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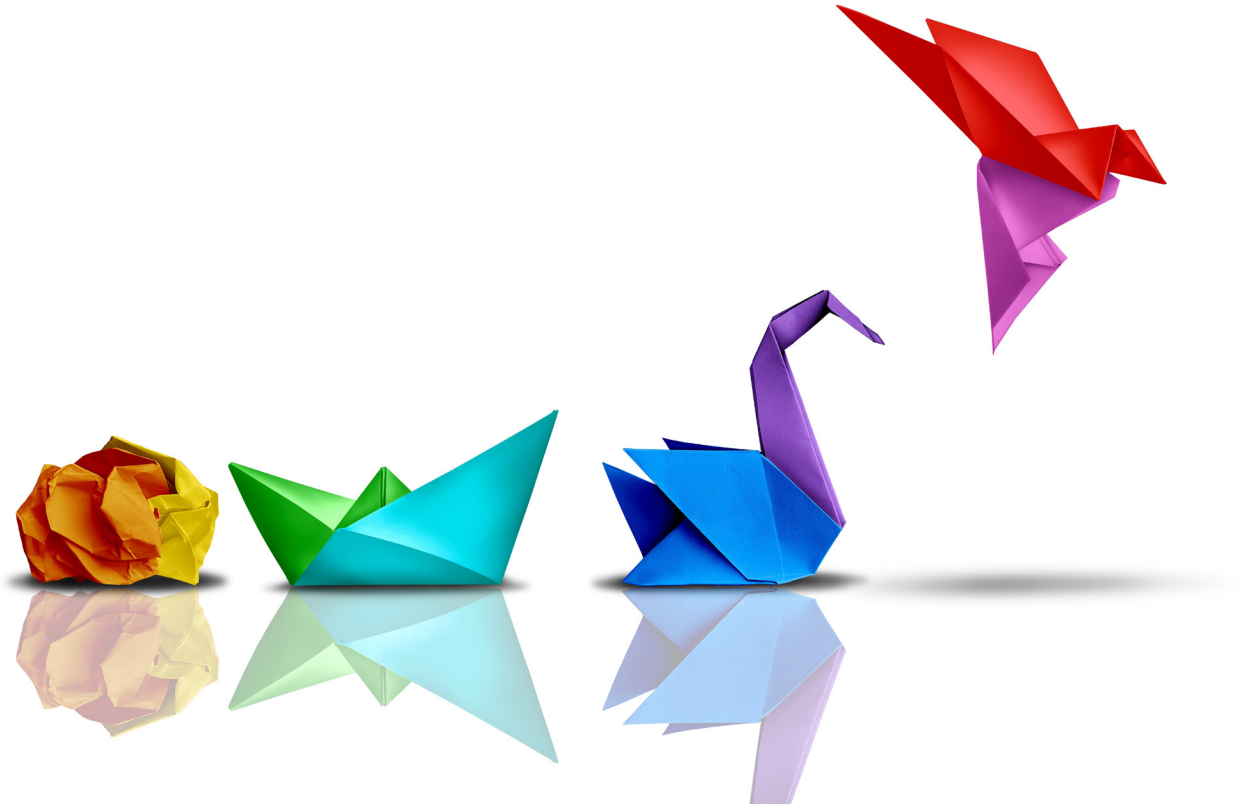

SUSTAINABLE FINANCING FOR HOME-BASED ASTHMA SERVICES:

Snapshots of Innovation and Progress Across the Country

May 2025

CONTENTS

ADDITIONAL SUPPORT

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EXECUTIVE SUMMARY

Asthma home visiting is an evidence-based intervention proven to improve health outcomes, lower healthcare utilization costs, and improve patient care. Yet far too many people with poorly controlled asthma lack access to these key services. Historically, asthma home visiting programs have had to rely on unstable grant funding to provide services. But in recent years, that pattern has begun to shift, and we are seeing progress in communities and states across the country in building systems for sustainable asthma home visiting services. Now is the time to learn from these successes and build on momentum across the country.

Building systems to expand and sustain access to asthma home visiting services can take a long time, and there are many pathways for achieving the same outcomes. As such, progress can look different from one place to the next.

