National Center for Healthy Housing

Pathways to Reimbursement:

Understanding and Expanding Medicaid Services in Your State

Healthcare reform has sparked a national conversation about the role of community-based preventive services in healthcare. Payers, including Medicaid, are increasingly looking toward preventive services as a way to improve care and reduce costs. Across the country, healthy homes programs are helping to reduce environmental hazards in the homes of patients with housing-related illness and injury, such as asthma and lead poisoning. These programs use evidence-based approaches that reduce healthcare utilization and result in cost-savings to payers, including Medicaid, the nation's largest insurance provider.

However, the programs that have the workforce and expertise to provide healthy homes services are often disconnected from the payers that can provide a sustainable and large-scale delivery system. To help bridge that gap, this brief provides healthy homes professionals with a basic introduction to the Medicaid program and offers suggestions for expanding or leveraging services within a state Medicaid program to increase access to healthy homes services for Medicaid enrollees.

Medicaid Basics

Medicaid is the nation's main public health insurance program for low-income people of all ages. Medicaid is financed through a federal-state partnership in which each state designs and operates its own program within broad federal guidelines. The Centers for Medicare and Medicaid Services (CMS) is the federal agency that administers the Medicaid program and manages the federal-state partnership for each state program.

State programs have traditionally provided Medicaid benefits using a fee-for-service delivery system in which providers are paid for individual services (e.g., providers are paid for each office visit, test, and procedure). However, Medicaid benefits in many states have been increasingly offered through a managed care delivery system, which offers greater flexibility in the way services are provided. As of 2013, three out of every four Medicaid enrollees were enrolled in Medicaid managed care, and this number is expected to grow following

3 THINGS TO KNOW ABOUT MEDICAID

- **Medicaid is the main public health insurance programs for people of all ages in the U.S.**
- **Medicaid is financed through a federal-state partnership, and each state designs and operates its own program (within federal guidelines).**
- **Medicaid benefits are increasingly offered through a managed care delivery system.**

the implementation of healthcare reform[1]. Other recent changes[1] include:

- the expansion of eligibility criteria in many states (which may increase the number of covered adults, but not necessarily with the same benefits package offered to those who meet traditional eligibilty requirements)
- an increased emphasis on prevention and community-based services
- an active interest in many states to test delivery system reforms
- a change to Medicaid regulations that allows Medicaid programs to reimburse for preventive services provided by professionals that fall outside of a state's clinical licensure system (e.g., certified asthma educators, community health workers), as long as the services are initially recommended by a physician or other clinically licensed practitioner[2]

Another important program is the Children's Health Insurance Program (CHIP), which provides health coverage for children whose families who can't afford private coverage, but do not qualify for Medicaid. Like Medicaid, CHIP is designed and administered by each state within broad federal guidelines.

With all of the emerging opportunities to finance healthy homes services through the healthcare system, it can be overwhelming to know where to start. Opportunities may exist within a state's current Medicaid authority, but in some states paying for healthy homes services may mean working with the state Medicaid agency to enact changes to the state's program.

Leveraging Existing Programs and Services

Some healthy homes services may already be eligible for reimbursement (or partial reimbursement) under your state's Medicaid program. For more information about your state's Medicaid and CHIP policies, visit www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html.

Medicaid Managed Care Contracts or Incentives

In many states, Medicaid Managed Care is provided by managed care organizations that contract with the state agency to provide care for Medicaid enrollees on a per-person basis, known as capitation. States can require or encourage managed care organizations to provide certain types of services, but managed care organizations can also take advantage of the greater flexibility they have to offer a range of services (compared to traditional fee-for-service models). For instance, although Medicaid does not typically cover services like home assessments or low-cost supplies (e.g., mattress encasements), managed care organizations may offer these supplies and services if permitted as part of their contract with the state.

Healthy Homes Example[3]: In 2002, a Medicaid managed care plan in New York, the Monroe Plan for Medical Care, developed and launched their own disease management program for children with asthma. The program included specialty care, case management, and education, but also covered home environmental assessments and supplies to help families reduce exposure to asthma triggers.

Reimbursement for Direct Services

Providers need to enroll with their state Medicaid program and receive a federal and state provider number to be able to submit claims for providing covered services to Medicaid enrollees.

Healthy Homes Example[4]: The Texas Childhood Lead Poisoning Prevention Program (TxCLPPP) began filing claims for environmental lead investigations in 2011. Environmental lead investigations (ELIs) are a required Texas Health Steps benefit for clients 0-20 years of age with elevated blood lead levels. The process involved obtaining a federal and state provider number for the Department of State Health Services. The rate was set by the state Medicaid agency at $327.31 per ELI (as of May 2014).

Medicaid Administrative Claiming

Medicaid program costs can be classified as service or administrative. While service costs include direct patient care, administrative costs cover activities like enrolling individuals and coordinating and monitoring services for Medicaid recipients. Some of these administrative costs for healthy homes services may be reimbursable (can be done in addition to reimbursement for direct services).

