Medicaid Contracting for Healthy Homes Services

Considerations for Managed Care Organizations

This issue brief is a companion piece to *Reimbursement Strategies for Healthy Homes Services: Considerations for State Medicaid Offices*.

Introduction

The purpose of this issue brief is to provide guidance and examples to Medicaid managed care organizations (MCOs) about contracting for healthy housing services.

Key Takeaways

- The home environment represents a significant social determinant of health. Common issues include lead exposure, asthma triggers, in-home injuries and falls, energy inefficiency, and poor weatherization.
- Healthy housing programs address the health, safety, and energy efficiency of the home environment through any combination of case management, in-home education, home assessment, and repairs.
- Healthy housing is a major factor in advancing health equity.
- Research evidence demonstrates the importance of healthy housing to improved health outcomes, reduced medical utilization, and positive return on investment.
- GHHI has supported several MCOs across the country with contracting for healthy housing services.

The Far-Reaching Effects of Unhealthy Homes

Decades of racially motivated policies and actions have disproportionately affected housing conditions in low-income communities of color across the US, endangering the health, safety, and well-being of countless families. Research shows that African Americans are more likely to live in poor-quality housing, which is part of the legacy of systemic racist housing practices such as redlining, where African Americans were denied loans to purchase in certain neighborhoods or improve their homes. Poor housing quality can cause lead poisoning, exacerbate chronic conditions such as asthma, and raise the risk of home-based falls among other hazards, drastically increasing costs for the healthcare system and creating undue financial strains on families.

An estimated 30 million families live in unhealthy housing in the United States. Given that Americans spend approximately 90% of their time indoors, improving the nation's housing stock as a healthcare measure is critical. Common healthy housing issues include exposure to lead poisoning hazards, asthma triggers, fall risks, and energy inefficiencies.

With the increasing understanding that the social determinants of health, and specifically housing quality, play a critical part of health and racial equity, MCOs are well positioned to contract for healthy housing services to benefit their most vulnerable members.

Healthy Housing Program Models

A comprehensive healthy homes intervention is comprised of evidence-based practices that improve housing conditions, health outcomes, quality of life, and life trajectory. The holistic model includes the following components:

- Single stream intake process with "no wrong door." Referrals may come from a broad set of sources including healthcare providers, healthcare payers, local agencies, utilities, and community-based organizations.
- Comprehensive assessment of the home environment to identify hazards that cause asthma exacerbations, injuries, falls, lead exposure, energy inefficiency, and poor weatherization.
- Home repairs that address the whole home as a single system, remediating hazards identified through the comprehensive assessment. Quality control and quality inspection ensure that home repairs meet a standard level of excellence.
- Home visits and home-based education that provide the family with the knowledge and skills to maintain a healthy home and sustain positive health outcomes.
- Evaluation of health and social outcomes by a third-party evaluator.

Cost-Benefit Analysis

Research evidence has not only established the health benefits of healthy housing services, but also the positive return-on-investment that these programs have for healthcare costs and societal outcomes.

Lead Poisoning Prevention: According to the CDC, primary prevention, which means removing hazards from the home before a child is exposed, "is the most effective way to ensure that children do not experience harmful long-term effects of lead exposure."[i] While screening children for lead early and remediating hazards after an increased blood lead level screen is important, it is often too late. Research studies quantifying the impact of lead poisoning prevention and hazard control measures show enormous benefits to individuals and the society at large, with a leading study showing a return of $17-$221 to society for each dollar invested—a net savings of $181-$269 billion.[ii]

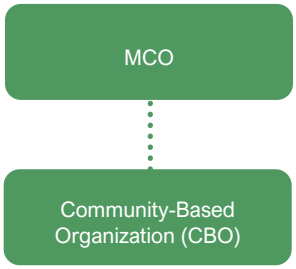
Asthma Management and Trigger Reduction: While there is no cure for asthma, symptoms can be effectively controlled with a combination of appropriate medical care, health education, and reduction or elimination of exposure to asthma triggers and respiratory irritants.[iii] The CDC Community Preventive Services Task Force implemented a systematic review of studies focused on comprehensive asthma interventions that assess the home environment, remediate environmental asthma triggers, and provide asthma management education, finding that they produced a return of $5-$14 for each dollar invested, a median decrease of 0.57 acute healthcare visits per year, and an decrease of 12.3 school absences per year on average.[iv] Additional recent studies have assessed the impact of comprehensive asthma programs on Medicaid total cost of care and shown a 29% reduction, the equivalent of $2,144 per child per year.[v] From 2016-2019, GHHI contracted with the leading actuarial firm Milliman to analyze datasets of 3-5 years of Medicaid claims from 12 health plans in different jurisdictions and develop cost savings projections. Milliman's model estimated average savings of $8,806 per person over 10 years.

