



Case Studies in Healthcare Financing of Healthy Homes Services: Medicaid Reimbursement for Home-Based Asthma Services in California

A large body of evidence suggests that home visiting programs that address indoor environmental triggers (e.g., cockroaches, mice, tobacco smoke, mold) can improve asthma control, reduce asthma-related hospitalizations and emergency department visits, and provide a positive return on investment.¹ These types of services are recommended as a component of comprehensive asthma care for people with poorly controlled asthma but are not widely available and often limited in scale. However, recent changes resulting from healthcare reform have increased opportunities for states to consider more sustainable and widespread implementation. Some states have already invested heavily in developing programs, policies, and funding to increase access to these critical public health services.

Yet many states may be unsure about how to translate these evidence-based practices into policy. This case study summarizes the current healthcare financing landscape in California for home-based asthma services with an emphasis on public financing. The case study is based on survey findings² and interviews with the state Medicaid agency, the state health department, and other stakeholders. It describes the current healthcare landscape, other important funding mechanisms, key barriers, next steps, and lessons learned. This information may be useful to stakeholders in other states that are seeking healthcare financing for home-based asthma or other preventive services, or for stakeholders within the state of California interested in a summary of current and future opportunities within the state.



AT A GLANCE

Medicaid Reimbursement for Home-Based Asthma Services in CA

Medicaid in California

Medi-Cal is California's Medicaid program, which is financed equally by the state and federal government. Roughly 12 million California residents, about 30% of the state's population, receive healthcare services through Medi-Cal. About 80% of Medi-Cal members receive their care through a Medi-Cal managed care plan. Medi-Cal is overseen by the Department of Health Care Services (DHCS).

Medicaid Reimbursement for Home-Based Asthma Services^a

Reimbursement type (page 2): Home-based asthma services are covered by a select number of plans as an administrative expense, meaning that Medi-Cal does not reimburse MCOs directly for the services.

Geographic coverage (page 3): Limited. Interviewees were aware of three managed care plans that provide home-based asthma services to enrollees in California.

Eligibility for services (page 3): Adults and children. Generally targeted towards higher-risk members.

Types of services covered (page 3): Assessment of primary residence, self-management education, and referrals to community-based services and supports. Some low-cost supplies are provided through leveraging of other non-Medicaid funding sources.

Staffing (page 4): Nurses, respiratory therapists, certified asthma educators (AE-C), social workers, community health workers.

Barriers and Next Steps for California (pages 5-7)

Interviewees described a range of barriers to increasing the number of MCOs that provide home-based asthma services, including a lack of funding for pilot projects, confusion over Medicaid billing codes, workforce concerns, MCO contracts with Medicaid Groups, and insufficient infrastructure. Moving forward, California is working on several opportunities to improve and increase access to home-based asthma services, including through the state's 1115 waiver renewal, discussions about expanding the role of nontraditional workers (e.g., community health workers), initiatives funded by the CDC National Asthma Control Program, and the state's plan for implementing Health Homes for Patients with Complex Needs.

Other Funding Mechanisms in California (page 4)

A wide variety of mechanisms are used to fund home-based asthma services in California, and in many cases a single program or initiative may rely on multiple funding sources. Funding sources in California include grants from the state or private foundations, hospital community benefit initiatives, social impact financing, and state funding from tobacco tax revenues and a 2005 settlement with BP. Interviewees were not aware of accountable care organizations or patient centered medical homes supporting these services.

Key Insights from California (page 8)

As Medi-Cal moves toward a managed care model, convincing MCOs to adopt these services requires strategies that emphasize cost-savings and return on investment. Additionally, California is a diverse state with diverse health needs: What works in one county may not achieve success in other counties across the state. Policies may need to strike a balance between achieving state-level progress while maintaining flexibility to allow for local innovation.

Medicaid in California

Medi-Cal is California's Medicaid program, which is financed equally by the state and federal government and overseen by the California Department of Health Care Services (DHCS).

Roughly 12 million California residents, about 30% of the state's population, receive healthcare services through Medi-Cal, making Medi-Cal the largest healthcare purchaser in the state.

About 80% of Medi-Cal members receive their care through a Medi-Cal managed care plan that contracts with the state program. Medi-Cal services are delivered by over 20 local plans and programs, each of which has substantial autonomy and diversity in designing and implementing approaches to patient care.

