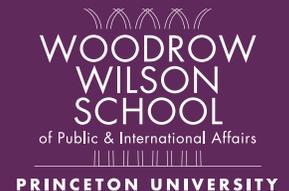


Leveraging CHIP to Protect Low-Income Children from Lead

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IN THIS BRIEF

- ✓ More than **4 million families with children live in homes with high levels of lead**, and approximately **half a million under the age of five require treatment**.
- ✓ **CHIP funding offers states an enhanced federal match** that can be used for lead abatement targeting low-income children.
- ✓ **These health services initiatives (HSI) do not require CMS waivers**. Instead, states can propose a state plan amendment describing its strategy, source of state funding, and estimated impact.
- ✓ **19 states presently have HSIs, including Michigan's which targets lead abatement**.
- ✓ **A majority of states are well-positioned to establish their own programs** and leverage enhanced CHIP funding against lead exposure.

Introduction

Despite dramatic improvements over the past few decades, lead poisoning continues to be a serious hazard for many children in the U.S., presenting significant risks to their health and learning. The Children's Health Insurance Program (CHIP) can provide critical financial support to states and local communities who often face financing challenges as they seek to implement cost-effective lead abatement activities to protect children. This issue brief describes the CHIP State Plan option (no waiver required) and the opportunity it provides for states to make significant, tangible reductions in lead exposure and improvements to children's health.

At least 4 million households with children are exposed to high levels of lead, and approximately half a million U.S. children ages one to five have blood levels above the recommended level.¹ Lead exposure can cause serious physical and neurological damage to children, impacting their chances for a healthy start, as well as lifelong health, educational attainment, and societal contributions. Even low levels of lead exposure can impact children's brain development and may result in reduced intelligence quotient (IQ), shortened attention spans, or hearing and speech problems.² Lead exposure also can cause anemia, hypertension, renal impairment, immunotoxicity and toxicity to the reproductive organs.³ Low-income children, many of whom live in older housing, are particularly vulnerable to lead exposure. Research has shown that lead abatement efforts can yield significant cost savings through a range of societal benefits.⁴

Currently, while many states use a variety of funding sources to finance lead identification and abatement programs, including resources from the U.S. Department of Housing and Urban Development (HUD) and from state and local departments of health, available financing typically falls far short of need. However, under a long-standing but relatively underutilized CHIP provision—known as the health services initiative (HSI)—states have an opportunity to leverage federal funding to develop and implement health initiatives for low-income children,

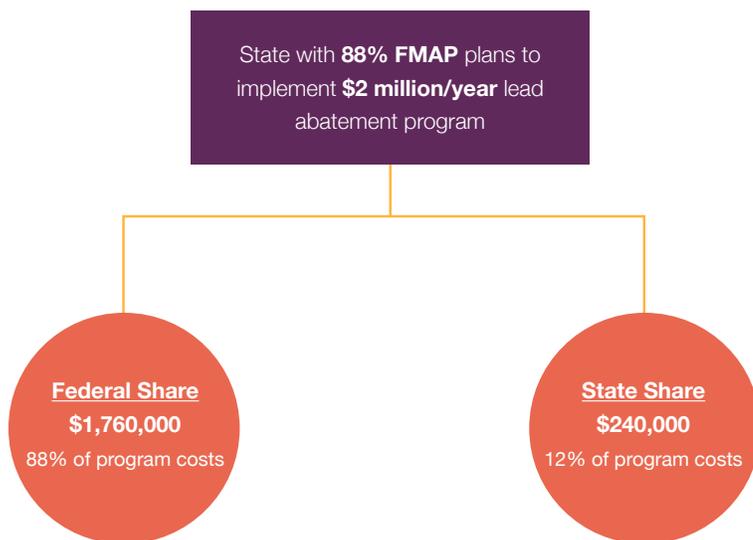
including those that support lead exposure testing, prevention and abatement. To date, 19 states have received approval for CHIP HSI for a variety of child health initiatives. This includes Michigan's recently approved CHIP HSI, authorizing approximately \$24 million to support its lead initiative. Maryland, which already has approval for one CHIP HSI, has a second CHIP HSI State Plan Amendment (SPA) to fund lead abatement activities pending with the Centers for Medicare & Medicaid Services (CMS). This brief summarizes the CHIP HSI federal guidance, describes the availability of federal funding and existing state HSI activities, and provides practical information intended to assist states in developing CHIP HSI SPAs that support lead abatement efforts.

