



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

A large body of evidence suggests that home visiting programs addressing 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.<sup>1</sup> 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 Washington State for home-based asthma services with an emphasis on public financing. The case study is based on survey findings<sup>2</sup> and interviews with public health agencies, local asthma advocates, and other stakeholders. It describes the current healthcare landscape, other important funding mechanisms, key barriers, next steps, and lessons learned. For this case study, we focus special attention on tribal communities living in the state of Washington. This information may be useful to stakeholders in other states that are seeking healthcare financing for home-based asthma or other preventing services, or for stakeholders within Washington interested in a summary of current and future opportunities within the state.



## AT A GLANCE

### Medicaid Reimbursement for Home-Based Asthma Services in WA

#### **Medicaid and Indian Health Services in Washington State**

Approximately 1.8 million individuals are enrolled in the Washington State Medicaid program. Medicaid is an important source of health insurance for American Indian/Alaska Native (AI/AN) populations in the state, with 29% of this population enrolled in Medicaid. While AI/AN populations have access to the tribal and urban Indian health facilities funded through the Indian Health Service (IHS), because there is no IHS hospital in Washington, all inpatient care and a large majority of specialty care (including asthma care) is provided outside of the IHS system. Additionally, as 45% of the AI/AN population lives in urban areas, usual healthcare services are likely accessed outside of IHS or tribal facilities. Therefore, Medicaid-participating hospitals and providers outside of the IHS system are important sources of care for tribal communities. In addition, when Medicaid-enrolled AI/AN populations access healthcare through an IHS or tribal facility, Medicaid reimburses for the cost of all Medicaid-eligible services rendered.

#### **Medicaid and MCO Coverage for Home-Based Asthma Services<sup>a, b</sup>**

In a 2014 survey conducted by the National Center for Healthy Housing and Milken Institute School of Public Health, survey respondents reported that there was no Medicaid reimbursement available in Washington State for asthma services in the home. Interviews and additional research have not uncovered any existing or prior Medicaid-supported coverage of home-based asthma services in Washington State either through FFS Medicaid or through a managed care organization.

#### **Other Funding Mechanisms in Washington State (page 4)**

As Medicaid support for home-based asthma services is currently nonexistent, programs that deliver these services for Medicaid-eligible patients rely on other public and private funding streams. A couple of tribal communities in Washington operate asthma programs specific to AI/AN populations. Other asthma programs in the state are not specific to tribes but may be accessible to some tribal populations, depending on geographic barriers.

#### **Barriers and Next Steps for Washington State (pages 5-6)**

Washington State faces a range of challenges in improving home-based asthma services; chief among these is loss of CDC funding for state asthma control efforts. Interviewees described specific barriers related to tribal communities, including asthma being a low-priority issue, distrust of home visitors, and difficulty engaging families to address asthma given their myriad health and other concerns. Confusion over the interaction between Medicaid and IHS Coverage is another major challenge. Interviewees describe new delivery system reforms – such as the Accountable Communities for Health and Medicaid Health Homes – as opportunities for better-integrating home-based asthma services within Medicaid.

#### **Key Insights from Washington State (page 7)**

In each interview, the most salient theme was that asthma was not perceived as a priority issue by key decision makers in Washington State. The lack of urgency on the part of decision makers to address asthma continues to pose several barriers to reimbursement in Washington. Ambiguity over which federal entity (Medicaid or IHS) has financial responsibility for healthy homes services when provided to AI/AN populations may contribute to the lack of prioritization of healthy homes interventions within the healthcare system.

#### **Medicaid in Washington**

Approximately 1.8 million individuals are enrolled in the Washington State Medicaid and CHIP program, which the Washington State Health Care Authority (HCA) oversees.<sup>3</sup> Washington has expanded Medicaid under the Affordable Care Act, which has increased Medicaid enrollment in the state by 55% since 2013.<sup>4, 5</sup> Adults with incomes up to 138% federal poverty level (FPL) and pregnant women with incomes up to 185% FPL are now eligible for Medicaid.<sup>6</sup>