This scan provides an overview of what progress and pathways can look like. It also features success stories from across the country, featuring both state Medicaid policy advances and stories about local partnerships, pilot programs, and other innovations that create a groundswell leading to statewide change and serving as models for communities across the country. The highlights include the following:

Minnesota has an enhanced asthma care law (EACL) for Medicaid beneficiaries that includes a home assessment of environmental asthma triggers and the provision of allergen-reducing products. CHW Solutions, a community partner, is currently working through implementation challenges to increase provision of the services.

Hawaii is leveraging a strong relationship between the state department of health and the state Medicaid agency to achieve the goal of Medicaid coverage for asthma self-management education and home environmental asthma trigger assessments through an incremental approach to state plan amendments.

New York's Medicaid system is implementing the New York Health Equity Reform (NYHER) waiver, to build a delivery system with a focus on health equity, including regional social care network lead entities (SCNs) that will provide asthma remediation services, building on a rich history of both asthma and healthy housing programs.

California's Medicaid system adopted the Asthma Preventive Services benefit, covering asthma self-management education and a home environmental asthma trigger assessment for qualifying individuals and is providing asthma remediation through a waiver using the federal "in lieu of services" rule, covering trigger remediation supplies and services.

Alexandria, Virginia, is using data-driven interventions to improve asthma and housing quality. Authentic community engagement has led to a stronger foundation for future policy change.

In Michigan, the Ingham Health Plan Corporation's track record and preparation, along with their partnerships, have been instrumental to achieving their success.

Every effort taken by a state or community to build, expand, and sustain home-based asthma services leads to lessons learned, including the following:

- Broad and committed partnerships are a tremendous strength to support both state and local efforts.
- Prioritizing local leadership and ensuring space for local flexibility and ongoing ownership in the decision-making process helps create and maintain programs. It takes an investment of time upfront to try out a model, and tenacity to prove the model. Then, the next step is scaling the model.
- There are multiple policy solutions that can achieve the same outcome. It's important to know the options and determine which is most feasible for a given place and time.
- Having model policies from other states to review, learn from, and adapt accelerates the adoption of preventive service policies for asthma nationwide.
- Expect to pursue multiple policy tracks and stay persistent. Every step is a building step, and knowledge builds toward successful policy change, even if the first policy target is not the pathway a state or community can ultimately make work.
- Passing a policy is not always the end goal. Figuring out how to effectively implement policies on the ground is just as critical to success. After policy development and passage, policy implementation requires ongoing dialogue between policymakers and implementers to be successful.

Understanding these lessons and incorporating them into new programs and policies leads to new models of success and momentum across the country.

INTRODUCTION

Evidence demonstrates that home-based asthma services improve health outcomes, lower healthcare costs, and improve patient experience. Yet far too many people with poorly controlled asthma lack access to asthma home visiting services even though evidence of their effectiveness is clear and strong. This gap is because asthma home visiting programs are traditionally funded with grant dollars for a trial period, or as pilot efforts. By the time programs are up and running, with trained staff, streamlined referrals, and home-based services reaching people with asthma, grant funding expires before a lasting impact is achieved for patients, families, communities, and health systems. However, in the past decade, this trend has shifted as strategic healthcare investments to address upstream drivers of disease take hold. Communities, states, health systems, and healthcare insurers and payers across the country are making progress to establish sustainable systems for lasting and effective asthma home visiting services.

Now is the time to learn from successes and build on momentum across the country.

This brief provides a scan of progress and identifies multiple pathways to achieve sustainable financing for home-based asthma care services. It also features success stories from across the country and highlights tools and technical assistance (TA) available to help states and communities to build sustainable asthma home visiting systems with stable payments, effective clinical integration, and a qualified home visiting workforce to bring asthma under control for everyone.

Building systems to expand and sustain access to asthma home visiting services can take time, and there are many possible pathways for achieving the same outcomes. Progress can look different from one place to the next. Milestones of progress—and examples—can include the following:

- **EXPANDING STRATEGIC AND CROSS-SECTOR PARTNERSHIPS**, such as implementing a joint demonstration to show a comprehensive approach to healthy housing, including asthma home visiting services in a community.
- **PRIORITIZING ASTHMA HOME VISITING SERVICES**, such as expanding the focus of an agency or organization (e.g., a community weatherization program) to include asthma home visiting services like environmental asthma trigger assessments.
- **ACHIEVING LOCAL SYSTEMS CHANGE,** like securing a managed care plan contract to cover asthma home visiting services for their members with uncontrolled asthma.
- **WORKING ON POLICY DEVELOPMENT**; for example, meeting with the state Medicaid agency clinical director, strategy director, and, ultimately, financing officers, to discuss policy mechanisms that may increase coverage for and access to home-based asthma services in your state.
- **CREATING AND ADOPTING NEW POLICIES**, like helping the state Medicaid agency write a policy to cover asthma home visiting services for eligible members and defining those groups.
- **IMPLEMENTING NEW POLICIES**, including supporting workgroups to plan implementation of new state Medicaid policies that cover asthma home visiting services.