Opportunity to Use CHIP Funding to Combat Lead Poisoning

Title XXI of the Social Security Act—the federal authority for CHIP—provides states with a unique opportunity to access federal funds that can be used in targeted ways to reduce children's exposure to lead. Under the statute, states have the option to draw down federal matching funds at the enhanced CHIP rate for certain non-coverage expenditures so long as those expenditures do not exceed 10 percent of the total amount that a state spends on CHIP health benefits.⁵ The non-coverage activities that are eligible for the CHIP federal matching rate include administrative costs related to the operation of CHIP as well as expenditures for HSIs targeted at improving the health of low-income children.⁶ Following the 1997 passage of CHIP, CMS (then known as the Health Care Financing Agency or HCFA) issued guidance establishing the parameters for HSIs and provided clarification on the types of expenditures that are allowable under the 10 percent cap.⁷ In that guidance, CMS defined qualifying health services initiatives as those designed to: “protect the public health, protect the health of individuals, improve or promote a State’s capacity to deliver public health services, and/or strengthen the human and material resources necessary to accomplish public health goals.”⁸ As recently confirmed by the approval of Michigan’s CHIP HSI and CMS’ newly released Frequently Asked Questions (FAQ) on HSIs,⁹ lead exposure prevention and abatement programs aimed at low-income children are an authorized use of HSIs under the CHIP authority.

As noted, states with approved CHIP HSI SPAs receive federal CHIP matching payments for the approved expenditures.¹⁰ The CHIP matching rate has always been higher than Medicaid’s matching rate, and the Affordable Care Act further increased the Federal Medical Assistance Percentage (FMAP) for CHIP expenditures (including HSIs) by 23 points through September 30, 2019¹¹ making the minimum CHIP FMAP rate 88 percent in Fiscal Year (FY) 2017.¹² (Under the regular CHIP enhanced match rate, the federal share of costs ranges from 65 to 82 percent.) Thus, with relatively modest investment, states can draw down federal funds for HSIs up to the limit for non-coverage expenditures, creating an opportunity for states and the federal government to make significant headway on lead testing, prevention and abatement that can literally change the lives of low-income children. (See Figure 1 for an example of funding shares for a CHIP HSI under current law.)

Figure 1: Example of State and Federal Funding for HSI



CHIP HSI SPA Process

The process for securing a CHIP HSI is relatively straightforward. The option is part of the CHIP state plan template that the state must complete and submit as it would for any other CHIP SPA.¹³

Before submitting an HSI SPA to CMS for approval, a state should develop a proposed lead abatement initiative and determine the funds available for an HSI lead abatement program. As noted, under federal law, total non-coverage expenditures, including expenditures for an HSI, may not exceed 10 percent of the total amount of its CHIP allotment that a state spends for CHIP health benefits. For example, if a state’s annual CHIP allotment is \$150 million, and its expenditures for coverage are \$100 million, the state can spend up to \$10 million for non-coverage expenditures. If that state has \$4 million in CHIP administrative costs, the state may spend up to \$6 million of its CHIP allotment on an HSI. Each year, of course, the state’s CHIP allotment and its expenditures for coverage and administrative costs might vary.

To develop and implement a CHIP HSI SPA, states . . .

Must:

- » Demonstrate the need for the initiative
- » Describe an HSI proposal that is targeted at improving the health of low-income children
- » Identify source(s) of state share funding
- » Estimate number of low-income children who will be served
- » Include a clearly defined timeframe for the initiative
- » Meet specific program design criteria

Need Not:

- » Seek a waiver
- » Limit the initiative to children enrolled in Medicaid/CHIP, so long as the HSI targets low-income children, but guidance encourages states to enroll eligible children
- » Operate the HSI initiative statewide
- » Have a “separate” CHIP program; states with CHIP-funded Medicaid expansions can receive HSI funding

However, as long as the state keeps its non-coverage costs (i.e., administrative expenditures and HSI spending) within the 10 percent limit, its expenditures for its approved HSI will be matched at the applicable CHIP matching rate. These spending limits can be anticipated based on historical spending patterns established in the state for coverage and administrative costs (though beginning in FY 2017, states will likely hit their CHIP allotment caps with the ACA’s 23 point bump); data for FY 2015 shows that the majority of states without an existing HSI had room under the 10 percent allowance that would permit for funding an HSI. In fact, 33 states had more than half of their 10 percent allotment for non-coverage available for an HSI.¹⁴ As such, the majority of states are well-positioned to develop a HSI CHIP SPA and leverage federal funding to address lead exposure.

