MyNursePal Inc

Module 6 How Healthcare Is Paid for in the United States?

Section 2

How Medicaid Works: Coverage, Payment Models, and Documentation Requirements

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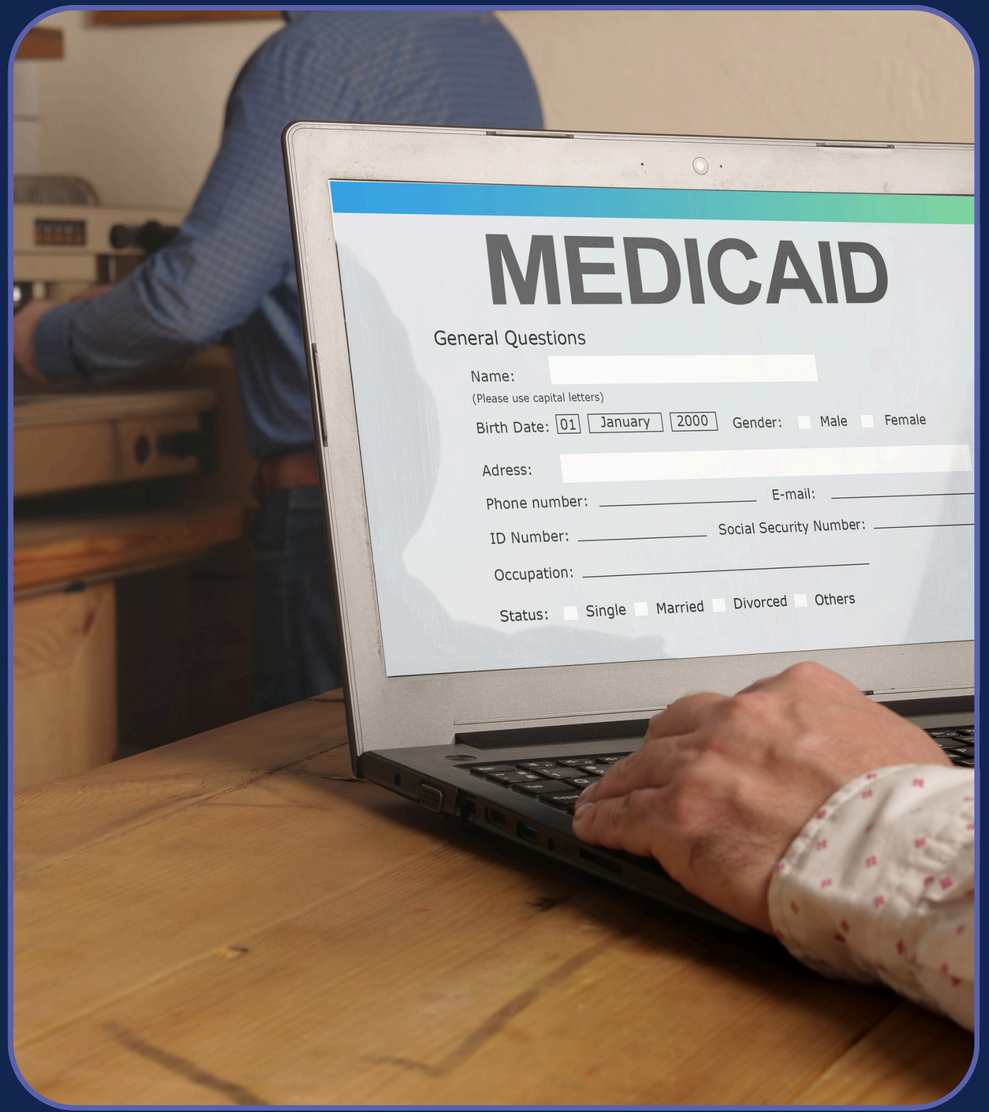

Objectives

By the end of this module, learners will be able to:

1. Explain the Medicaid programs in the US
2. Describe what HCBS waivers are and how they support community-based services.
3. Identify common Medicaid payment and billing models
4. Understand how EVV, authorizations, documentation, and audit rules shape software requirements.
5. Apply foundational compliance concepts to system design and workflow development.

Introduction

Medicaid is the United States' public health insurance program for people with low income or special needs.
It's jointly run by the federal government and individual states, which means:
The federal government (CMS) sets the overall rules and provides part of the funding.
Each state designs and manages its own Medicaid program, deciding who qualifies, what services are covered, and how providers are paid.
This creates 50 slightly different Medicaid systems (one for each state) — all following CMS guidelines but with unique rules and data requirements.

Whom does Medicaid Serve?

- Low-income families & children
- Pregnant women
- Elderly adults needing long-term care
- Individuals with disabilities (physical, intellectual, or developmental)

Care Settings Funded by Medicaid

- Hospitals
- Nursing facilities (SNFs, Nursing Homes, etc.)
- Home Health
- Adult Day programs
- Residential group homes
- Independent Supported Living programs
- Community services.

How is Medicaid Funded?

