



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

A large body of evidence suggests that home visiting programs that address indoor environmental triggers (e.g., cockroaches, mice, tobacco smoke, and 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 New York 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 New York State interested in a summary of current and future opportunities within the state.



AT A GLANCE

Medicaid Reimbursement for Home-Based Asthma Services in NY

Medicaid in New York

The New York State Department of Health's (NYSDOH) Medicaid program, the nation's largest by expenditure, began enrolling certain Medicaid-eligible populations in managed care in 1997. Over time, the state has transitioned additional populations to managed care. All 62 counties in New York have implemented a mandatory managed care program for certain beneficiary populations. Approximately 72% of beneficiaries are enrolled in a managed care plan as are over 92% of children and nondisabled adults.

Medicaid and MCO Coverage for Home-Based Asthma Services^{a,b}

Reimbursement type (page X): While some MCOs report providing home-based asthma services, there is no statewide Medicaid benefit for these interventions. The state's Medicaid program only explicitly covers *clinical* interventions for asthma under its fee-for-service (FFS) benefits and does not require that MCOs provide these services. However, interviewees noted that managed care plans can still elect to cover and provide home-based asthma services, and multiple MCOs in the state currently or have previously done so. At least one MCO covered these services as an administrative expense; most have provided them through partnerships or referrals to local health departments or community agencies or organizations, meaning that NYSDOH Medicaid does not reimburse MCOs directly for these services. Finally, through an 1115 Medicaid waiver approved in 2014, the state is reinvesting savings generated by healthcare reform into a Delivery System Reform Incentive Payment (DSRIP) program, which is funding seven projects across the state to provide home-based asthma services.

Geographic coverage (page X): Limited: Only a few MCOs cover or have previously covered some home-based asthma services.

Eligibility for services (page X): Adults and children, generally targeted towards higher-risk members.

Types of services covered (page X): Generally limited to self-management education, education about triggers in the home environment, visual assessments, and referrals to specialists or other community-based services and supports.

Staffing (page X): Nurses, respiratory therapists, other licensed professionals certified as asthma educators, and non-licensed outreach workers. Many of the pending DSRIP initiatives have proposed using community health workers (CHWs) to deliver services.

Barriers and Next Steps for New York (pages 6-8)

Interviewees described a range of barriers to increasing the number of MCOs that provide home-based asthma services, including a need for economic evaluations that use a payer perspective, lack of infrastructure for delivering services, inconsistencies in provider referrals, restrictions on payments for asthma educators, Medicaid policy restrictions, and nonstandardized training for providers. Moving forward, seven DSRIP-funded projects have designed projects to address home-based asthma services that, if successful, could become part of broader implementation across the state.

Other Funding Mechanisms in New York (page 5-6)

As Medicaid support for home-based asthma services is limited, many programs across the state rely on other public and private funding streams (such as state or private foundation grants) or innovative partnerships to ensure program sustainability.

Key Insights from New York (page 8-9)

Foundation dollars have been valuable in spurring MCOs in New York to invest in asthma management initiatives; these resources have pushed MCOs to focus on asthma and provide an opportunity to learn whether home-based asthma programs lead to a positive return on investment. State-funded initiatives, ranging from quality incentive payments for managed care organizations to the state-funded Healthy Neighborhoods Program and regional asthma coalitions, have also provided critical resources. To spur innovation, provide services in high-risk communities, and generate evaluation data. Finally, the DSRIP process is encouraging the development of innovative collaborations which may lead to successful payment models of interest to MCOs across the state.

Medicaid in New York

In New York State, the Medicaid program is administered by the Office of Health Insurance Programs, within the New York State Department of Health (NYSDOH). The state's Medicaid program, the nation's largest by expenditure, began enrolling certain Medicaid-eligible populations in managed care in 1997. Over time, the state has transitioned additional populations to managed care. All 62 counties in New York, including the five counties that make up New York City, have implemented a mandatory managed care program for certain beneficiary populations. Populations covered by managed care vary from county to county, but the majority (approximately 72%) of beneficiaries in the state are enrolled in a managed care plan (as of August 2015, just over 4.6 million individuals were enrolled in an MCO out of approximately 6.4 million total Medicaid/CHIP beneficiaries).^{3,4} Over 92% of children and nondisabled adults are enrolled in an MCO plan.⁵

^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.