Medicaid-Supported Reimbursement for Home-Based Asthma Services^b

As reported in a 2014 survey conducted by the National Center for Healthy Housing and Milken Institute School of Public Health, Medicaid-supported coverage of home-based asthma services exists in California, but is limited in scale.² While home-based asthma services are provided in many innovative programs throughout the state, Medicaid currently plays a small role in supporting these services.

According to interviewees, there is no provider who is currently receiving fee-for-service Medicaid reimbursement from Medicaid for home-based asthma

^a Information based on responses to both the interview questions and responses to the original 2014 survey (www.nchh.org/Resources/HealthcareFinancing/Snapshot.aspx).

^b For the purpose of the original survey and the follow-up interviews and case studies, home-based asthma services were defined according to the Community Guide to Preventive Services definition of home-based, multitrigger, multicomponent asthma interventions. These interventions typically involve trained personnel making one or more home visits, and include a focus on reducing exposures to a range of asthma triggers (allergens and irritants) through environmental assessment, education, and/or remediation.

services, and there is no health plan with a Medicaid contract in place to claim reimbursement for these services directly. As reported by representatives from Medi-Cal, a recent survey of Medi-Cal Medicaid managed care organizations (MCOs) in the state revealed that several MCO plans have member or physician incentive programs related to asthma (e.g., incentivizing physicians to perform an asthma risk assessment),³ but Medi-Cal has not conducted a specific survey of MCOs around home-based asthma services. However, interviewees are aware of three MCOs in the state that either currently offer or have recently offered home-based asthma services to plan enrollees:^c

- Alameda Alliance for Health, Asthma Start Program (a program run in concert with the county public health department; see box on page 5)^{4,5}
- Inland Empire Health Plan, Health Navigator Program⁶
- L.A. Care Health Plan, LA Cares About Asthma⁷

Home-based asthma services are covered by the plans as an administrative expense – in other words, Medi-Cal does not currently reimburse MCOs directly for these services.^d

Medicaid-supported coverage of home-based asthma services in California is quite limited geographically. The three MCOs described above cover home-based asthma services for plan enrollees living in the three counties in which the plans operate. However, there are many vulnerable residents in the state's remaining 55 counties that have no Medicaid-supported access to home-based asthma services.

Interviewees were aware of a couple of instances where a county public health department has used Medicaid Targeted Case Management (TCM) dollars⁸ to secure Medicaid financing for some asthma home-based services. While asthma education is not a TCM-reimbursable service, some case management and assessments provided during in-home visits may qualify for TCM funding.⁹ In these instances, the county public health department is using TCM dollars to supplement either an internal asthma program or a program supported through collaboration with one of the above MCO plans. Other than these instances, there is no direct Medicaid reimbursement for asthma

home-based services in California. Medi-Cal managed care has always reimbursed for some aspects of the programs, but traditional fee-for-service has not. The managed care Medi-Cal programs do not reimburse as part of their capitated rate; instead, they pay from their education or administrative fund at a 15-minute rate that is not to exceed two hours on the initial visit and then one and a half hours for later visits.

What home-based asthma services are provided?

The services supported through the mechanisms described above are focused largely on education and referrals. The type of home-based asthma services offered to MCO enrollees tends to focus on asthma self-management education, development of an individualized asthma action plan, home environmental assessment to identify asthma triggers, and referrals to specialists or other community-based services and supports (for example, assisting families with advocating to landlords to improve housing).

Reimbursement for supplies needed for patients with asthma is limited. The Alameda County Public Health Department's Asthma Start Program does offer some basic supplies as part of their in-home asthma program, such as mattress covers to reduce dust mite exposure and HEPA vacuum cleaners. However, these supplies are purchased by the county health department using grant funding and are not specifically a Medicaid-supported expense. Interviewees were not aware of Medicaid dollars being used for structural remediation of homes or services like integrated pest management.

Where county public health departments are using TCM dollars to supplement asthma programs, these dollars are used to fund needs assessments, care plan development, and referrals and linkages to services provided during in-home visits.

What patient populations are eligible to receive home-based asthma services through Medicaid?