This review provides snapshots of four states that have created, adopted, and implemented policies to support asthma home visiting services financially. It also highlights two states in which local programs are building a groundswell of support for asthma care policy change to increase access to home-based asthma services by expanding partnerships and achieving local systems change.

PROGRESS WITH STATE MEDICAID POLICIES

Medicaid is the nation's main public health insurance program for lower-wealth people of all ages. The program spends more than $10 billion annually to treat asthma in children and adults.[i] Developing new healthcare payment policies to pay for care delivered in new places (like homes) and often by new people (like community health workers) is complex work. Every state and community pays for and approves healthcare providers according to its own layers of rules, traditionally with a focus on clinicians in clinical settings. To create a more effective system, the United States is undergoing a major healthcare transformation; part of that transformation requires writing new, more effective Medicaid policies.

However, policy writing and fine-tuning is not the same as achieving positive health outcomes and healthcare cost impact. Impact is only achieved through successful implementation. Though different stories about different states, every case reflected in this review highlights the need for implementation planning and preparation to proceed in lockstep and in close communication with policymaking. Where policymaking happens without implementation planning and coordination, new policies, though well intended, cannot be implemented and therefore fail to reach the people they were intended to serve.

In many states, state environmental, public health, housing, and Medicaid programs as well as nongovernmental partners are effectively collaborating to develop, expand, and implement policies and infrastructures that will support the access to, delivery, and financing of in-home asthma interventions for Medicaid beneficiaries. Below are snapshots of recent progress across different states.

[i] American Lung Association. Asthma trends and burden. Accessed May 26, 2023. https://www.lung.org/research/trends-in-lung-disease/asthma-trends-brief/trends-and-burden

A MULTIPRONGED APPROACH IN MINNESOTA

Minnesota's experience demonstrates the value of a multipronged approach to building systems to support and sustain asthma home visiting services. Though the state legislature passed an asthma coverage law in 2021, successful implementation has required creativity and tenacity. While some key champions are focused on policy development, others, including community-based providers, build programs and pursue policy systems change with local Medicaid managed care providers to increase access to asthma services.

In 2021, Minnesota enacted a new law to cover "enhanced asthma care services" for Medicaid beneficiaries under the age of 21 with poorly controlled asthma. Covered services under the Enhanced Asthma Care Law (EACL) include a home assessment of environmental asthma triggers and the provision of allergen-reducing products, including allergen encasements for mattresses, box springs, and pillows; allergen-rated vacuum cleaners, including filters and bags; dehumidifiers and filters; HEPA single-room air cleaner and filters; integrated pest management, including traps and starter packages for food storage containers; damp mopping systems; waterproof hospital-grade mattresses (if members do not have access to a bed); and furnace filters (for homeowners only).

The passage of the EACL was hailed as a huge win, but as time passed, it became clear that no one was providing asthma services despite clear evidence of need and, on the books, coverage. A local taskforce reached out to longtime partner, CHW Solutions, a Minnesota-based small business dedicated to sustainable models for community health worker (CHW) services, to see if they could develop an effective model of implementation.

With their can-do attitudes, CHW Solutions co-founders Megan Nieto and Megan Ellingson are figuring it out. They had a CHW on their team who had completed a training program on asthma, has personal experiences with asthma, and lives in the ZIP code with the highest asthma rates. They knew she would be an ideal person to support families of children with asthma in her own ZIP code. Partnering with a local Medicaid health plan, HealthPartners, CHW Solutions gathered a list of eligible clients and began making calls to offer asthma services.