While one-third of beneficiaries – more commonly referred to as “members” in New York State – currently receive services through fee-for-service (FFS) arrangements, the trend in New York is toward managed care. As the state implements the recommendations of the NY State Medicaid Redesign Team (MRT; described in further detail below) more Medicaid-eligible populations in the state will be transitioned into specialized managed care arrangements with the goal of “care management for all.”^{6, 7} By eliminating exemptions and exclusions for special populations not previously subject to mandatory managed care enrollment and by shifting services that have remained outside of managed care benefit packages (such as pharmacy benefits) into the capitated plan rates, the state will move most Medicaid beneficiaries and services remaining in FFS into some form of managed care.^{8, 9} Ultimately, New York aims to enroll 95% of the Medicaid population in managed care by 2018, with certain very limited populations remaining in FFS.¹⁰

Medicaid and MCO Coverage for Home-Based Asthma Services^b

As reported in a 2014 survey conducted by the National Center for Healthy Housing and the Milken Institute School of Public Health, Medicaid-supported coverage of home-based asthma services exists in New York but is limited in scale.

Given that almost all Medicaid beneficiaries are enrolled in managed care, or will be by 2018, MCOs in New York are the primary providers of asthma services. At minimum MCOs in New York are required to cover that which is covered under FFS Medicaid. There is no benefit under FFS for home-based asthma interventions; Medicaid only covers *clinical* interventions for asthma, with referral to a health department or community agency for home assessment, in accordance with guidelines developed by the *NYS Consensus Asthma Guideline Expert Panel*.^{11, 12}

Without any FFS requirement for home-based asthma coverage, MCOs in the state are not obligated to provide these services, and NYSDOH does not otherwise require, through the managed care contracting process, that MCOs address management of home-based asthma triggers. MCOs can offer

benefits beyond FFS requirements, but these benefits are counted as an administrative expense.^c While a few MCOs partner with home care agencies that provide in-home asthma management services for high-risk patients, interviewees were able to provide detail about only one MCO – *YourCare Health Plan run by Monroe Plan for Medical Care* (see text box) – that covers comprehensive home-based asthma services (i.e., those that include home environmental assessments). One interviewee noted an awareness of MCOs that reported having a policy to cover home-based asthma services but lacked an infrastructure to deliver services or refer patients to established programs. However, covering services through administrative expenses or referrals and partnerships with community-based organizations means that, although there is some coverage of home-based asthma services in New York, Medicaid does not directly reimburse for these expenses.

Although NYSDOH does not promote home-based asthma interventions under managed care, it has previously supported asthma quality improvement initiatives. All MCOs are required to conduct one Performance Improvement Project (PIP) annually in a priority topic area. In the past, NYSDOH has encouraged plans to focus on reducing disparities in asthma care and preventing avoidable hospital readmissions.¹³ At least one MCO used quality incentive support to expand the geographic scope of their home-based asthma services.¹⁴ While these types of projects have not focused exclusively on services in the home, NYSDOH has held conferences on asthma to present data from this work facilitating the sharing of best practices among MCOs on successful quality improvement initiatives related to asthma, including home-based asthma services.¹⁵

What home-based asthma services are provided?

According to interviewees, most MCOs in the state do not provide services for asthma management beyond clinical asthma education and referrals to community-based organizations for additional community-based care.¹⁶ A few MCOs partner with home care agencies to provide members with high-risk asthma access to asthma management services in their homes, but these programs do not always include environmental assessment of asthma triggers. For example, in 2014,

^c Medicaid MCO program costs can be classified as a medical service or administrative expense. Medical services are reimbursable by Medicaid and include the various clinical services offered by physicians and other practitioners in health centers, laboratories, and in inpatient/outpatient hospital settings. Administrative expenses cover nonmedical activities important for MCO operations, such as enrollment, advertising, claims processing/billing, and patient grievances/appeals. These types of services are paid for from plan revenue. Administrative expenses also include medical management services and quality improvement activities, such as coordinating and monitoring services for Medicaid recipients. Home-based asthma interventions often fit this category of plan spending. An MCO may be motivated to cover certain medical management services and quality improvement activities under its administrative budget (in other words, investing what would otherwise be profit back into patient care) if these services save it significant dollars elsewhere, such as by reducing urgent care costs.

