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Medicaid Changes Could Address Health-Related Social Needs and Improve Health Outcomes in Illinois

Michelle Dawn Shumate, Northwestern University

In 2023, 40% of Americans will face significant material hardship: limited access to essential resources such as nutritious food, medical care, affordable housing, and basic utilities. Unfortunately, most people who experience material hardship do not receive any help—not from friends or from social service agencies or nonprofits. In fact, less than 10% of individuals experiencing material hardship received help from social service agencies, and less than 6% received help from a nonprofit; only one in four households that could not pay an energy bill received help from any source.

What happens when a person in Illinois is unable to pay rent or has a disconnected phone? These unmet health-related social needs have significant health consequences—some research estimates that these needs account for between 30% and 55% of a person's health outcomes. It is crucial for the state of Illinois to do more to meet the needs of its most vulnerable community members, many of whom are eligible for Medicaid. Illinois policymakers can amend how our Medicaid program functions to address unmet health-related social needs better, and tackle issues related to housing, food, and utilities as part of a comprehensive approach to improving health outcomes.

Illinois Community Members Describe Their Hardships

In dozens of interviews with individuals experiencing material hardship, I heard how hard it is to find any help in Illinois. Interviewees spoke of difficulty in figuring out who could help them, and their struggle to determine which supports they were eligible to receive. Because of how difficult these processes are (or are perceived to be), many people reported not seeking help at all. This "tough it out" approach jeopardized their health; they skipped meals, ate poorly, or missed needed health appointments.

I spoke with an Illinoian I'll call Michael, who grew up in Kentucky and had been living just outside of Chicago for a couple of years when the pandemic hit. He lost his job, and like many that I talked to, had very little savings. He moved into his friend's place because he was out of money and was depressed; eventually, he reached out to his family for help. They provided him with some financial assistance to get by, though they did not have much. Both friends and family suggested that Michael reach out to local resources like charities. But, he stated, "It was tougher for me because I have not tried it before. So, I didn't know how I'm going to start with that." Like many help-seekers, Michael didn't have someone who could help explain the process or support him in contacting local resources.

Another study participant I'll call Sarah, was in her 20s and living with her dad. She had struggled with mood and anxiety disorders, which affected her ability to keep a job. She was on medications, but her doctors did not believe her symptoms were severe enough for her to qualify for disability benefits. Sarah's primary

interaction with nonprofits or agency help had been through mental health and medical centers. She had received referrals upon being discharged from the hospital. She noted, "They will print out a sheet with the health clinics or community centers that are covered by your insurance plan or take lower-income clients. But I have to do a little bit of my own research to just kind of figure out if this is gonna be helpful for me." Sometimes the numbers of referral choices were overwhelming—like 20-page packets—or not entirely useful—like listings for providers that had closed or whose contact information had changed. She was referred to several mental-health day programs,
but was unable to access them due to distance and not owning a car. Other programs had limited hours or specific requirements that she did not meet. She recounted trying to access some programs where the wait list was 8-10 months long. She summed up the experience of so many help seekers: "I legitimately need help. I think it can be difficult to know what the appropriate place is to ask for help."

New Opportunities

Medicaid and Medicare have offered state health officials several new options within the last year to address health-related social needs, including:

- Clarifying in-lieu-of service opportunities, allow managed care organizations to offer cost-effective, medically appropriate substitutes for services that are covered by Medicaid benefits. For example, Health Choice Illinois could follow the lead of California in offering medically supportive food and meals and housing navigation. These community supports are expected to reduce or obviate the need to use state-plan services in the future and can be covered as medically appropriate substitutes to Medicaid benefits.
- Using a 1115 demonstration—the waiver that allows states to experiment with changes to their Medicaid programs—to explore housing support, nutrition support, and health-related social needs case management.

To better address the health-related social needs of its Medicaid-eligible community, Health Choice Illinois and the Department of Healthcare & Family Services could consider:

1. **Applying for an 1115 demonstration waiver for health-related social needs case management.** The December 2022 guidance from CMS offers states the ability to fund health-related case management, and could help Illinois expand existing case management offerings to include coordination with services addressing housing, food, or utility needs.
2. **Investing in a state-wide community resource platform and directory.** Platforms like these connect healthcare and community-based organizations that address health-related social needs, and healthcare organizations can fulfill their obligation to provide quality referrals for social needs by integrating these systems into their existing electronic medical records system. States like Pennsylvania, Arizona, North Carolina, and New York have already begun to model resource platforms.
3. **Requiring managed care organizations to make community reinvestments and designate a portion of those required investments for capacity-building grants to community-based organizations.** Illinois should follow the lead of other states and require MCOs to invest a share of their profits in community services. A portion of managed care organizations' community reinvestment allocations could be designated for training and technology integration that would aid in the transition to a community resource referral platform, and promote the newly purchased community resource referral system.

4. **Embedding community health workers in locally trusted, community-based organizations in Health Equity Zones.** The Equity Zones initiative in Chicago employs a hyper-local approach to address systemic health equity issues; managed care organizations could contract with community health workers to perform much-needed local outreach to help residents understand and obtain access to services. These workers are key to encouraging people who are "toughing it out" to seek help.

Read more in Carboni, J. L., Annis, C., Barrios, M. E., Gibson, Z., Miles, J., Armstrong, N., Cantor, G., Smilowitz, K., & Shumate, M. "Collaborative Networks: The Next Frontier in Data-Driven Management," IBM Center for Business of Government (2022): 49.