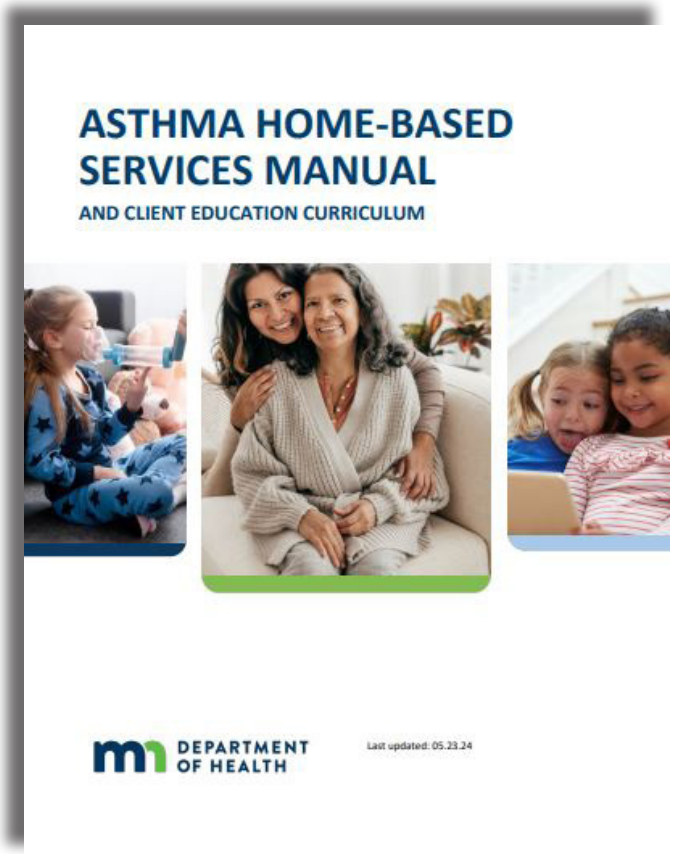
Though policies are necessary to expand and sustain home-based asthma services, passing a policy is not the final step. Rather, figuring out how to implement a policy on the ground is a fundamental step for achieving the goal of improving asthma outcomes.

Meanwhile, Megan Ellingson and Megan Nieto began the process of implementing the policy on the ground, which required creativity and tenacity, something CHWs tend to have in ample supply. The first challenge was that the state policy required allergen-reducing products distributed by an official durable medical equipment (DME) provider, but when the state put out the call for DME providers who could supply these products, no one applied. Megan Nieto called 17 DME providers in Minnesota to see if they would partner; none were interested. Ellingson and Nieto reached out to their contact at HealthPartners to discuss the DME barrier. HealthPartners had a relationship with a DME supplier in neighboring Iowa, who happily engaged. Together, they reviewed the eligible product list and identified high-quality options that were available to be shipped directly to the patients' doorsteps. Megan's experience with providing asthma home visiting services led to valuable insights when assessing the choice of products.

The second challenge was that EACL requires the comprehensive home assessment be performed by specific workers, such as registered environmental health specialists, but many of them work for local health departments who are not able to bill Medicaid. Initially, the broader asthma field believed that environmental asthma trigger assessments provided by these professionals were necessary to determine which allergen-reducing products were appropriate. CHW Solutions leadership determined, however, that CHWs can provide in-home asthma education using a Minnesota CHW benefit adopted in 2009 and include a home assessment component using a standardized asthma trigger checklist to identify triggers and match them to products to help reduce them. Those products could then be sourced from the DME provider CHW Solutions identified earlier.

The third challenge was that CHW Solutions needed a licensed medical provider oversight to purchase products in the form of an individual patient order. CHW Solutions was able to establish quick relationships with the patients' primary care providers to request an order for the products. CHW Solutions sent an email or a fax to the providers identifying the products needed, demonstrating the need through sharing the asthma trigger checklist, asthma education notes, and home observations with the provider.

Though policies are necessary to expand and sustain home-based asthma services, passing a policy is not the final step. Rather, figuring out how to implement a policy on the ground is a fundamental step for achieving the goal of improving asthma outcomes. As Megan Ellingson shared, "It takes an investment of time upfront to try out a model and tenacity to prove the model. Now we have to take it to the next step of scaling the model." That's exactly what CHW Solutions is taking on next. They've begun conversations with some large health plans about their successful implementation of the asthma policy, the actual costs that need to be covered to scale the services, and the positive impact on families. In the words of a mother of a child with asthma who received asthma education and allergen-reducing products from CHW Solutions, "I'm incredibly grateful. This is life-changing."



In the meantime, the Minnesota Department of Health's Asthma Program has also been supporting systems change within local health departments (LHDs). Given that LHDs already have an infrastructure for providing home visits conducted by public health nurses, some LHDs have added an asthma visit to that existing infrastructure. The LHDs bill Medicaid for a child visit, education to a child, and education to a caregiver using HCPCS codes while leveraging existing program systems for referrals and payments.