Home-based asthma services offered by MCOs in CA are generally targeted toward high-risk members with asthma, determined by recent emergency room visits or hospitalizations. For example, Inland Empire Health Plan sets participation at an enrollee having had two or more avoidable ED visits in the preceding 12 months and not being current with well-child visits. These

^cA fourth MCO possibly offering home-based asthma services was surfaced by interviewees during follow-up discussions - Kern Family Health Care, Bakersfield City School District Asthma Program.¹⁰ However, at publication time, interviewees were not aware of sufficient information to include this program in detail throughout this case study.

^dMedicaid program costs can be classified as service or administrative. Administrative costs cover activities like enrolling individuals and coordinating and monitoring services for Medicaid recipients. The MCOs listed here are paying for home-based asthma services as an administrative expense.

MCOs have linkages to local hospitals and make efforts to engage high-risk patients upon discharge. Where county public health departments are using TCM dollars to supplement asthma programs, these programs also target high-utilizers.

Two of the three MCOs offering home-based asthma services in California also connect with community-based providers to enhance their reach to patients in need prior to hospitalization. For example, the Asthma Start Program offered by the Alameda County Health Department accepts referrals from community and county health clinics. These referrals usually happen as a result of a patient describing potential asthma triggers in their home. The Asthma Start Program also receives referrals from school truancy officers for children who are missing a significant amount of school because of their asthma (truancy itself is not a qualifying criteria for services, but this connection to schools helps the program better connect to high-risk children with asthma). In addition, MCOs refer their high-risk asthma enrollees to Asthma Start services.

Two of the three MCOs focus their in-home asthma services on children aged 0-18 years. The other MCO provides services to both children and adults.

What types of providers are eligible to provide home-based asthma services?

The three MCOs offering home-based asthma services utilize a range of providers, employed through a variety of mechanisms, to deliver in-home asthma services to eligible plan enrollees:

- In one program, a team of licensed social workers employed by the county health department conducts asthma-related home visits.
- Another MCO directly employs a team of community health workers, called “patient navigators,” to provide these services.
- In the third, the MCO contracts out to community organizations and providers that are already delivering asthma home-based services to the community.

According to CA’s original survey response, nurses, respiratory therapists, and certified asthma educators may also be providing some of these services. Interviewees had the impression that because the MCOs are not receiving direct reimbursement from Medicaid for these services (the funding comes from their administrative budget line), the MCOs have a lot of flexibility to broaden the types of providers who can offer these services to plan enrollees.

How well is information shared between these providers and the larger healthcare team?

Interviewees report that the Alameda Alliance for Health is very committed to sharing information collected from Asthma Start home visits with the larger team of health providers interacting with the patient. Interviewees were not aware of whether and how information flows from the other home-based programs to other patient providers.

Are these services improving outcomes for individuals with asthma? What evidence is there for a return on investment?

Interviewees were not aware of any state surveys of the effectiveness of home-based asthma services. Medi-Cal reported that there are no current efforts in place at the state level to quantify the value of home-based asthma services. However, individual programs are tracking their success. Evaluations of the Asthma Start Program in Alameda County show that the program has greatly reduced emergency department visits and hospitalizations among participants, and 95% of children in the program have maintained or reduced their symptoms. These outcomes have led to an estimated return of \$5.00-\$7.00 for each dollar invested (see text box for additional details about this program). The Asthma Start Program is also part of a new pilot project with the University of California-Berkeley, Impact4Health, and Alameda County Healthy Homes; this pilot will further describe the return on investment for Asthma Start services.

Other Mechanisms for Funding Home-Based Asthma Services, Outside of Medicaid

As Medicaid support for home-based asthma services is very limited, programs that deliver these services for Medicaid-eligible patients rely on other public and private funding streams or innovative partnerships to ensure program sustainability.

According to CDPH, most programs across the state that perform home-based asthma work are funded, or have been funded in the past, by state- or private foundation-sponsored grants. Some programs are funded with hospital community benefit dollars,¹¹ but most hospital initiatives to address asthma provide only patient education and not in-home services. Other programs are supported with funding from a 2005 settlement between the State of California and BP.¹² In some cases, “First 5 California” tobacco tax dollars go towards funding these types of services.¹³ For example, the California Asthma Initiative, established with First 5 funding dollars, helped launch efforts to address asthma in Alameda County, forming the Asthma Start

Program within the Alameda County Public Health Department. Over time, the Alameda County Public Health Department engaged the Alameda Alliance for Health (the county's MCO plan), which today offers these services to enrollees.