Nearly 70% of Medicaid enrollees in Washington are enrolled in a managed care arrangement through Apple Health, which is mandatory for most children and families.<sup>7</sup> Certain populations are exempted from mandatory enrollment, including disabled populations, individuals who are also enrolled in Medicare (dual eligibles), and individuals living in a county that does not have at least two Apple Health managed care health plans with adequate networks.<sup>8</sup> Additionally, members of tribal populations can choose whether to enroll in managed care or remain in fee-for-service (FFS).<sup>9</sup>

#### **Indian Health System and Medicaid Coverage for Tribal Communities**

In Washington, approximately 2.9% of the total population (almost 192,000 individuals) identifies as American Indian/Alaska Native (AI/AN).<sup>10</sup> There are 29 federally recognized Indian Tribes in the state,<sup>11</sup> and members of these tribal communities and other people of AI/AN descent can access

<sup>a</sup> Information based on responses to both the interview questions and responses to the original 2014 survey ([www.nchh.org/Resources/HealthcareFinancing/Snapshot.aspx](http://www.nchh.org/Resources/HealthcareFinancing/Snapshot.aspx)).

<sup>b</sup> 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.

health coverage through a number of means:

*Coverage through the Indian Health Service.* The Indian Health Service (IHS) is the primary source of funding for tribal and urban Indian health programs.<sup>12,13</sup> IHS arranges for the provision of healthcare to AI/AN populations through IHS-funded hospitals and health clinics. In Washington, there are 61 IHS-funded health clinics, 34 of which are tribally-operated medical clinics located in rural or remote areas of the state (individual tribes have the option of operating their own direct care facilities with IHS funding).<sup>14</sup> However, there are no IHS hospitals in the Pacific Northwest, so all inpatient care and a large majority of specialty care is provided outside of the IHS system.<sup>15</sup>

In general, services provided through IHS- and tribally-operated facilities are limited to members of and descendants of members of federally recognized tribes that live on or near federal reservations. Urban Indian health programs serve a wider population, including those who are not able to access IHS- or tribally-operated facilities because they do not meet eligibility criteria or reside outside the service areas. Washington State is home to two urban Indian health clinics in Spokane and Seattle. Nationwide, the majority of AI/AN populations live in metropolitan areas,<sup>16</sup> and in Washington, over 45% live in the Spokane and Seattle regions, far from most IHS and tribal facilities.<sup>17</sup>

Although IHS clinics provide a range of services, the IHS does not provide tribal communities with a defined set of benefits. Therefore, eligibility for IHS services alone does not meet Affordable Care Act requirements that individuals be enrolled in a health plan that qualifies as minimum essential coverage.<sup>18, 19</sup> For this reason, unless covered by a job-based insurance, tribal members may enroll in a qualified health plan through the state health insurance marketplace or access coverage through Medicaid or Medicare based on eligibility.<sup>20</sup>

*Medicaid Coverage.* Medicaid is an important source of insurance coverage for AI/AN populations. Nationwide, more than one million American Indians and Alaska Natives are enrolled in coverage through Medicaid/CHIP.<sup>21</sup> As of 2013, 29% of the AI/AN population in Washington State was enrolled in Medicaid,<sup>22</sup> and this number has likely increased as a result of Medicaid expansion in the state.

As Medicaid enrollees, AI/AN populations have the same access to services as all Medicaid-enrolled populations, and tribal populations in the state are able to access Medicaid services without any cost-sharing or premium requirements.<sup>23, 24</sup> In addition, these populations continue to have access to

IHS- and tribally-operated facilities and services. When Medicaid-enrolled AI/AN populations access healthcare through an IHS or tribal facility, Medicaid reimburses for the cost of all Medicaid-eligible services rendered.<sup>25</sup>

Reimbursements from Medicaid are an important source of revenue for IHS and tribally-operated facilities. Congress allocates a limited budget to the IHS, and funds remain insufficient to meet the healthcare needs of AI/AN populations.<sup>26</sup> According to the American Indian Health Commission for Washington, Indian Health Services in the state are funded at 55% of the level of need.<sup>27</sup> Because of this shortfall in funding, IHS programs and facilities in the state have aggressively sought third-party payment strategies, primarily in the form of Medicaid reimbursement.