To support this work, the Asthma Program created and released *The Asthma Home-Based Services Manual* in 2024 to provide structure and guidance for LHDs to develop an asthma home-based program. The manual is an outline of operational considerations, step-by-step implementation, and workflow guidance for LHDs to provide home-based asthma education by public health nurses. Additionally, the Dakota County Public Health Department shares many of their tools and forms for other LHDs to replicate or tailor.

The Minnesota experience illustrates the value of a multipronged approach, led by multiple stakeholders: home visiting organizations, managed care plans, the state health department, and local health departments. Employing multiple workforces and different strategies, the stakeholders are building a system to increase access to much-needed asthma home visiting services.

KEY LESSONS MINNESOTA

- Passing a policy is not always the end goal. Figuring out how to implement policies on the ground effectively is just as critical to success.
- It takes an investment of time upfront to try out a model and tenacity to prove the model. Then, the next step is scaling the model.
- A multipronged approach to policy and program work can increase access to services faster than a single approach.

PARTNERSHIPS AND COMMITMENT PAVE THE WAY TO POLICY CHANGE IN HAWAI'I

"Our community has a strong passion for working with parents to help their *keiki* control their asthma," notes Jordan Fuhrmeister with the Hawai'i Department of Health. That passion isn't just a sentiment but is reflected in the Hawai'i Asthma Plan (HAP) 2030 adopted in 2019. Organized into four areas—Community Design and Access, Education, Health Care, and Worksite—the Plan prioritizes goals and strategies that lead to policy, systems, and environmental change for children with asthma.

> "Our community has a strong passion for working with parents to help their *keiki* control their asthma,"
>
> **Jordan Fuhrmeister**
> **Hawai'i Department of Health**

Turning the Plan into action is the responsibility of the Hawai'i Asthma Leadership Team, with members that include health plans, hospitals, nonprofits, educators, and others. The Leadership Team's Health Care Workgroup formed in 2022 and has made strides toward the 2030 goal to establish coverage of asthma self-management education by Med-QUEST (Hawai'i's Medicaid program), as they are currently in the process of drafting a state plan amendment (SPA) that will require health plans to cover asthma self-management education and trigger assessments for Medicaid members.

Unique partnerships have made this progress possible. First, even though its federal grant funding ended in 2019, the Hawai'i Department of Health committed staff to facilitate the Hawai'i Asthma Leadership Team. At the same time, the Hawai'i Department of Human Services Med-QUEST Division committed staff to lead development of the asthma SPA with the Hawai'i Department of Health. Jordan shared, "The Med-QUEST Division is very supportive of the Department of Health Asthma Control Program coming to them and working to define what is best for the health of Hawai'i residents." The two state agencies communicate regularly and share a commitment to collaboration that is a model for other states.

Another partnership enabling Hawai'i's progress is between Med-QUEST and the Centers for Medicare and Medicaid Services (CMS), the federal agency that reviews and approves SPAs submitted by state Medicaid agencies. The two agencies have worked closely on numerous SPAs for years; therefore Med-QUEST Division staff have recommended that a stepwise approach may be most effective for Hawai'i. As such, Med-QUEST Division, in collaboration with the Hawai'i Department of Health, is drafting the initial SPA to cover asthma self-management education and trigger assessments by qualified healthcare providers that currently have an enrollment pathway into the Medicaid system; the two state agencies hope to expand the qualifications and enrollment pathways for additional providers, including nonlicensed professionals, in the future. For example, the state is working with the Hawai'i Community Health Worker Association to determine how to advance community health workers (CHWs) in the Medicaid system, which could allow CHWs to provide asthma self-management education and home visits among other activities.

One factor that facilitated Hawai'i's progress is that leadership team members have two similar SPAs from other states to use as models. Both Missouri and California have adopted SPAs related to asthma preventive services, providing the Hawai'i team with concrete examples and inspiration to support discussion of what types of modifications would be needed to tailor a policy for their state. As more states like Hawai'i adopt SPAs, more model policies will help accelerate the adoption of preventive service policies for asthma nationwide.