Healthy Homes Example[4]: As of 2011, the Texas Childhood Lead Poisoning Prevention Program began receiving reimbursement for administrative claims based on 16 tasks that program staff perform and the percentage children they serve that are Medicaid enrollees (enabling statute 42 U.S.C. §1396(a)).

NOT SURE WHERE TO START?
Try the simple flowchart on page 5.

Other Programs to Explore

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is a mandatory set of services and benefits for Medicaid enrollees under 21. Typically, states have limited these services to those addressed within the scope of a well-child visit. However, federal regulations do not limit health education provided under EPSDT to clinical settings, and recent rule changes have given states even more flexibility in defining provider types who can offer health education in a home setting where exposures may occur (e.g., for a child with lead poisoning or a child with asthma).[3, 5]

Under the 2010 Affordable Care Act, states have the option of amending their state plans to establish Health Homes to coordinate care for Medicaid enrollees with chronic conditions, like asthma. Health Home providers (not to be confused with healthy homes providers!) are expected to provide patient-centered care that integrates all primary, acute, behavioral health, and long-term services and supports. Some states have defined their Health Home programs to include nontraditional providers (e.g., community health workers) as part of the care team, which may open up new opportunities for providing healthy homes services within a community. Find out if your state proposed, submitted, or has been approved for health home status: www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html.

Making Changes to a State Medicaid Program

State Plan Amendments (SPAs) and waivers are the two primary ways a state can propose changes to its Medicaid program. SPAs and waivers have different purposes, requirements, and submission processes. However, both can be important mechanisms in expanding a state's Medicaid program to include additional coverage of healthy homes services.

State Plan Amendment (SPA)

Although there are rules and requirements that states must follow in order to claim federal matching funds, states have significant flexibility in designing their Medicaid programs. A *state plan* is an agreement between a state and the Federal Government that describes how the state will administer its Medicaid program, including who will be covered, what services will be provided, how providers will be reimbursed, and more. When a state wants to amend its state plan, they send a State Plan Amendment (SPA) to CMS for approval. The proposed changes must still comply with all federal rules and requirements, but there is no requirement that the changes be budget neutral. For traditional, fee-for-service systems there are requirements that the changes must apply to enrollees across the state (statewideness), that comparable services are available to all enrollees (comparability), and that enrollees must retain their choice of providers. Importantly, these requirements do not apply to managed care delivery systems (even those established through a state plan authority)[6]. A state may seek an amendment at any time; CMS will review and respond within 90 days. Note that if CMS requests additional information during the 90-day window, the approval "clock" stops and does not resume until the requested information has been received. Once a SPA has been approved, the change is permanent (unless modified by a subsequent amendment). For more information about your state's Medicaid and CHIP policies, visit www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html.

Healthy Homes Example[7]: Multnomah County Environmental Health worked with its state Medicaid program on a State Plan Amendment to add its *Targeted Case Management–Healthy Homes Program* to Oregon's State Plan under Title XIX of the Social Security Act–Medical Assistance Program. Reimbursable services include, but are not limited to, the environmental assessment, care plan coordination, and linking patients with community agencies and resources.

Waivers

A waiver is a request from a state Medicaid program to have certain Medicaid program requirements "waived" so that the state can test a new service or policy approach that falls outside of federal Medicaid requirements. There are four major types of waivers and demonstration projects, including the Section 1115 Research and Demonstration Project waiver type (which is likely to be most relevant for healthy homes programs). A Section 1115 waiver allows CMS to grant a state Medicaid program authority to test, pilot, or demonstrate a new policy

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or service, including expanding eligibility to individuals not already covered by Medicaid or Children's Health Insurance Program (CHIP), providing services that are not typically covered by Medicaid, or testing a change in the way healthcare services are delivered. Projects must promote the objectives of the Medicaid and CHIP programs, be budget neutral to the Federal Government over the course of the project period, and are typically approved for an initial five-year period (with an optional renewal period of three additional years). State Medicaid programs submit waiver applications to CMS. Waiver applications may be subject to several rounds of negotiation and revision during the approval process.

Healthy Homes Examples[3, 8]: As part of the Mass Health Comprehensive 1115 Demonstration Waiver, the state of Massachusetts proposed piloting a bundled payment for asthma care that would allow providers to be reimbursed for a range of services, including addressing environmental asthma triggers in the patient's home. The waiver was approved in 2011, but the pilot project is still pending CMS approval.

The state of New York received approval for a waiver to reinvest $8 billion in federal savings generated by previous reforms into new programs to promote community collaborations and reduce avoidable hospitalizations. Funds will be allocated using a Delivery System Reform Incentive Payment (DSRIP) program. Services that address environmental asthma triggers are eligible for this funding.