Many programs piece together a patchwork of Medicaid and non-Medicaid funding for home-based asthma services. In the Alameda example described above, home-based asthma services are funded through a mix of state-sponsored grants, countywide tax measures, Medicaid Targeted Case Management reimbursements, and support from the county MCO plan.

Another innovative way that home-based asthma services can be funded in California is through social impact financing. Social impact financing models can support evidence-based interventions, such as home visits and remediation, that are not traditionally covered

by Medicaid or other health insurers. Interviewees are aware of two promising social financing models being explored or already underway in California, one in Fresno and one in Alameda County.¹⁴ Interviewees are not aware of accountable care organizations (ACOs) or patient centered medical homes currently supporting these services.

Do commercial or private insurers in the state provide or cover home-based asthma services?

Interviewees were not aware of private or commercial insurers who cover or provide home-based asthma services to enrollees.

Barriers to Implementing Home-Based Asthma Services within Medicaid

According to the California Department of Health Care Services (DHCS), as of 2015, over 80% of Medicaid beneficiaries—over nine million individuals—in



THE ASTHMA START PROGRAM ALAMEDA COUNTY, CA

www.acphd.org/asthma.aspx

The Alameda County Public Health Department's Asthma Start Program (Asthma Start) kicked off in 2001 with funding from Every Child Counts/First Five and a focus on delivering in-home case management services related to asthma. Since the founding of the program, various sources of funding have been secured to continue program support.

Asthma Start sends social workers to meet with individuals (infant to 18 years of age) and families affected by asthma in their homes to determine a baseline of understanding about asthma in the household and assess the culture and environment of the home. Initial questions during the home visit may include the following: *Is there asthma medication on hand? Is the medication in the home up to date? Is the medication easily accessible?* Additionally, during the home visit, the social worker will provide an overview of asthma triggers and how to eliminate or reduce them in the home environment. Social workers will then determine what supplies the Asthma Start program can provide for the family to reduce asthma triggers in the home, ranging from vacuums to non-bleach-based mold cleaners. If social workers identify that a program participant requires additional interventions that are beyond the scope of the Asthma Start Program (such as housing, food, and employment), referrals are made to various community-based services, including the Alameda County Healthy Homes program. While each child's progression through Asthma Start is different, depending on their circumstances and needs, a child usually finishes the program in two to three home visits over a three- to six-month timeframe.

Many program participants first come in contact with Asthma Start after a referral from community and county health clinics; these referrals usually happen as a result of patient describing potential asthma triggers in their home. Asthma Start also receives referrals from school truancy officers for children who are missing a significant amount of school because of their asthma. Finally, MCOs refer their high-risk asthma enrollees to Asthma Start services, typically after a child has visited a hospital for an asthma-related emergency. As approximately 40 to 50 referrals are sent to the Asthma Start program each week, conversations regarding program expansion are becoming a necessity.

Asthma Start is currently involved in several efforts to evaluate program impact. Asthma Start social workers collect data on several measures to assess their efforts. For example, social workers administer a pre- and post-test to record asthma symptoms at the beginning and end of the program intervention. Evaluations of the Asthma Start Program in Alameda County show that the program has greatly reduced emergency department visits and hospitalizations among participants, and 95% of children in the program have maintained or reduced their symptoms. These outcomes have led to an estimated return of \$5.00-\$7.00 for each dollar invested. The Asthma Start Program is also part of a new pilot project with the University of California-Berkeley, Impact4Health, and Alameda County Healthy Homes; this pilot will further describe the return on investment for Asthma Start services.

California are enrolled in an MCO plan.¹⁵ Medi-Cal beneficiaries in all 58 California counties receive care through an MCO, although some counties in the state have higher levels of MCO penetration. The state is increasingly looking to expand its Medicaid managed care program to cover more of their existing high-cost populations and services, particularly those beneficiaries with one or more chronic illnesses. California is implementing a new initiative under which more than one million aged and disabled beneficiaries will be required to enroll in Medicaid managed care.¹⁶

Given trends toward managed care, enhancing coverage for asthma services through MCO plans is an important next step for asthma advocates in the state. As evidenced by the three plans in California offering home-based asthma services to plan enrollees, MCO plans can already offer these services as part of their administrative expense budget line. Even though they are not directly reimbursed by Medi-Cal and have to count expenses against their administrative budget, these plans have been motivated to offer such services because of the well-established return on investment of providing asthma management services in the home. Providing preventive services to plan enrollees saves the MCOs money on avoided hospitalizations and emergency department visits. Yet, despite the ability to provide these evidence-based and cost-effective services, MCO plans in only three of 58 counties offer home-based asthma services of any kind. Thus, there may be opportunities for Medi-Cal to encourage or incentivize more MCOs across the state to provide these evidence-based services.