Generally, the federal government and the states share in the cost of the Medicaid program; in the case of Washington State, the federal and state government split Medicaid costs 50/50. However, when services are provided at IHS- or tribally-operated facilities, the federal government covers 100% of Medicaid costs, thereby relieving states of this financial responsibility. Medicaid services provided to AI/AN populations outside of the IHS system are reimbursed at the usual match rate. This policy provides a strong financial incentive for state Medicaid programs to facilitate the use of IHS- or tribally-operated health facilities by AI/AN Medicaid beneficiaries.<sup>28</sup> However, because there is no IHS hospital in Washington, all inpatient care and a large majority of specialty care (including asthma care) is provided outside of the IHS system, at the usual match rate. Additionally, because 45% of the AI/AN population lives in urban areas, usual healthcare services are likely accessed outside of IHS or tribal facilities.

*Medicaid Managed Care and AI/AN Populations.* Federal law prohibits states from requiring AI/AN populations to enroll in Medicaid managed care organizations (MCOs), unless the MCO is operated by the IHS, a tribe, or an urban Indian health program.<sup>29</sup> The state of Washington does not require any AI/AN populations to enroll in managed care, and provides these individuals the option to enroll in the various MCO plans available in the state.<sup>30</sup>

Interviewees were not aware of the percent of AI/AN populations enrolled in an MCO, and Washington State does not publish this data. However, interviewees believed that the percentage is high given the special protections federal law provides for American Indian and Alaska Native beneficiaries who are enrolled in an MCO. Medicaid MCOs that enroll

AI/AN populations must have a sufficient number of Indian health providers participating in their networks to ensure timely access to care.<sup>31</sup> In addition, the MCO must also allow AI/AN beneficiaries to select an Indian health provider as his or her primary care provider and go outside the managed network to seek care through an Indian health program or urban Indian organization.

### Medicaid and MCO Coverage for Home-Based Asthma Services<sup>b</sup>

Tribal populations in Washington State suffer a disproportionately high burden of asthma. At every income level, AI/AN experience higher rates of asthma prevalence.<sup>32</sup> Nearly one-quarter of the AI/AN adult population at or below 200% FPL suffers from asthma.<sup>33</sup> About 17% of AI/AN 12<sup>th</sup> graders statewide have asthma, which is almost twice the national rate.<sup>34</sup> Despite this burden, the IHS does not specifically cover asthma services, as it does not offer a defined set of health benefits for tribal communities. While a few individual tribes operate asthma programs funded through federal and state public health dollars (described below), tribal populations in Washington depend on Medicaid and MCOs to cover the asthma management services they need. This is especially true for tribal populations who require hospitalization or specialized care for asthma, as there is no IHS-funded hospital in the region.

Despite this burden, survey respondents to a 2014 survey conducted by the National Center for Healthy Housing and Milken Institute School of Public Health reported that there was no Medicaid reimbursement available in Washington State for asthma services in the home. Interviews and additional research have not uncovered any existing or prior Medicaid-supported coverage of home-based asthma services in Washington State either through FFS Medicaid or through an MCO.

### 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. Interviewees pointed to several programs that currently deliver such home-based asthma services in Washington:

*Tulalip Air Quality Program.* The Tulalip Tribes Department of Environment facilitates the Tulalip

Indoor Air Quality Program.<sup>35</sup> Using culturally relevant approaches to outreach and education, the program works to reduce environment exposures that trigger asthma and other related health problems. This program is funded in large part by the Environmental Protection Agency (EPA) and boasts several initiatives, including:

- *Environmental Home Assessments.* The program has recently launched an asthma home visiting program through a partnership with the Tulalip Health Clinic. Using an electronic referral system, clinic providers refer certain high-risk patients for environmental home assessments. Trained community health workers (CHWs) provide the assessments. The program receives specific funding from EPA to train CHWs to conduct home assessments.
- *Collaboration with WIC Programs.* The Tulalip Air Quality Program has been engaging in creative efforts to secure additional funding for their home visitation programs, including potential new funds to support the purchase of basic remedial supplies through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Reportedly, Tulalip is working with its WIC coordinator to establish another referral system in which the coordinator would refer pregnant women and women with infants to their program for home visits.
- *Healthy Homes Working Group.* To increase the reach and impact of the program, Tulalip recently launched the Healthy Homes Working Group. The working group serves as a mechanism for tribes to share best practices, strategies, and research regarding the successes and challenges in outreach and education around indoor air quality. Additionally, the working group seeks to establish a model for effective home interventions for tribal populations.