Affinity Health Plan started a pilot asthma initiative in partnership with a home care agency to offer two in-home asthma visits to high-risk asthma patients; these visits are limited to education on medication and asthma action plan adherence, and the pilot does not include home environmental assessment.¹⁷

Under the original Monroe Plan for Medical Care's/YourCare Health Plan's (Monroe/YourCare) asthma management program, more comprehensive coverage for home-based asthma interventions is part of the model, including home environmental assessment. The services supported by this model focuses on asthma self-management education, home assessment to identify asthma triggers and discuss mitigation strategies, and referrals to specialists or other community-based services and supports.

Interviewees were not aware of instances in which MCOs have covered, or Medicaid has otherwise reimbursed for, supplies or remediation services needed to mitigate asthma triggers in the home. While the Monroe/YourCare model does not offer environmental mitigation services, the plan will be providing some of those services through its social financing project (see text box), but this effort is funded through private foundation dollars and not with Medicaid funding.

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

According to interviewees, where asthma disease management services are available, most MCOs in New York require pre-authorization with a clearly defined need, for example hospitalization or re-hospitalization for poorly controlled asthma, and/or non-compliance with an asthma action plan. For example, members are identified for participation in Affinity Health Plan's pilot asthma initiative (described above) if they have paid claims associated with an asthma diagnosis and have had at least one asthma-related emergency department or inpatient admission in the last two years.

What types of providers are eligible to provide home-based asthma services? How are these professionals trained to address asthma triggers in the home?

In New York, nursing professionals are the frontline of home-based asthma services. Where MCOs partner with home care agencies for home-based asthma management, services are provided by a licensed registered nurse (RN), a nurse with bachelor's degree (BSN), or a licensed respiratory therapist. Where hospitals work to address asthma under community benefit obligations (see further description below), hospital systems deploy nurses into home settings. Interviewees are only aware of at least one

circumstance (Monroe Plan for Medical Care, see text box) where nurses team with nonlicensed outreach workers to deliver home-based asthma services to Medicaid recipients. Other non-Medicaid programs that offer home-based asthma services (see further descriptions below) employ an array of nonlicensed professionals, including environmental health specialists, sanitarians, health educators, community health workers, and other public health professionals, and most of the pending DSRIP initiatives include community health workers (CHWs) as part of the proposed care team.

For some MCOs, nurses and other licensed professionals providing asthma management services may be required to become Certified Asthma Educators (AE-Cs), and/or they may receive training on home-based asthma management through a program led by a NYS-funded regional asthma coalition or a public health department.¹⁸ New York was the first state to enact payment for AE-Cs to provide asthma education. However, only nurses, respiratory therapists, or other New York State-licensed professionals (such as pharmacists or physicians) are eligible for reimbursement in the state and education must be provided in the clinical setting.¹⁹

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

As Medicaid support for home-based asthma services is 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 interviews, many 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. Selected examples include:

- *Little Sisters of the Assumption Family Health Service (LSA)* operates a home-visiting program to combat high-risk asthma in East Harlem, New York. In the 12-month program, CHWs conduct home environmental assessments, providing families in need with equipment (e.g., HEPA filters and safe cleaning products) and some remediation services, including mold abatement and integrated pest management services.²⁶ Like other similar programs in the state, LSA is funded with a combination of federal and private grant funding.
- *Foundation dollars* have also supported MCOs in the state to offer more comprehensive asthma services. In 2001, the Robert Wood Johnson Foundation (RWJF) supported five MCOs, including three in New York State (Affinity Health Plan, HealthNow NY, and Monroe Plan/YourCare), with three-year grants to collaborate with local health



MONROE PLAN FOR MEDICAL CARE'S YOURCARE HEALTH PLAN: Improving Asthma Care for Children

Interviewees cite the Monroe Plan for Medical Care/YourCare Health Plan (Monroe Plan/YourCare) as demonstrating best practices in asthma management programs. The program targets members with moderate-to-severe asthma and offers comprehensive education and home assessment for patients: Culturally competent outreach workers visit children and adults in their homes to conduct an assessment to identify asthma triggers and discuss mitigation strategies, and nurses provide follow-up education with patients as needed to reinforce clinical recommendations.²⁰ The program also offers asthma management education to healthcare providers and gives assistance to providers in creating asthma action plans for patients.