Once a state determines the availability of funding for its HSI, generally, a state has considerable flexibility to design a lead abatement program that meets the needs of low-income children under the age of 19. Regardless of whether a state operates a CHIP-funded Medicaid expansion or a separate CHIP program, a state can implement an HSI program by claiming funding through the usual CHIP administrative cost claiming process. There are no statewideness requirements for CHIP or CHIP HSIs, which allow states to target their lead abatement programs to specific communities and children with the greatest needs. Since an HSI does not restrict or eliminate CHIP eligibility or benefits, states are not required by federal law to provide public notice prior to submitting a CHIP HSI SPA.¹⁵ No waiver is required; states must only receive CMS approval for their CHIP SPA.

However, to receive HSI funding for lead poisoning prevention and abatement, states must demonstrate the need for the

HSI and meet defined program design criteria. Specifically, they must: 1) ensure that individuals performing abatement services are state certified; 2) demonstrate that abatement work effectively removes all lead hazards; 3) work with CMS to develop metrics to measure the effectiveness of the lead abatement activities; and 4) for any HSI focused on water-based lead abatement, ensure (alone or in combination with other resources or state and local efforts) complete (not partial) abatement of service lines and other related fixtures.¹⁶

Overview of State HSI Activities

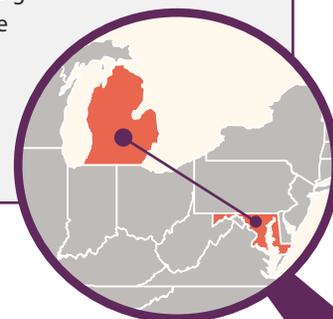
HSIs have been available under CHIP since the program was first established. Currently, 26 HSI SPAs are approved in 19 states, including Michigan which is using the HSI option to fund programs that support lead hazard detection, abatement and prevention (described in detail below).¹⁷ Some states’ HSIs focus primarily on projects to support statewide poison control centers that provide daily, 24-hour emergency telephone treatment advice, referral assistance and information to manage exposure to poisonous and hazardous substances with respect to low-income children. Other states use the HSI funding to support a myriad of other initiatives including supporting school health services, home visiting for at-risk newborns and parents, and smoking cessation, among others.¹⁸

Given the urgent need to address lead exposure among low-income children, a targeted, effective strategy is essential for accomplishing state and local goals. No one strategy is right for all communities, however. Below is a description of the approaches that two states have adopted or are planning to adopt. Note that the states described here—Michigan (approved HSI) and Maryland (HSI SPA pending with CMS)—had pre-HSI lead initiatives and either built on those initiatives or varied their approach to improve on earlier efforts.

CASE STUDIES

Michigan: In response to the recent water crisis in Flint, Michigan developed an HSI to fund lead abatement activities in eligible homes—owner-occupied, rental and residential structures—inhabited or visited regularly by Medicaid or CHIP-eligible children or Medicaid or CHIP-eligible pregnant women, both in Flint and other targeted communities throughout the State.¹⁹ In November 2016, CMS approved Michigan’s HSI SPA to use approximately \$24 million per year for five years to ameliorate lead risk by: 1) removing (or otherwise encapsulating) lead based paint and lead dust hazards; 2) removing and replacing surfaces or fixtures within the eligible home such as water service lines identified during an environmental investigation as lead hazards; 3) removing or covering soil lead hazards on the eligible home’s property; 4) testing activities associated with pre- and post-abatement paint, dust, soil or water activities; and 5) providing training to build a qualified workforce to complete the lead abatement activities.²⁰