*Yakima Valley Farm Works Clinic: Childhood Asthma Project (CAP).* The Yakima Valley Farm Works Clinic (YVFWC) is a group of eight health clinics serving a rural area in eastern Washington. The clinic primarily serves the region's large Hispanic immigrant population, but members of the Yakima Nation frequently access clinic services because the tribal territory is adjacent to one of the YVFWC locations. YVFWC administers the Childhood Asthma Project (CAP), a program that sends CHWs to patient homes

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to address a number of conditions, including asthma. CHWs are trained by the clinic as asthma educators (using the American Lung Association's Asthma Educator Institute and Master Home Environmentalist training) and offer home assessments, education on asthma trigger identification and avoidance, asthma self-management education, and assistance with medication adherence.<sup>37</sup>

In the late 1990s, the EPA provided a grant to the YVFWC for an asthma home visiting pilot program.<sup>38</sup> Since that initial seed funding, YVFWC has maintained its home visitor program through the clinic's operational budget. Because the program is facilitated through the YVFWC clinic, it benefits from a strong referral system and support from the clinic's providers who are essential for linking high-risk patients to home-based services. Eligible patients receive three home visits, and the program serves approximately 280 low-income, rural participants each year.<sup>39</sup>

In 2010, researchers from Washington State University College of Nursing conducted an evaluation of CAP to assess its feasibility and acceptability among rural Latino populations.<sup>40</sup> The evaluation demonstrated that the intervention produced positive outcomes, including behavior change to mitigate asthma triggers and less frequent use of urgent care.

*Clean Air for Kids.* Clean Air for Kids Asthma and Allergies Management Program is a referral-based home visiting asthma program. The Tacoma-Pierce County Health Department administers the program, working with the MultiCare Health System and partners in the Puget Sound Asthma Coalition, which include approximately 30 other local healthcare, community, and academic organizations.<sup>41</sup> The program links high-risk asthma patients (identified by recent hospitalization, emergency department visit, or other medical encounter) to Asthma Outreach Workers who visit patients in their homes to review physician instructions, conduct a medication review, instruct patients on asthma self-management, and educate families on asthma trigger identification and avoidance. Asthma Outreach Workers relay information gathered from home visits back to the MultiCare Health System. All services are free to clients.<sup>42</sup> The program occasionally has adequate funding for basic low-cost supplies, but the availability of that funding fluctuates.

The program provides services to the nearby Puyallup and Yakima tribes, but is available to nontribal communities as well. In 2014, the Washington Board of Health awarded Clean Air for Kids with the Warren Featherstone Reid Award, the state's highest honor

for cost-effective and quality healthcare services.<sup>43</sup>

*Washington State Department of Health: Three Visit Model.* The Washington State Department of Health created the three-visit model for in-home asthma services in 2011 in partnership with the Cowlitz County Health Department.<sup>44</sup> Under the model, three in-home visits are conducted over the course of three months, and the interventions offered at each visit serve the following goals: (1) to assess and increase the participants' knowledge about asthma management, and (2) to identify and eliminate asthma triggers in the home. The home visiting model is designed to be effectively implemented using community volunteers, medical assistants, CHWs, and other paraprofessionals as home visitors. The model is designed to be widely applicable to asthma programs, and several programs across the state have utilized this model (including the YVFWC program and a former asthma program offered by the Seattle Indian Health board). Data indicate that this model can successfully decrease hospitalizations, emergency room visits, urgent care visits, and missed school or work days.<sup>45</sup>

*Tribal Healthy Homes Network (THHN).* The Tribal Healthy Homes Network (THHN) is an advocacy group that is specifically focused on the impact of asthma and lung disease among AI/AN populations. THHN's efforts promote healthy tribal homes and communities by serving as a clearing house for technical support, program guidance, resources, and funding. The Tulalip Tribes of Washington lead the THHN and participate in many of the network's field and research projects. The American Lung Association of the Mountain Pacific region provides THHN with physical office space and healthy homes expertise. THHN also receives technical support and their core program funding from the EPA.<sup>46</sup>

### **Barriers to Implementing Home-Based Asthma Services within Medicaid**

*Loss of National Asthma Control Program Funding.* As of September 2014, Washington State's asthma program, which was historically managed by the Department of Health, ceased operation due to the loss of funding from the Centers for Disease Control and Prevention's (CDC) National Asthma Control Program (NACP).<sup>47</sup> The loss of these federal dollars has meant that several basic asthma-related functions are no longer available in the state, such as basic asthma surveillance, updating of educational resources, and training of clinical staff on EPR-3 guidelines.