Before implementing their disease management program, Monroe Plan/YourCare participated first in *Improving Asthma Care for Children*, a program sponsored by the Robert Wood Johnson Foundation (RWJF) in 2001,²¹ and then in the *Business Case for Quality*, a demonstration project developed by the Center for Health Care Strategies and funded by RWJF and The Commonwealth Fund in 2004.²² Using quality incentive support from the NYSDOH Medicaid program, Monroe/YourCare was able to take lessons learned from these pilot projects to develop a comprehensive asthma management strategy and expand the geographic scope of their home-based asthma service. Monroe/YourCare's intervention has successfully reduced asthma-related acute care among members with pediatric asthma: Over the first three years of the program, ER visits decreased from 1.1 visits per person to .95 visits per person; inpatient admissions decreased from 98.3 admissions per thousand to 84.15 per thousand.²³ In 2008, the U.S. Environmental Protection Agency recognized the Monroe Plan with the National Environmental Leadership in Asthma Management Award.²⁴

Monroe Plan has recently undergone administrative changes that impact its program's reach. For 27 years, Monroe Plan, an independent practice association, partnered with Excellus BlueCross BlueShield to administer Excellus' Medicaid managed care and Child Health Plus programs to enrollees in Rochester and the Finger Lakes and Southern Tier regions in upstate New York. As of August 1, 2015, Monroe Plan and Excellus BCBS ended their relationship, and Monroe no longer administers Excellus' plans.²⁵ Currently, the plan Monroe Plan offers its asthma care program as YourCare Health Plan, a prepaid health services plan that provides Medicaid managed care and Child Health Plus programs to approximately 55,000 enrollees in Buffalo and the Western New York region.

With the coming implementation of New York State's Health Homes Designated to Serve Children program, Monroe/YourCare's model will be undergoing some modification to enhance the coordination of outreach activities with the children's health homes and other community agencies in order to minimize member confusion and the redundancy of services. Through the change, the Monroe Plan/YourCare has continued its asthma initiative and intends to distinguish itself again as a large and robust program. Monroe is currently participating in a feasibility study in the Buffalo region to determine whether and how to implement a social impact financing model for asthma that would offer home assessment as well as trigger remediation (see description below).

systems and community-based organizations to spur innovative asthma management practices, including healthy homes components.²⁷ Affinity Health Plan and Monroe Plan participated in a second round of RWJF funding in 2004 (the *Business Case for Quality*, see text box). Affinity Health Plan and Monroe Plan/YourCare have both continued to focus on lessons learned from these pilot programs (with Monroe's approach being much more comprehensive than the current approach by Affinity, as described elsewhere in this case study), but HealthNow NY has not maintained their asthma program beyond providing clinical education.²⁸

- **New York State Healthy Neighborhoods Program.** Interviewees discussed many sources of private funding, but only one major source of state funding. The New York Department of Health's Center for Environmental Health runs the New York State Healthy Neighborhoods Program. The Healthy Neighborhoods Program focuses on improving

housing conditions for the state's most vulnerable communities through a holistic, healthy homes approach.^{29, 30} While centrally managed at the state level and funded through the NYS General Fund, services are delivered through grant-funded local health departments.

The Healthy Neighborhoods Program offers home assessments to residents and targets high-risk communities (identified using housing, health, and socioeconomic indicators from census and surveillance data), using a combination of door-to-door canvassing and referrals to reach residents. Home assessments are conducted by environmental health specialists – sanitarians, health educators, public health nurses, or other public health professionals with training in healthy homes interventions – and address a host of healthy homes issues, including tobacco control, lead poisoning prevention, indoor air quality, injury prevention, and asthma. One-quarter of the homes assessed receive

an optional three- to six-month reassessment to identify any new or ongoing problems and to work with residents on remediation strategies.

The program does not pay for home remediation or pest management services to address asthma triggers, but residents are provided educational materials and referrals to other community resources following the home assessment. Interviewees were aware of at least one county Healthy Neighborhoods Program wherein environmental health specialists double as housing code enforcement officers; in these cases, when home assessments are conducted for families that are not homeowners, code enforcement officers have jurisdiction to force landlords to abate unsafe housing conditions, including those that contribute to poorly controlled asthma.