Maryland: In December 2016, Maryland submitted its HSI SPA to CMS for approval (its second HSI SPA; the State’s first HSI SPA funds Maryland Poison Center expenditures relating to children). The lead-focused HSI SPA advances a two-prong initiative to combat lead exposure among low-income children in Maryland. Under the first component (Healthy Homes for Healthy Kids), the State seeks to expand its lead identification and abatement programs for low-income children through programs delivered by the Maryland Department of Housing and Community Development. Under the second component (Childhood Lead Poisoning Prevention & Environmental Case Management), Maryland seeks to expand its county level programs to provide environmental assessment and in-home education programs with the aim of reducing the impact of lead and other environmental toxins on vulnerable low-income children. Environmental case managers and community health workers in local health departments are conducting the Case Management program, targeting counties with the greatest need and making referrals for lead abatement.



Conclusion

While CMS’ HSI guidance is two decades old, states are only recently becoming aware of the opportunities to use HSI funding to support lead abatement activities that are so vital to the health and wellbeing of low-income children. Given the considerable health, educational and societal risks associated with lead poisoning among low-income children, HSI funding presents a unique opportunity for states to stabilize and supplement existing funding for lead abatement activities and help prevent lead poisoning for the next generation of children.

Endnotes

1. Centers for Disease Control and Prevention available at <http://www.cdc.gov/nceh/lead/>. The reference level at which the CDC recommends public health actions be taken is 5 µg/dL.
2. Lead Poisoning and Health Fact Sheet, August 2015, World Health Organization available at <http://www.who.int/mediacentre/factsheets/fs379/en/>; Childhood Lead Poisoning Data, Statistics, and Surveillance, Centers for Disease Control and Prevention available at <http://www.cdc.gov/nceh/lead/data/index.htm>.
3. Ibid.
4. Partnership for America’s Economic Success, “Cutting Lead Poisoning and Public Costs,” The Pew Center on States (February 2010). Available at <http://www.pewtrusts.org/en/research-and-analysis/reports/2010/02/22/cutting-lead-poisoning-and-public-costs>.
5. Social Security Act § 2105(a)(2).
6. Ibid.
7. State Health Official Letter, Health Care Financing Administration, December 8, 1997 available at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD120897b.pdf>; State Health Official Letter, Health Care Financing Administration, August 6, 1998 available at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/sho080698.pdf>.
8. State Health Official Letter, Health Care Financing Administration, April 6, 1988 available at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/sho080698.pdf>. For example, if a state’s total CHIP expenditures on coverage were \$580 million, that state would be eligible to draw down enhanced CHIP matching funds of up to \$58 million for administrative expenses, children’s health service initiatives, or for other allowable expenditures.

9. Centers for Medicare & Medicaid Services, "Frequently Asked Questions (FAQs) Health Services Initiative," January 12, 2017 available at <https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf>.
10. Office of the Assistant Secretary for Planning and Evaluation, "FY2017 Federal Medical Assistance Percentages" available at <https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages>.
11. Social Security Act § 2015(b); Patient Protection and Affordable Care Act § 2101(a).
12. ACA repeal legislation might affect the duration of the FMAP with ACA bump; Paul Ryan's "A Better Way" plan proposes to eliminate the 23 percentage point bump in CHIP funding.
13. See Section 2.2 of State Plan Template available at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/childrens-health-insurance-program-chip/downloads/title-xxi-state-plan-revised-091311-508final.docx>.
14. Ibid.
15. 42 CFR 457.65
16. Centers for Medicare & Medicaid Services, "Frequently Asked Questions (FAQs) Health Services Initiative," January 12, 2017 available at <https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf>.
17. Ibid.
18. Based on a review of states' HSI SPAs on Medicaid.gov in July 2016.
19. Federal law does not require that HSIs benefit only enrolled or eligible Medicaid/CHIP children, but Michigan, in part because of its recent waiver to expand eligibility levels to provide services related to lead exposure, chose to limit the HSI to Medicaid/CHIP-eligible children.
20. Michigan Model Application Template for the State Children's Health Insurance Program available at http://www.michigan.gov/documents/mdhhs/SPA_MI-16-0017-CHIP_Lead_Abatement_Submission_540572_7.pdf.

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