*Loss of Funding for Asthma Advocacy.* The loss of NACP funding has also resulted in the loss of financial

and administrative support for the Washington Asthma Initiative (WAI).<sup>48</sup> The WAI is a coalition of groups, healthcare providers, individuals, and government agencies from across the state working to improve asthma diagnosis, treatment, education, and management. Their efforts have largely centered on advocating for reimbursement of home-based asthma services and other key asthma care-related issues. Since NACP stopped funding asthma efforts in the state, the WAI has continued to exist, but solely on the dedication of volunteer members (see further descriptions of WAI's current efforts below).

*Asthma Not a Top Priority.* Interviewees described a lack of prioritization of asthma as a key health issue needing to be addressed. Although asthma is a leading cause of health expenditures for AI/AN populations in the state, IHS and tribal health decision-makers consistently prioritize other health conditions, such as obesity, diabetes, heart disease, addiction, and substance abuse, in healthcare program implementation and financing.<sup>49</sup>

While home visitation programs are somewhat common in tribal communities (especially where populations live in rural settings), CHWs and others entering the home are already overwhelmed by addressing other chronic conditions and health needs and simply incorporating asthma services within these visits is not feasible. For example, many IHS-funded home visits in Washington are focused on the needs of elderly populations, and there is a concern that putting CHW resources toward asthma would diminish the care provided to elderly tribal members, a population on whom there is placed a large cultural value.

Interviewees observed that where home visiting programs are in place, there is a supply of trusted CHWs that could be deployed for addressing asthma in home settings. However, interviewees underscored the difficulty, even in pilot demonstration projects, of convincing tribal health clinics to divert one of their few staff or volunteer CHWs toward addressing asthma over other health concerns in the community.

Moving forward on asthma would require significant tribal, public health, or Medicaid resources to be put toward training additional CHWs to deliver home-based asthma services. The CHW training offered by the Washington State Department of Health may be an opportunity. This free, eight-week training course teaches CHWs skills in health education, informal counseling, social support, care coordination, health services enrollment and navigation, ensuring preventative health screenings, outreach, and advocacy.<sup>50</sup> Although not specific to asthma, it may

present an opportunity to increase the capacity of the CHW workforce to address asthma in home settings.

*Lack of Funding for Home-Based Asthma Services.* Interviewees observed that, without consistent and sustainable funding for home-based asthma services, hospitals and clinics in the state (tribal or otherwise) are not able to implement and institutionalize home-based asthma services within the care delivery system in Washington.

*Confusion over Medicaid/IHS Interaction for Coverage of Home Services.* As described above, in general, when Medicaid-enrolled AI/AN populations access healthcare through an IHS or tribal facility, Medicaid reimburses for the cost of Medicaid-eligible services rendered. Supposing Medicaid (either under FFS or an MCO plan) were to cover home-based asthma services in the state, would Medicaid become responsible for covering such services for tribal communities? If Medicaid is responsible for covering services at an IHS or tribal facility, does this responsibility extend to home settings? Or do these services remain under the jurisdiction of the Indian Health Service? These questions remain unresolved.

*Distrust of Asthma Home Visitors.* According to interviewees, only a handful of tribes have been able to implement and sustain asthma home visiting programs as tribal communities are often mistrustful of strangers entering their home to conduct health services or home health assessments (asthma-related or otherwise), in fear of resulting consequences. Tribal communities have had historically negative experiences with, for example, Child Protective Services and other agencies or initiatives that have caused disruption to family and homelife. Overcoming such deep-rooted mistrust of government services is a significant challenge for more widespread implementation of healthy homes services.