The Healthy Neighborhoods Program is not a case management program, and it relies heavily on community-based partners to help remediate asthma triggers and on clinical partners to incorporate home environmental management into usual medical care for asthma. To engage these partners, funded health departments employ a number of strategies, including but not limited to:

Collaborations with managed care plans. Between 2007-2010, the Healthy Neighborhoods Program in Erie County forged a unique relationship with the state Medicaid program and four regional managed care plans to develop and implement a pilot program to integrate management of environmental triggers into routine asthma care. Here, participating health plans used hospitalization, emergency department utilization, and medication usage data to identify patients with poorly controlled asthma, referring these patients to the Healthy Neighborhoods Program services.³¹ This program was known as the Healthy Home Environments for New Yorkers with Asthma (HHENYA) Program. While state funding supported the local Healthy Neighborhoods Program, the HHENYA pilot was created, coordinated, and evaluated using funding from the CDC National Asthma Control Program. Notably, findings from the HHENYA pilot formed the basis for the NYSDOH's incorporation of home-based asthma services into the state's Medicaid waiver, described elsewhere in this document.

Collaboration with providers. Some programs partner with hospital programs that work to address asthma under community benefit obligations.³² Funding from the CDC's National Asthma Control Program has provided support to two Healthy Neighborhoods Program locations to

expand the asthma component of the home visit and to build bidirectional referral systems, further linking and integrating community-based asthma programs with clinical care.

Collaboration with regional asthma coalitions. Interviewees also described the importance of collaboration between the Healthy Neighborhoods Program and the eight regional asthma coalitions in the state. These coalitions work to mobilize local resources to support healthy homes efforts.

Interviewees cited the Healthy Neighborhoods Program as the most important program in the state for addressing asthma among vulnerable residents. The New York State Healthy Neighborhoods Program has operated since 1985 and reaches nearly 7,000 homes every year, making it a significant provider of services in both its stability and reach within high-risk communities. However, the program is still not available statewide, funding only 18 of 62 counties in the state. Despite its limited reach, evaluations of the program show successful reductions in asthma-related hospitalizations and emergency department visits among program participants, and corresponding savings in healthcare utilization, based on a soon-to-be-released cost-benefit analysis of the program.^{33, 34}

Barriers to Implementing Home-Based Asthma Services within Medicaid

ROIs that monetize societal benefits may not be compelling to MCOs. While home-based, multitrigger, multicomponent asthma interventions have been recognized by the Task Force on Community Preventive Services as providing a strong return on investment (ROI),³⁵ interviewees explained that for many MCOs in New York, the evidence base may not be convincing enough for investing in a comprehensive home-based asthma management program. The problem is that much of the ROI associated with the studies evaluated by the Community Guide depends on indirect savings that accrue to the community (e.g., reduced school absenteeism and reduced missed work days by caregivers); these types of savings, while important for communities, do not amount to direct healthcare savings reflected on an MCO's bottom line. In addition, where health savings are possible (e.g., reduced emergency department visits and hospitalizations), these are coupled with increased expenditures for program implementation (e.g., training and hiring asthma educators) and increased primary care and pharmaceutical costs (when high-risk patients are linked to needed health services). Given these considerations, for-profit plans that have a responsibility to shareholders may not have the

incentive to embrace asthma home-based management interventions despite the potential for ROI. Interviewees opined that nonprofit health plans (such as Monroe Plan for Medical Care/YourCare Health Plan) may be more willing to adopt such interventions for the benefit of the community. In 2010, the Asthma Regional Council of New England reported that among multiple MCOs reporting a positive ROI for home-based asthma services, the Monroe Plan realized a modest ROI of \$1.48 saved in direct medical costs for every dollar invested in their asthma management program.³⁶ This suggests that a heavier emphasis on ROIs with a payer perspective, those that do not monetize societal benefits, may be more compelling to payers within the state.