- Both the federal and state governments finance Medicaid:
- The federal government pays a percentage, known as the Federal Medical Assistance Percentage (FMAP), which varies by state.
- The state typically covers the remaining costs, often through its health or social services department.
- **Because both levels contribute money, both levels require data transparency and reporting compliance.**

Developers Note!

- Because both Federal and State governments contribute money to Medicaid, MyNursepal Pro must support:
  - State-specific billing formats.
  - Federal audit readiness
  - Secure data retention

What is Medicaid Waiver?

- "Medicaid Waivers" are special permission programs that let states use Medicaid funds in more flexible ways — especially to pay for non-institutional care.
- Traditionally, Medicaid would only pay for nursing home or hospital care.
- HCBS waivers "waive" that rule, allowing states to pay for:
  - Home support and direct care staff
  - Adult day programs
  - Independent Supported Living (ISL)
  - Residential group homes
  - Personal care and transportation services

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Developers Note!

- So you see, HCBS is an expansion of Medicaid that allows coverage outside an institution. But like every good thing that the federal program provides, it brings on unique regulations that designers and software developers must take note of

Developer Considerations

- HCBS Waivers allow Medicaid to pay for services that help people live in their homes and communities—not in institutions.
- For developers, HCBS means building features that support:
  - Individual authorizations
  - EVV-verified visits
  - Task and time tracking
  - Complex unit calculations
  - State-specific billing logic
  - Long-term audit-ready data retention
- Understanding HCBS is essential because almost every feature developers build for Medicaid programs must align with waiver rules.

How Medicaid Pays Providers

- Medicaid utilizes various payment methods, depending on the type of service and the state in which it is administered.
- The two most common are:
  - Unit-based Billing
  - Per-Diem or Monthly Billing

Unit-based Billing

- Payment is calculated by the time or task units performed — for example, 15-minute intervals, per-visit, or per-day.
- Example: If a caregiver provides 2 hours of personal care and each unit = 15 minutes, that's eight units billed for the day.

Per-Diem or Monthly Billing

- Used for facilities or programs that provide continuous care (e.g., residential group homes).
- Payment is fixed for each day or month of authorized service.

Developer Relevance

- Therefore, MyNursePal Pro must:
- Track start and end times, completed tasks, and caregiver identity for each visit.
- Support different billing unit rules by state (e.g., some use 15-minute units, others 30-minute units).
- Calculate totals automatically and generate claims in formats required by each state's Medicaid system (often **EDI X12 837P or 837I).**
- Provide real-time reporting and audit logs for compliance checks.

What Is EDI X12 837P / 837I?

- Electronic Data Interchange (EDI) is a standard format used by healthcare organizations to transmit billing and claims data electronically between systems.
- Think of it as the “language” that computers use to talk to each other when sending insurance claims.
- Medicare, Medicaid, and private insurance companies use it.
- It ensures accuracy, security, and automation in billing.
- It’s defined by HIPAA standards and maintained by the ASC X12 committee, a part of the American National Standards Institute (ANSI).

The X12 837 Transaction

- The X12 837 is the specific EDI format used to submit healthcare claims electronically.
- In other words, when MyNursePal Pro (or a billing system) submits a claim for a nurse visit, therapy session, or home care task, it sends that claim in an 837 file to the payer (Medicare, Medicaid, or private insurance).

837P vs. 837I

Refer to the handout for the difference between 837P vs. 837I

Summary

- The EDI X12 837P and 837I files are electronic claim forms that replace paper billing.
- They tell Medicare, Medicaid, or private insurance:
  - Who got care
  - Who gave the care
  - What kind of care was given
  - When it happened
  - And how much to pay
- For MyNursePal Pro, every EVV visit, OASIS assessment, or progress note must eventually be connected to this claim data pipeline, as the documentation in your app serves as the source of what is included in an EDI file.

Developer Relevance

- While developing MyNursePal Pro, you are not only managing documentation but also generating the data that will populate these EDI files.
- That means your database and APIs must capture every data element that will eventually populate an 837 file.

How the Billing Cycle Works

- When your system completes a billing cycle (e.g., a week of home visits):
- MyNursePal Pro aggregates all completed and verified visits.
- Each visit's data (date, provider, service, payer, units, cost) is compiled into an 837P or 837I claim file.
- The claim file is transmitted electronically to the payer portal or a clearinghouse (e.g., Availity, Change Healthcare, state Medicaid systems).
- The payer reviews the claim and sends back an EDI 835 payment/remittance file.
- If you want, I can turn this into a downloadable PPT slide as well.

Developer Relevance

If you're designing or integrating the billing module, you need to ensure:

1. All claim data fields are structured and validated (service codes, dates, NPIs, payer IDs).
2. EDI generation logic can build both 837P and 837I files as required by the payer.
3. APIs or file exports conform to HIPAA-compliant EDI standards (ANSI X12 5010 or 7030 versions).
4. Audit logging for every claim submission and payer response is built in.
5. Error handling: When an 837 file is rejected (e.g., due to an invalid CPT code or missing NPI), the system flags it for review.

Coming Up

Module 6 Section 3

UNDERSTANDING PRIVATE INSURANCE

Stay tuned ....