SPAs AND WAIVERS AT A GLANCE[9]

	State Plan Amendment	Waivers
When to use it	To propose a change to a state's Medicaid plan that falls within federal rules and requirements.	To submit a formal request to have specific federal rules or requirements "waived" to test a new service, delivery system change or policy that falls outside of federal rules or regulations.
Requirements	Must comply with federal rules and requirements and typically must meet criteria for statewideness, comparability, and choice of providers (exceptions for managed care delivery systems). No budget or cost requirements.	Must meet cost requirements specific to the type of waiver (e.g., 1115 waivers must be budget neutral). No requirements for statewideness, comparability, or choice of providers.
Approval process	CMS will review and respond within 90 days. If CMS requests additional information during the 90 day window, the "clock" is stopped until the information is received.	Depends on the type of waiver, but can involve a lot of discussion and negotiation between CMS and the state. 1115 waiver approval processes must be transparent and provide opportunity for public comment.
Duration	If approved, the change is permanent (unless modified by a subsequent SPA).	For 1115 waivers, the approval is typically for an initial five-year period with an option to renew for an additional three years.

Sources:

[1] *Medicaid: A Primer – Key Information on the Nation's Health Coverage Program for Low-Income People*. (2013). The Kaiser Commission on Medicaid and the Uninsured. http://kff.org/medicaid/issue-brief/medicaid-a-primer/

[2] Childhood Asthma Leadership Coalition. *Medicaid and Community-Based Asthma Interventions: Recent Changes & Future Steps*. Available at www.nchh.org/resources/healthcarefinancing.aspx.

[3] Harty, M.-B., & Horton, K. (2013). Using Medicaid to Advance Community-Based Childhood Asthma Interventions: A Review of Innovative Medicaid Programs in Massachusetts and Opportunities for Expansion under Medicaid Nationwide. The George Washington University.

[4] Personal correspondence with Kitten Holloway, Performance Improvement and Planning Coordinator, Environmental Epidemiology and Disease Registries Section, Texas Department of State Health Service. See *Reimbursement for Healthy Homes Services: A case study of leveraging existing Medicaid authority in Texas* for more information (www.nchh.org/resources/healthcarefinancing.aspx).

[5] Burton, A., Chang, D. I., & Gratale, D. (2013). *Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models.* Nemours.

[6] Centers for Medicare and Medicaid Services. *Managed Care*. http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html

[7] U.S. EPA. (2014). *Effective Strategies for Obtaining Reimbursement.* www.asthmacommunitynetwork.org/EffectiveStrategiesWebinar

[8] New York State Department of Health. *Delivery System Reform Incentive Payment (DSRIP) Program: Reducing Avoidable Hospital Use through Delivery System Reform*. www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm

[9] Adapted from: *State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs*. (2012). Families USA.

NOT SURE WHERE TO START?
Try the simple flowchart on page 5.

Figure out where to start by answering a few simple questions.

Begin here

Do you want to change something about your state Medicaid program? For example, do you want to change the way it's administered, or implement a service, benefit, or delivery system change that is not already part of your STATE's Medicaid program?

YES

NO

Examples might include paying for supplies that aren't typically covered, using a different type of worker to provide a service or part of a service, providing a service in a different setting (e.g., home-based health education), expanding who is eligible for a service, or creating a completely new type of service or benefit. If you need more information about your state's Medicaid or CHIP policies, visit www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html.

Is the change that you want to implement allowable under current federal rules and regulations?

YES

NO

You may need a State Plan Amendment (SPA). To implement the SPA, other types of action at the state level may also be needed (e.g., state appropriations, change to Public Health Law).

You may also want to learn more about using Medicaid Managed Care contracts to encourage coverage of these services or benefits.

You may need a waiver. In addition to the waiver, other types of action at the state level may be needed (e.g., SPA, state appropriations, changes to public health law). Read about waivers in MA, OR, and NY.

Are you a state or local agency interested in getting Medicaid reimbursement for your current activities in coordinating care for Medicaid recipients (e.g., a state lead program that provides case management for children with elevated blood lead levels)?

YES

OR

Do you want to be reimbursed for providing direct services OR for administrative activities (e.g., case coordination, surveillance to identify cases)?

DIRECT SERVICES

ADMINISTRATIVE ACTIVITIES

Find out how Texas did it for environmental lead investigations.

You may want to explore Medicaid Administrative Claiming.

Are you looking for ways to leverage existing services and benefits in your state's Medicaid program?

YES

NO

Read about NCHH's 2014 survey to see if your state reported that healthy homes services are already covered or that there is work going on to cover these services. You may also want to learn more about the EPSDT benefit or Health Homes program in your state to identify additional opportunities to cover healthy homes services.

If you're looking for some other ideas, you may be interested in learning more about the role of private payers, hospital community benefits, or social impact bonds in financing healthier homes.

Brief #1
Healthcare Financing for Healthy Homes

For additional resources, including many of the sources cited in this document, visit:
www.nchh.org/resources/healthcarefinancing

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