Lack of infrastructure to provide services and inconsistencies in provider referrals. Interviewees described challenges that home-based asthma programs (both MCO-funded and public/private grant-funded) have faced in getting patients connected to available services. One interviewee noted awareness of multiple MCOs that claimed to have a policy “on the books” to provide home-based asthma services but failed to provide services to any patients due to a lack of established vendors to provide services in the home. Likewise, other programs reported challenges getting some hospitals in the state to routinely refer high-risk asthma patients to existing community-based services. This is significant because even where home-based asthma services are technically available, patients remain unconnected to these critical supports to help improve control of their asthma. Interviewees anticipate that with further implementation of the Affordable Care Act and emphasis on asthma through the Delivery System Reform Incentive Payment (DSRIP) program (described below), hospitals and MCOs will be more encouraged to connect patients to community-based resources.

Restrictions on Asthma Certification: Impact on Rural Areas. While any qualified person can become a certified asthma educator (AE-C) in the state, only nurses, respiratory therapists, or other licensed professionals (such as pharmacists or physicians assistants) with the AE-C designation may register with Medicaid as a provider of asthma self-management training (ASMT). This restriction may disincentivize nonlicensed health professionals, such as community health workers (CHWs), from attaining the AE-C designation; and, according to interviewees, this restriction may impact the availability of a trained

workforce to address asthma in rural areas. There are very few AE-Cs registered with NYS Medicaid, and most such professionals are concentrated in urban areas of the state.³⁷ While one interviewee stated that it would benefit patients in rural and underserved areas to allow CHWs who attain an AE-C designation to become Medicaid-registered, other interviewees stated concern that CHWs are not the most appropriate workforce to address the myriad of complex issues patients with high-risk asthma face. However, all interviewees described the importance of the CHW workforce in serving communities in need, and were supportive of New York developing models of asthma training for CHWs generally.

Medicaid Reimbursement Policy.

Although AE-Cs are qualified to provide services to patients in any setting, state Medicaid rules require AE-Cs to be associated with a healthcare clinic/hospital to receive Medicaid reimbursement. While an AE-C could be associated with a clinic/hospital and still practice in a home or other community setting, interviewees report that this reimbursement restriction tends to limit the services of AE-Cs to clinical settings in most circumstances.

Training for Home-Based Asthma Services Is Not Standardized. Across the state, training for providers that conduct home-based asthma services is not standardized. Some providers are designated as AE-Cs and registered with Medicaid, but CHWs and other providers working in many community-based programs (supported through public health dollars or private funding) receive training on home-based asthma management through a program led by a regional asthma coalition, hospital partner, or a public health department. Interviewees described the wide variety across the state in these training programs and lack of uniformity in the profession of providers that conduct home-based asthma services. Moving forward, stakeholders may have to decide whether there should be some standards for CHWs and other providers who offer home-based asthma management services, and, if so, what standardization should look like.

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

Delivery System Reform Incentive Payment (DSRIP) Program. In January 2011, Governor Cuomo issued an executive order to establish the NY State Medicaid Redesign Team (MRT), a team of stakeholders

representing diverse sectors within the healthcare delivery system, responsible for proposing a multiyear reform plan to lower healthcare spending and improve the quality of health services delivered in the state.³⁸ By implementing recommendations made by the MRT (including imposing a global spending cap and moving more beneficiaries into managed care), NY produced \$17.1 billion in federal Medicaid savings. An 1115 Medicaid waiver approved in 2014 allows the state to reinvest, over a five-year period, \$8 billion of the federal savings generated by MRT reforms.³⁹ Of this funding, \$6.42 billion is allocated to the Delivery System Reform Incentive Payment (DSRIP) program.

The purpose of DSRIP is to fundamentally restructure the healthcare delivery system in New York by reinvesting in the Medicaid program and promoting community-level collaborations, with the primary goal of reducing avoidable hospital use by 25% over five years. The state has approved 25 Performing Provider Systems (PPSs)^d to implement DSRIP projects in every county in the state. PPSs developed DSRIP project plans by conducting a community assessment of need, and then selecting between five and 11 project focus areas from a pre-approved list of over 40 potential projects.⁴⁰ As asthma is a driver of avoidable hospital and urgent care use, DSRIP promotes three different asthma-specific projects that can be implemented by PPSs.⁴¹

Two of the asthma-specific project areas focus on improving evidence-based asthma care in clinical settings, the first promoting medication adherence programs, and the second promoting the implementation of evidence-based medicine guidelines for asthma management. The third asthma-specific project approved for DSRIP implementation promotes asthma management services in home settings; according to interviewees, the inclusion of this home-based self-management program was driven, at least in part, by the HHENYA pilot project referenced earlier in this case study.

