate the programs in other geographies, Breathe Easy would require a local or regional Housing Specialist that could visit homes, conduct assessments, and train families and caregivers. We plan to create an educational/training video that families could use to learn more about the equipment in the kit as well as other strategies for reducing in-home environmental triggers of asthma. At scale in multiple geographies, the program would require an additional program manager who would provide oversight to multiple housing specialists and oversee the statewide program.

<u>Home Repairs</u>

Medicaid has programs to provide modifications to improve accessibility of housing and safety under the Medicaid CAP/DA and CAP/C programs. RP is a Medicaid vendor and has participated in the home modification program. The process for modifications and reimbursements is established. It is also slow and bureaucratic.

As part of the process, RP works with case managers who develop the scope of work. RP visits the property and prepares a construction bid for the project based on the scope of services proposed by the case manager and the conditions of the home. RP will also consult with the caregiver and with the medical provider if needed in the preparation of the bid. RP submits the bid to the case manager who selects the bid that will best meet the needs of the patient and caregiver at the best price. Approvals can

take between 10 days and three (3) months. If selected, RP completes the modification using standard construction practices and submits for reimbursement to the case manager. Reimbursement takes between 30-45 days because the case manager must visit the site to check that the work is complete.

The costs for this program are unique to every situation since every modification varies based on the patient and caregiver needs and the existing housing situation. Therefore, a reimbursement structure works best, with the understanding that construction management and indirect expenses should be an allowable reimbursement.

For other home repair programs to address occupant's health condition, such as asthma, a similar process can be put into place. The challenge of home repair programs is that the patient must qualify as well as the home. For example, structural repairs on a rental property are difficult to justify without a long term lease because it provides a perverse incentive for landlords by paying for improvements to their property and rewarding them for deferred maintenance. Even with long-term lease agreements, there is no protection that the rental household will stay in that home since renters tend to be more transient and they can be evicted if they do not pay their rent. Given the income limits, we assume that most of those patients who will qualify for Medicaid under the standard plan will be renters rather than homeowners.

Certain federal housing repair programs, such as the Weatherization program, have standard protocols and detailed costs lists, including such details of cost related to how long ductwork is. The detailed cost protocols work in the Weatherization program because the type of work is standard across housing. Weatherization programs will only work with houses that are not in need of extensive structural repairs and have a standard scope of work.

For home repairs under Medicaid, the repairs needed will depend on the home. While the Weatherization cost protocol can provide a roadmap, the housing conditions encountered in each situation will determine the cost. The repair required for mold depends on whether mold is caused by a leaky roof or a leaking faucet. If a carpet is being replaced due to asthma, there can be a standard flooring finish for the replacement, but if the subflooring has damage and needs to be replaced, there will be added costs. Given that the condition of the housing will vary, it will be difficult to come up with a set price list and RP therefore recommends the bid and reimbursement model. The challenge will be to develop a process that responds relatively quickly so it does not take a year to complete a home repair.

The cost estimate worksheet did not allow for the home repair reimbursement model and it is nearly impossible to estimate the direct variable costs in the absence of a specific project. A home repair program would need a program or construction manager who can prepare home repair bids, interact with the case manager, medical provider, and the client, and oversee the construction process. Depending on the caseload, this could be a full time or part time position.