The most salient theme of the conducted interviews was that asthma is not perceived as a priority issue by key decision-makers in Washington State. This lack of urgency on the part of decision makers to address asthma continues to pose several barriers to reimbursement.

*Barriers to Families Taking Action on Asthma.* Interviewees described the many difficult issues that AI/AN populations face in addition to their health. Addiction, unemployment, extreme poverty, and substandard housing are just some of the many concerns that these populations have that may be more pressing than concerns over asthma triggers in the home. If home-based asthma programs do not also help families address these many other challenges (or at least link them to other service providers), it is unlikely that these programs will be successful.

*Difficulty Engaging Providers.* The Washington State Healthy Housing Initiative's Healthy Housing Strategic Plan emphasizes the importance of care coordination and consistent referrals to ensure that patients with asthma are connected to professionals who can help them to control their asthma and remedy asthma triggers within the home.<sup>51</sup> However, based on experiences with past pilot projects seeking to implement home-based asthma services, some interviewees described overtaxed tribal clinic staff as reluctant to take on the additional coordination and staff time required to link patients with home-based asthma services (where such services are available).

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

*Accountable Communities of Health.* The State Innovation Models (SIM) Initiative, funded by the Center for Medicare and Medicaid Innovation (Innovation Center), is providing financial and technical support to states for the development and testing of state-led, multipayer, healthcare payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states. In December 2014, Washington State received \$64.9 million to implement and test its State Health Care Innovation Plan.<sup>52</sup> Under their SIM plan, the state will make several targeted investments, including fostering innovation and collaboration in communities through the implementation of regionally organized *Accountable Communities of Health* (ACH).<sup>53</sup>

The ACH supports collaborative decision-making and action on a regional basis to improve individual healthcare delivery and health systems, focusing on the social determinants of health, clinical-community linkages, and whole person care. Asthma would seem a natural fit as part of an ACH model, and interviewees see this investment as an opportunity to elevate home-based asthma services in the state. At this time, a

couple of ACH efforts have been officially designated in Washington, but most are still in the development and pilot testing stages.<sup>54</sup> Reportedly, asthma advocacy groups have taken a number of strategies to promote asthma as a candidate for inclusion in an ACH model.

*Expanding the Role of Community Health Workers in the Provision of Asthma Services.* Washington, like many states, is 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, 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 CHWs with training and expertise in providing asthma services may receive FFS Medicaid reimbursement. According to interviewees, while advocates have engaged in some discussions around implementing this rule change, Washington State is largely waiting to see how the rule takes effect in other states first.

*Medicaid Health Homes.* The Affordable Care Act (ACA) creates a new state Medicaid option to permit individuals with one or more chronic conditions – specifically including asthma – to seek care through a “health home.”<sup>55</sup> Under the law, a health home is responsible for providing or coordinating all patient care, as well as a specific set of “health home” services, including many services important for asthma management such as care coordination and health promotion, patient and family support, and coordination with community and social support services.<sup>56</sup>

Washington State has established a Medicaid health home targeting persons with asthma, among other chronic conditions.<sup>57</sup> Under Washington's health home approach, community health centers and rural health clinics (including tribal health centers) are eligible to serve as a lead health home provider, and CHWs, peer counselors, and other nonclinical personnel can serve as allied health staff as part of the health team.<sup>58</sup> In addition, health homes must include community health clinics and tribal health providers within provider networks. While public documents describing Washington's health home model do not specifically mention asthma services as a covered component, the model does focus on health promotion, self-management education, and active referral to community-based services, in addition to including the types of community-based providers that are important to asthma care.

It remains to be seen how Washington's health home model will impact populations with asthma, or tribal populations generally. However, this model may be a desirable way for states to test community asthma interventions, including home-based interventions, as the federal government will pay an enhanced federal Medicaid match rate of 90% during the first eight quarters of state participation.<sup>59</sup>

*Continued Advocacy Efforts.* Despite challenges posed by severe funding cuts, the Washington Asthma Initiative (WAI) has continued to attract a number of highly committed volunteers who continue to work toward establishing reimbursement for home-based asthma services. In September 2014, upon the loss of NACP funding, the WAI organized a day-long summit primarily to invite attendees to join a newly established Reimbursement Task Force. According to interviewees, summit attendees showed a lot of energy around keeping an asthma initiative in place to advocate around asthma in general, and specifically improving access to and Medicaid reimbursement for home-based asthma services. Task force members work on a volunteer basis and have focused recent efforts on making the business case for Medicaid reimbursement for asthma services in home settings to the governor and state legislature. The task force has also worked to push forward home-based asthma interventions within the ACH projects underway in the state.