3.d.ii: Expansion of asthma home-based self-management program. The objective of this project is to “ensure implementation of asthma self-management skills including home environmental trigger reduction, self-monitoring, medication use and medical follow-up to reduce avoidable ED and hospital care.”⁴² PPSs that select this project area must partner with home care or other community-based organizations

^d PPSs are groups of providers required to collaborate to implement innovative projects focusing on system transformation, clinical improvement, and population health improvement. PPSs can include both major public hospitals and certain “safety net providers,” which includes health homes, clinics, federally qualified health centers, community based organizations, and others.

to develop a comprehensive home-based asthma management program that includes self-management education, home assessment, and remediation of asthma triggers.

Seven PPSs designed DSRIP projects to address asthma home-based self-management. Many of these projects support using nontraditional providers to deliver home-based asthma care. For example, Stony Brook University Hospital has designed a project to incorporate community health workers (CHWs) into their patient-centered medical home team to offer four or five home visits over six months to children with high-risk asthma.⁴³ Under this project, CHWs will offer asthma home assessment services and self-management education, and will link patients to resources for trigger reduction interventions (such as mold abatement or integrated pest management). Other projects propose using CHWs to conduct a similar scope of services. Most of the projects proposed under this domain do not support trigger remediation services beyond making referrals to external (non-DSRIP-funded) programs. However, according to interviewees, several PPSs specifically propose to use DSRIP funding to engage a community-based organization to offer a culturally competent, home-based assessment program that includes trigger reduction interventions.⁴⁴ DSRIP encourages PPSs to engage and collaborate with ongoing projects in their region, and all of the PPS projects under this domain propose to coordinate efforts with NYS regional asthma coalitions.

Although only seven of the 25 PPSs chose to focus DSRIP funding on home-based asthma services, interviewees noted that the PPSs implementing these projects are large and represent a broad catchment area. Interviewees are hopeful that these projects will be far-reaching and will fill gaps in asthma care across the state. One interviewee noted that the ability of DSRIP projects to create service models that build on local resources and capacity could be essential to overcoming the challenge of MCOs or other providers who are willing to provide a home-based asthma service benefit but lack a ready-made infrastructure.

DSRIP projects are still in their infancy stages – reportedly, the Stony Brook project mentioned above is in the process of training CHWs to perform home environmental assessments – but eventually, DSRIP payments to PPSs will be based on performance linked to achievement of project milestones. Along with collecting data on performance measurement, the state is planning a formal evaluation of all initiatives funded through DSRIP, in effort to learn where there are opportunities to drive down costs and improve care quality. Where projects are successful, they could

become part of broader implementation across the state, including within the Medicaid program.

Social Impact Financing. Social impact financing models (including Social Impact Bonds and Pay for Success contracts) are an emerging mechanism to fund home-based asthma services.⁴⁵ In its most basic form, private investors participating in these initiatives pay the upfront costs for providing social services (such as home visits and remediation to address asthma) and have the opportunity to share in any savings generated to the health sector (typically an insurer or hospital system) as a result of decreased healthcare expenditures. Social impact financing models have been used in other states to support home-based asthma interventions, and a feasibility study is underway in Buffalo, NY, to determine whether such a financing model would be appropriate for implementation in this region.⁴⁶ The Green and Healthy Homes Initiative and the Calvert Foundation are spearheading this effort, partnering with the Community Foundation for Greater Buffalo and the YourCare Health Plan (Monroe Plan).

According to interviews, if the feasibility study goes well, this project should start in mid-2016. The project intends to target high-risk children with asthma enrolled in the YourCare Health Plan (allowing remediation services to occur more readily). It is still to be determined how this project will interact with Monroe/YourCare's asthma management program; interviewees explained that there is a desire to integrate all of this work, but the details have not been finalized.

Expanding the Role of Asthma Educators, Healthy Homes Specialists, and Other Community Health Workers in the Provision of Asthma Services in New York. Many states are engaging in discussions about how to adopt and implement a new federal Medicaid rule change that allows state Medicaid programs to cover and pay for preventive services provided by professionals that may fall outside of a state's clinical licensure system – such as asthma educators,

healthy home specialists, and other CHWs – so long as the services have been initially recommended by a physician or other licensed practitioner. Interviewees reported that New York has engaged in some discussion around implementing this rule change but that the state has moved in the direction of DSRIP and through this mechanism is testing models of care using a nontraditional workforce (such as the community health workers effort underway at Stony Brook University Hospital, as described above). Given DSRIP efforts, the state is unlikely at this time to pursue changes to the state Medicaid plan to incorporate the federal rule change.