Fall Prevention: Evidence has shown that multifactorial fall prevention programs that include a combination of exercise, education, and home modification for older adults lead to a statistically significant reduction in the rate of falls. One such intervention model called CAPABLE has resulted in approximately $10,000 per year in Medicaid savings for enrollees compared to a control group,[vi] and another study also showed over $10,000 in annual Medicare savings for CAPABLE participants.[vii]

Example Contract Structures

In our work with MCOs across the country, we have found that one size certainly does not fit all. MCOs may have preferences on how they contract for healthy housing services based on state mandates and incentives; internal strategy and priorities; perceived administrative burden for certain contract types; and potential impacts to medical loss ratio and future capitation rate-setting. In this section we discuss specific examples of MCO contracts with healthy housing programs.

Direct Payment using Administrative Funds



Maryland

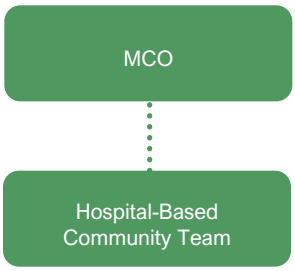
- Amerigroup Maryland was interested in a contract with GHHI based on internal analysis of outcomes. Amerigroup had previously been a referral partner for several years.
- Amerigroup pays 75% of costs after first visit and 25% after month 5 of enrollment.
- Services covered: home education visits, supplies, home assessment, IPM.

Michigan

- Priority Health was able to utilize a contract with Healthy Home Coalition to satisfy Michigan Medicaid's requirement of MCOs to address social determinants of health to receive the 1% premium withhold.
- Services covered: home assessment and home remediation of environmental asthma triggers.

Other Examples: Utah, Texas

Per Member Per Month Payment using Administrative Funds



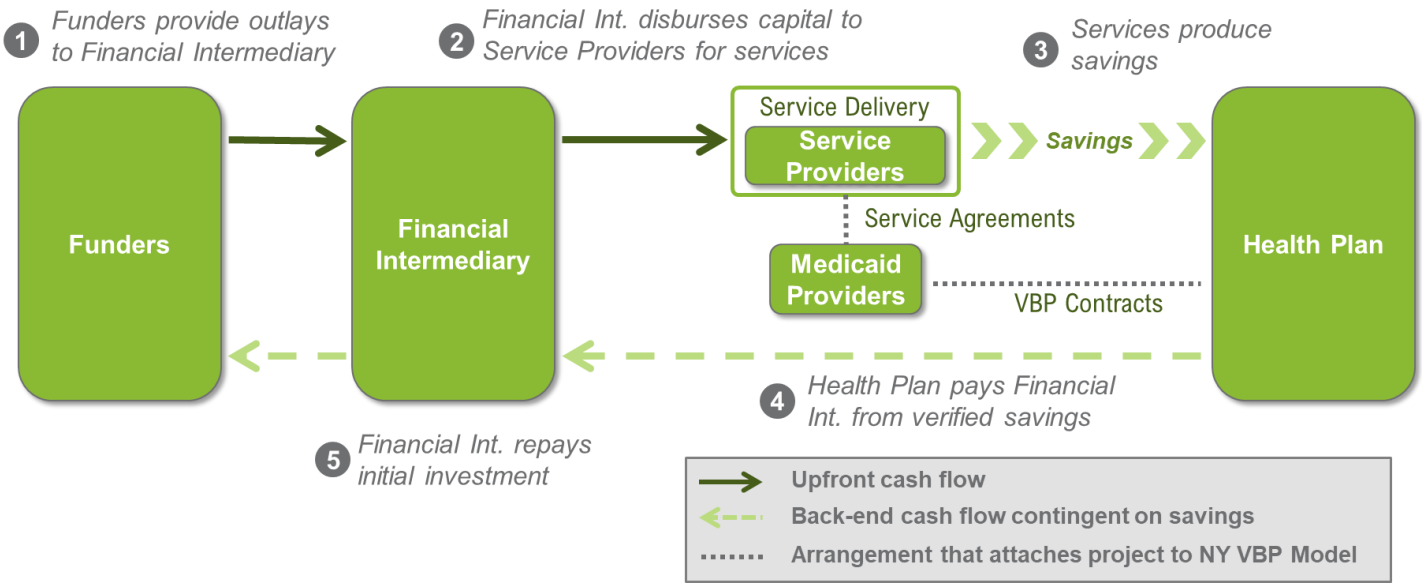
Tennessee

- Health plans currently provide a prospective PMPM payment to Methodist Le Bonheur Children's Hospital for asthma home visiting services under its CHAMP (Changing High-Risk Asthma in Memphis through Partnership) program.
- The Methodist Le Bonheur team consists of community-based community health workers, clinic-based nurses, social worker, and pediatrician.
- Services covered: home assessment, clinic- and home-based education, multiple home visits and phone calls, access to a 24/7 nurse call line