Interviewees described frustration with understanding the reasons why there is not wider implementation of home-based asthma services by MCOs given the strong track record of these services reducing morbidity and reducing costs. Interviewees felt that the business case for these services should entice MCOs to take on comprehensive asthma management programs even without direct reimbursement from Medi-Cal.

Interviewees described several barriers to more MCOs in California implementing home-based asthma programs for enrollees with asthma:

- *Lack of funding for pilot projects.* In many cases, despite the strong evidence for the return on investment for home-based asthma services, MCOs want to do a pilot of their own patient population to be certain that these services will bring improved outcomes and cost savings. Most plans in the state have not put up the resources to implement a pilot, and some have asked whether such pilots can be funded by the state health department, which does not currently have

resources to support such projects. In other cases, MCOs do not seem to be aware of the business case for home-based asthma services.

- *Confusion over Medicaid billing codes.* Some MCOs are concerned about billing codes and whether there are opportunities within existing Medicaid billing codes for reimbursement. The complexity of the Medicaid billing codes and lack of information from Medi-Cal on this issue has served to stymie some MCOs from looking into other opportunities for providing the services, such as through their administrative budget.
- *Workforce concerns.* Another reported factor is concern from MCOs about the type of healthcare workforce appropriate to deliver home-based asthma services. In many instances, it may be appropriate or cost-effective for an asthma educator or healthy home specialist or other similar nonlicensed health professionals/community health workers to provide in-home asthma education and assessments. Reportedly, some health plans conceptually support the idea of nonlicensed health professionals delivering home-based asthma services but have two major concerns: (i) if providers are not licensed, how can the MCO assure service quality; and (ii) in the event that Medi-Cal starts reimbursing for certain home-based asthma services under a Medicaid health home or the 1115 waiver (both described below), would Medi-Cal accept for reimbursement services offered by non-licensed professionals?
- *MCO contracts with medical groups.* It is often difficult to know where decisions about providing services, like home-based asthma services, are made. Reportedly, many MCOs in the state enter into contracts with medical groups to coordinate and provide patient care. Under these scenarios, while the MCO requires the medical groups to meet quality measures, plan administrators do not dictate how quality measures should be met and what types of services are required. Therefore, it may be medical providers who need education on the potential role and impact of home-based asthma services and not the MCOs themselves.
- *Insufficient infrastructure.* Finally, in some regions of the state, there is not sufficient infrastructure in place for an MCO to implement a home-based asthma program for plan enrollees. MCOs have given feedback to the state health department that they cannot implement home-based asthma initiatives without being able to partner with existing programs that have community connections and expertise in providing evidence-based asthma services to high-risk populations.

According to advocates interviewed, it would be helpful for Medi-Cal to take on a leadership role in educating MCOs about the effectiveness of home-based asthma services for Medicaid-eligible populations, both in terms of patient outcomes and cost savings. Medi-Cal could also serve a role in assuring plans that a broad range of providers are appropriate to offer these services to beneficiaries. As of the time of the interviews, Medi-Cal has not taken on this type of education and outreach as a priority, especially given the significant task of enrolling new populations per the Affordable Care Act's Medicaid expansion.

There has been some discussion among advocates in the state as to whether it would be helpful for advocates to go directly to MCOs to make a pitch for home-based asthma services. State health department representatives interviewed also reported an interest in approaching MCOs on asthma services. Currently, the state health department is working to structure a streamlined and coordinated effort to approach MCOs in coordination with other parts of the health department who have similar requests, such as for MCOs offering more comprehensive behavioral health or diabetes management programs.

Future of Medicaid Reimbursement for Home-Based Asthma Services: How Is the State Working to Expand Coverage and Reimbursement?