The Centers for Disease Control and Prevention's 6|18 Initiative. CDC is spearheading an initiative to align evidence-based preventive practices with emerging value-based payment and delivery models.⁴⁷ Asthma has been identified as one of six common and costly health conditions and home-based asthma services as one of 18 proven interventions to improve health and control healthcare costs. New York is participating in this initiative, which provides state Medicaid programs with technical assistance to help implement priority interventions.

Lessons Learned

Foundation dollars have been valuable in spurring MCOs in New York to invest in asthma management initiatives. In the case of Monroe Plan/YourCare, the plan was able to take lessons learned from an RWJF-funded pilot project to develop a comprehensive home-based asthma management program. While foundation support is not necessary – MCOs can elect to cover and pay for home-based asthma services through their administrative budgets – foundation dollars (or support from other state/federal resources) may push MCOs to focus on asthma and give health plan leadership an opportunity to learn whether such programs lead to a positive return on investment. Helping MCOs better understand how in-home asthma services impact their specific patient population may help plans overcome concerns about return on investment for asthma programs.

State-funded initiatives have also provided crucial support in at least three ways. The state Medicaid quality incentive payments and forums for sharing best practices have supported at least one MCO in expanding their offerings of home-based asthma services. Additionally, state-funded healthy home and asthma intervention programs provide access to services in high-risk communities. The New York State Healthy Neighborhoods Program has operated since 1985 and reaches nearly 7,000 homes every year, making it a significant provider of services in both its stability and

The DSRIP initiative in New York is an opportunity to further engage MCOs and healthcare providers in ensuring that home-based asthma services are available to the patients that need them most.

reach within high-risk communities. State-funded programs have also provided an opportunity to pilot delivery models and evaluate specific questions about the viability and promise of home-based asthma services to improve health and provide healthcare savings.

Finally, New York's current efforts to restructure the healthcare delivery system via the DSRIP initiative is an opportunity to engage MCOs and healthcare providers further in ensuring that home-based asthma services are available to the patients who need them most. However, the DSRIP initiative does not change Medicaid regulations requiring many asthma services to be delivered by licensed professionals. This may present a challenge for broader implementation of the DSRIP projects that are testing home-based asthma services. Should the projects that are integrating CHWs into the management of asthma prove successful (e.g., that these programs reduce hospitalizations and ED visits while delivering quality care to patients with asthma), current Medicaid

regulations could be re-evaluated for their further adoption. Absent regulatory change, these efforts may not be sustainable when DSRIP funding ends.

However, under all DSRIP projects, PPSs are expected to coordinate and communicate with MCOs, primary care providers, health home providers, and specialty providers to ensure continuity and coordination of care. PPSs are currently exploring different types of value-based payment arrangements with MCOs around chronic care models (bundling, per-member per-month capitated payments, et cetera), and exploration of various approaches to funding asthma home-based services may lead to a successful payment model that will be of interest to MCOs across the state. In an ACO model, asthma home-based services could be included among the covered benefits to reduce avoidable emergency department and hospital utilization. In this way, the DSRIP process may yield adoption of home-based asthma initiatives by MCOs without regulatory changes or foundation support.

ACRONYMS

AE-C	<i>Certified Asthma Educator</i>
CHW	<i>Community Health Worker</i>
DSRIP	<i>Delivery System Reform Incentive Payment</i>
HHENYA	<i>Healthy Home Environments for New Yorkers with Asthma</i>
LSAFHS	<i>Little Sisters of the Assumption Family Health Service</i>
MCO	<i>Managed Care Organization</i>
MRT	<i>New York State Medicaid Redesign Team</i>
NYSDOH	<i>New York State Department of Health</i>
PPS	<i>Performing Provider System</i>
RWJF	<i>Robert Wood Johnson Foundation</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 years two and three 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.

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

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Asthma Case Study #3 Healthcare Financing for Healthy Homes

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

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