The Tribal Healthy Homes Network (THHN) also held a summit in the fall of 2014, organizing asthma stakeholders on similar issues. Currently, WAI and THHN are working together to advocate for better home-based asthma services in the state. Working collaboratively on these issues is important as, if reimbursement for home-based asthma services is ultimately established, the mechanisms will look very similar in both tribal and nontribal areas, although potential implementation issues may differ.

### Lessons Learned

*Making Asthma a Priority.* In each interview, the most salient theme was that asthma was not perceived as a priority issue by key decision-makers in Washington State. The lack of urgency on the part of decision makers to address asthma continues to pose several barriers to reimbursement in Washington, including the persistent lack of funding for WAI, the difficulty of engaging clinical providers on this issue, and the exclusion of asthma-related activities in many home visiting programs that do exist, particularly in tribal communities. Advocates in Washington are working on making the business case to key decision-makers on the importance of addressing asthma through

home interventions. The Medicaid health home and Accountable Communities of Health models are important opportunities for testing community asthma interventions and documenting outcomes and cost savings.

*Educating Stakeholders on the Interaction between Medicaid and Indian Health Services.* The interplay between Medicaid and IHS coverage for services is complicated. Interviewees describe the confusion advocates and decision-makers have around which program will be responsible for covering home-based asthma services, assuming these services were covered by Medicaid. This confusion is not the only reason that the healthcare system (IHS, Medicaid, or otherwise) is not providing coverage for home-based asthma services, however, ambiguity over which federal entity has financial responsibility for these services when provided to AI/AN populations may contribute to the lack of prioritization of healthy homes interventions within the healthcare system. Clarifying fiscal responsibilities and roles is important and may require guidance from the U.S. Department of Health and Human Services (HHS).

*Importance of Maintaining Advocacy Efforts.* Washington is a state that has worked hard to bring asthma stakeholders together despite very limited resources. The recent loss of NACP funding has galvanized the individuals and organizations engaged in asthma advocacy efforts around the issue and targeted their efforts on educating policymakers on the return on investment for home-based asthma interventions. Interviewees stated that future opportunities to apply for CDC funding through the NACP would serve to reinvigorate partnerships and collaborations.



## ACRONYMS

<b>ACA</b>	<b><i>Affordable Care Act</i></b>
<b>ACH</b>	<b><i>Accountable Communities of Health</i></b>
<b>AI/AN</b>	<b><i>American Indian/Alaska Native</i></b>
<b>CAP</b>	<b><i>Childhood Asthma Project</i></b>
<b>CHIP</b>	<b><i>Children’s Health Insurance Program</i></b>
<b>CHW</b>	<b><i>Community health worker</i></b>
<b>IHS</b>	<b><i>Indian Health Service</i></b>
<b>FFS</b>	<b><i>Fee-for-service</i></b>
<b>FPL</b>	<b><i>Federal poverty level</i></b>
<b>HCA</b>	<b><i>Washington State Health Care Authority</i></b>
<b>MCO</b>	<b><i>Managed care organization</i></b>
<b>NACP</b>	<b><i>National Asthma Control Program</i></b>
<b>SIM</b>	<b><i>State Innovation Model</i></b>
<b>THHN</b>	<b><i>Tribal Healthy Homes Network</i></b>
<b>WAI</b>	<b><i>Washington Asthma Initiative</i></b>
<b>WIC</b>	<b><i>Special Supplemental Nutrition Program for Women, Infants, and Children</i></b>
<b>YVFWC</b>	<b><i>Yakima Valley Farm Works Clinic</i></b>

## 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*<sup>2</sup> 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](http://www.nchh.org/Program/DemystifyingHealthcareFinancing.aspx).*

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### Asthma Case Study #7 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](http://www.nchh.org/resources/healthcarefinancing.aspx)

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