Moving forward, California is working on several opportunities to improve and increase access to home-based asthma services, including through the state's 1115 waiver renewal, discussions about expanding the role of nontraditional workers, initiatives funded by the CDC National Asthma Control Program, and the state's plan for implementing Health Homes for Patients with Complex Needs:

- *1115 waiver renewal.* California is currently in the process of renewing its Medicaid Section 1115 waiver, which expires October 31, 2015. On March 16, 2015, Medi-Cal released a concept paper explaining the agency's proposed approach to redesigning their waiver.¹⁷ In an effort to capitalize on the Affordable Care Act and to bring forward new delivery system and financing innovation, the concept paper proposes several programs aimed at delivery system transformation and alignment. For example, the waiver's proposed "Whole Person Pilot Program" opens the door to interventions focused on social and environmental factors. Home environmental services may fit into the program. This could represent an opportunity to test out payment models that include the provision of low-cost services and supplies, such as integrated pest management services or mattress encasements.

- *Expanding the role of asthma educators, healthy homes specialists, and other community health workers in the provision of asthma services in California.* California, like many states, is engaging in discussions about how to adopt and implement a new federal Medicaid rule change allowing state Medicaid programs to cover and pay for preventive services provided by professionals that may fall outside of a state's clinical licensure system, so long as the services have been initially recommended by a physician or other licensed practitioner. This rule change means that, for the first time, asthma educators, healthy home specialists, and other community health workers with training and expertise in providing asthma services may seek Medicaid reimbursement.

Interviewees explained that these discussions are ongoing in the state. While the state has submitted a state plan amendment (SPA) related to behavioral health treatments and associated providers, no specific progress toward developing the SPA that would be needed for Medi-Cal to start offering reimbursement for services provided by asthma or other disease-area professionals has been made. Reportedly, the advocacy community is determining whether to put forward a draft of a SPA to help stimulate discussions. While the rule change impacts more than just asthma services, asthma has been front and center in discussions among advocates. Should the state submit a SPA to enable reimbursement for community health workers and other professionals important to asthma care delivery, this could alleviate concerns that some MCOs in the state have over whether these types of professionals are appropriate providers of in-home asthma services.

- *CDC National Asthma Control Program funding.* On September 1, 2014, the CDPH entered a five-year cooperative agreement with CDC to receive funding from the National Asthma Control Program (NACP). In this newest grant cycle with CDC, NACP awardees are asked, among other things, to strengthen and expand asthma control efforts in home settings and to work with health care organizations to promote coverage for and utilization of

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comprehensive asthma control services, including home visits. The NACP asks health departments to work on expansion of home-based asthma strategies in the context of health reform and in partnership with health systems, health insurers, and other stakeholders.

With NACP funding, the CDPH is embarking on a new effort to (i) better understand how Medi-Cal and MCOs in the state reimburse for asthma-related services generally; (ii) summarize the landscape of asthma reimbursement in California; and (iii) develop and disseminate a business case that would be convincing to MCOs to take on coverage of asthma in-home services. Part of building the business case is to learn from counties that have comprehensive coverage for asthma services under Medicaid managed care plans, such as in Alameda County, and to spread these innovative ideas to other counties in the state. Eventually, if funding permits, the health department would like to fund some pilot projects in the state in partnership with MCOs.

The effort underway at CDPH has great potential for addressing key barriers to implementation described above, including helping MCOs in the state to understand the return on investment for home-based asthma services. CDPH's stated goals of disseminating best practices statewide will also equip more MCOs to implement home-based asthma programs for plan enrollees.

- *Medicaid Health Home for Patients with Complex Needs.* Medi-Cal is in the process of designing a SPA to adopt the Medicaid Health Home provisions of the Affordable Care Act.¹⁸ In November 2014, DHCS proposed the Health Homes for Patients with Complex Needs (HHPCN) model, which lists asthma as an eligible chronic condition that may ultimately be selected for inclusion in the program.

The HHPCN model was initially developed under the California State Innovation Model (CalSIM) initiative, which did not secure a State Innovation Model Award from the Centers for Medicare and Medicaid Innovation (CMMI). Despite a failure to receive CMMI funding, the State has determined it will proceed to implement elements of the CalSIM plan, including the HHPCN model. Medi-Cal intends to submit a Section 2703 state plan amendment (SPA) application in summer/fall of 2015.