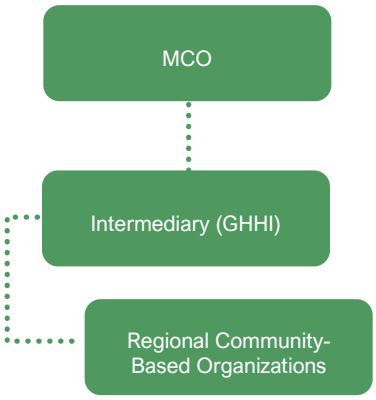
Value-based Payments and Pay for Success Financing

New York

- Health plan payments directly tied to reduction in total cost of care for enrollees. If no savings are assessed, no payment is made from the Health Plan to Provider.
- Health Plan payments are considered medical for purposes of medical-loss-ratio and future rate setting considerations.
- Payments are budget neutral for the Health Plan.
- Service Providers (Community-Based Organizations) receive upfront funding for service provision. Financial risk is transferred to third-party Impact Funders.



Statewide Model with Intermediary and Regional Service Providers



North Carolina

- As intermediary, GHHI is the single contracted partner for the MCO and responsible for delivery of services, partnering with local service providers, data management, and billing/invoicing.
- Program services are available to high-risk members statewide
- GHHI identifies, vets, and provides technical assistance to service providers as needed, to ensure that a standard model is delivered to address asthma and falls risk.
- MCO provides fixed fee per member referred to intermediary to receive healthy homes services.

Key Lessons Learned

- Most existing contracts between MCOs and community-based organizations for healthy housing services require the use of the administrative portion of the MCOs' premium due to restrictive Medicaid regulations. Many MCO leaders determine that benefits such as improved member outcomes, higher quality scores, and lower costs outweigh the negative impact on the MLR.
- Value-based payment models such as in the New York example above, though complicated to develop, currently offer the most viable contracting option for funding the broadest set of services while avoiding the need to use MCO administrative funds. Some states allow for certain healthy housing services to be counted as medical spend through simpler mechanisms such as "in lieu of" services[viii] and CHIP Health Services Initiatives[ix] but these examples are limited. In 2022 we have seen more state movement to using 1115 waivers that could potentially scale home modifications and other non-medical services that address the social determinants of health. Examples include California, Massachusetts, and Oregon.
- To sustainably fund healthy housing programs, it is important for healthcare partners to understand that outcomes and cost savings from these services accrue over multiple years. MCOs that have reaped the most benefits for their bottom lines and their members are those that acknowledge the expected outcomes timeline up front, plan on multi-year partnerships, and perform long-term evaluations.
- MCOs can play a critical role in advocating to state Medicaid leaders for more flexibility to address unhealthy housing in a sustainable way. GHHI has witnessed new avenues for covering healthy housing services emerge through policy mechanisms such as innovative waivers and state plan amendments as a result of MCOs participating in coordinated workgroups as well as self-directed efforts to make the case at the state level.
- MCOs that have been successful in establishing contracts for healthy homes services ensure buy-in from multiple staff across executive and program levels. These internal 'champions' are essential to maintaining progress on contract development through challenges such as staff turnover and competing priorities that are common to MCOs.

End Notes

i https://www.cdc.gov/nceh/lead/prevention/default.htm
[ii] https://pubmed.ncbi.nlm.nih.gov/19654928/
iii Zahran, H. S., Bailey, C. M., Damon, S. A., Garbe, P. L., & Breysse, P. N. (2018). Vital signs: asthma in children—
United States, 2001–2016. Morbidity and Mortality Weekly Report, 67(5), 149. Retrieved from https://www.cdc.gov/mmwr/volumes/67/wr/mm6705e1.htm
iv Asthma Control: Home-Base Multi-Trigger, Multicomponent Environmental Interventions. Community Preventive Services Task Force. 2011. Accessed August 2016. http://www.thecommunityguide.org/asthma/multicomponent.html.
[v] https://downloads.cms.gov/files/cmmi/hcia-diseasespecific-thirdannualrpt.pdf
vi Szanton, S. L., Alfonso, Y. N., Leff, B., Guralnik, J., Wolff, J. L., Stockwell, I., ... & Bishai, D. (2018). Medicaid cost savings of a preventive home visit program for disabled older adults. Journal of the American Geriatrics Society, 66(3), 614-620.
[vii] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1305
[viii] https://www.dhcs.ca.gov/Documents/MCQMD/ILOS-Policy-Guide-September-2021.pdf
[ix] https://www.greenandhealthyhomes.org/publication/chip-hsi-and-healthy-homes/