Medi-Cal intends to include many services under the health home umbrella that are important for persons with asthma, including comprehensive care management, care coordination and health promotion, individual and family support, and

referral to community and social support services. At this stage of the planning, Medi-Cal does not specifically include in-home services for patients with asthma under the HHPCN model design, but certainly a focus on asthma within the state's health home would be a positive step toward Medi-Cal supporting asthma services in the state more comprehensively and holistically.

Lessons Learned

Interviewees describe two major lessons learned from recent efforts in securing additional home-based asthma services in the state. First, Medi-Cal is increasingly moving toward a managed care model. To make positive strides in access to home-based asthma services under Medicaid, stakeholders have to embrace the realities of this shift to managed care. If the state were still under a fee-for-service model, arguments about the need to address asthma disparities or improve quality of care might persuade decision-makers to broaden asthma services for Medi-Cal beneficiaries. However, convincing individual MCOs to adopt these services requires a stronger emphasis on strategies that speak to cost-savings and return on investment.

Second, pushing for statewide policies is not the only approach worth considering. California is a diverse state with diverse needs: what works in one county may not achieve success in other counties across the state. For example, part of the success of the Asthma Start Program in Alameda County is in working with truancy officers in the school system to get additional program referrals for high-risk asthma patients. This type of communication between the health department and school system may not be possible in other counties where the health department and school districts have fewer resources to invest in tracking students with asthma. Policies may need to strike a balance between achieving state-level progress while maintaining flexibility to allow for local innovation.

ACRONYMS

ACO	<i>Accountable care organization</i>
CaISIM	<i>California State Innovation Model</i>
CDPH	<i>California Department of Public Health</i>
CHW	<i>Community health worker</i>
CMMI	<i>Centers for Medicare and Medicaid Innovation</i>
DHCS	<i>Department of Health Care Services</i>
HHPCN	<i>Health Homes for Patients with Complex Needs</i>
MCO	<i>Managed care organization (also MCP, managed care plan)</i>
NACP	<i>National Asthma Control Program</i>
SPA	<i>State plan amendment</i>
TCM	<i>Targeted Case Management</i>

DEFINITION OF SERVICES

Home-based asthma services

The original survey that formed the basis for these follow-up case studies used the *Community Guide to Preventive Services* definition of home-based, multitrigger, multicomponent asthma interventions. These interventions typically involve trained personnel making one or more home visits and include a focus on reducing exposures to a range of asthma triggers (allergens and irritants) through environmental assessment, education, and/or remediation. See Appendix A of *Healthcare Financing of Healthy Homes: Findings from a 2014 Nationwide Survey of State Reimbursement Policies*² for the full definition.

About the Project

This multiyear project is working to document and demystify the landscape and opportunities surrounding healthcare financing for healthy homes services. In year one of the project, the National Center for Healthy Housing (NCHH) conducted a nationwide survey to identify states where healthcare financing for lead poisoning follow-up or home-based asthma services was already in place or pending. In year two of the project, NCHH and a project team led by the Milken Institute School of Public Health conducted a series of interviews in key states identified by the survey. An interview guide was developed to ask key informants in each state questions about the extent and nature of Medicaid-supported services within the state, details of services covered, barriers to implementation, next steps for expanding services and increasing access, and lessons learned. In each state, the project team conducted interviews with at least one representative from the state Medicaid agency, a program contact in the state health department, and one to two additional stakeholders (e.g., advocates, local programs, payers, or providers). The interviews were used to develop detailed case studies to distill lessons learned in states with Medicaid reimbursement for healthy homes services and ultimately to better equip other states in seeking reimbursement for these services. In California, the project team conducted interviews with representatives from the Alameda County Health Department, California Department of Health Care Services, California Department of Public Health, and Regional Asthma Management and Prevention.

For more information: www.nchh.org/Program/DemystifyingHealthcareFinancing.aspx.

Endnotes and Sources

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Asthma Case Study #1 Healthcare Financing for Healthy Homes

We gratefully acknowledge the following organizations for providing information for this case study:

Alameda County Health Department
California Department of Health Care Services
California Department of Public Health
Regional Asthma Management and Prevention

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

This case study was made possible through a contract between the American Public Health Association and the National Center for Healthy Housing, funded through cooperative agreement 1U38OT000131 between the Centers for Disease Control and Prevention and the American Public Health Association. The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of the American Public Health Association or the Centers for Disease Control and Prevention.