KEY LESSONS HAWAI'I

- Genuine partnerships between state agencies and state Medicaid, and between Medicaid and the federal government, can be a key asset to making policy progress possible.
- Policy change can be achieved all at once or through incremental steps. There's no one right way.
- Having model policies from other states to review, learn from, and adapt accelerates the adoption of preventive service policies for asthma nationwide.

BUILDING ON LESSONS LEARNED TOWARD SYSTEM SUCCESS IN NEW YORK

Over nearly two decades and through program and policy changes, the state of New York has made progress toward broad, sustainable financing for home-based asthma services. Pathways have included state Medicaid coverage for skilled nursing visits and community health worker (CHW) services, demonstration projects under Medicaid waivers, pilot projects under a value-based payment structure, and pursuit of an in lieu of services" (ILOS) policy. Central to New York's progress has been the flexibility and persistence of leaders at the New York State Department of Health (Department), to pursue multiple policy mechanisms depending on what appeared most feasible at the time.

New York's Delivery System Reform Incentive Payment (DSRIP) program, run under a Medicaid waiver from 2014to 2020, funded regional demonstration projects across health and social care provider systems to drive population health and clinical quality improvement. Multiple projects centered on expanding guidelines-based asthma care and integrating home-based asthma services. Asthma project design in part, built on findings from the Department's Healthy Neighborhoods Program, in operation since 2008, which demonstrated that low-intensity healthy homes interventions decreased avoidable (and costly) healthcare utilization. Under DSRIP, there were eight asthma projects across New York. A review of New York's DSRIP efforts highlighted asthma CHW and home visiting services among DSRIP's promising practices, approaches with potential to achieve improvements in Medicaid health outcomes with adequate scaling and resource investment. At the close of DSRIP, New York Medicaid continued transitioning to a value-based payment system; however, aspects of home-based asthma services supported directly through DSRIP were not yet sustainably integrated.

Launching in 2025, the social care networks will be responsible for screening all Medicaid members for health-related social needs and providing enhanced services addressing these needs to eligible members.

Medicaid beneficiaries in an enhanced population meeting clinical criteria indicating poorly controlled asthma will be eligible for medically necessary asthma remediation services including in-home asthma self-management education, home environmental trigger assessment, and home remediation and provision of supportive products for asthma trigger reduction.

The New York State Asthma Control Program's work to expand and sustain home-based asthma services continued, nonetheless, in collaboration with the Department's Office of Health Insurance Programs, which implements Medicaid in New York. In 2018, the New York State Energy Research and Development Authority (NYSERDA) approached the Department to consider joint development of a healthy homes value-based payment pilot (pilot) to improve asthma-related health outcomes, address building performance as a factor impacting health, and reduce unintentional household injury. Launched in 2021, the pilot aimed to support children with asthma enrolled in Medicaid and their families. Reflecting multiple policy priorities across New York at the time, the pilot provided a pathway for expanding on the prior success of DSRIP's asthma projects. It additionally aligned with New York's Climate Leadership and Community Protection Act, the Prevention Agenda (the state's health improvement plan), met Medicaid's VBP program requirement to advance interventions addressing social determinants of health, and contributed to CDC's EXHALE Technical Package, a set of six-evidence-based strategies shown to improve asthma-related health outcomes and reduce avoidable healthcare costs due to asthma. EXHALE's inclusion of home-based asthma services with evidence showing the return on investment for home-based asthma services further strengthened the Department's rationale for expansion.

Under the pilot, the Department and NYSERDA engaged four Medicaid managed care organizations and nine value-based payment partners to combine asthma

home skilled nursing visits, CHW support for care coordination and asthma self-management education, home improvements addressing energy efficiency and weatherization, asthma trigger remediation, and home safety. When faced with ongoing nursing workforce shortages exacerbated by the COVID pandemic, use of the skilled home nursing visit model was unsustainable, and pilot design pivoted to a full reliance on a CHW model. As the pilot nears the end of implementation, the Department and NYSERDA will work towards a joint evaluation report describing barriers encountered, lessons learned, identified best practices, and the impact of pilot health services and home improvement intervention components.

Building on momentum from the pilot, the New York State Asthma Control Program pursued the development of an ILOS policy for home-based asthma services as a mechanism for sustainably supporting services. During the same period, the Office of Health Insurance Programs was developing the New York Health Equity Reform (NYHER) 1115 Medicaid Waiver Amendment. Approved by CMS in January 2024, NYHER outlined plans to build a delivery system with a focus on health equity, including regional social care network (SCN) lead entities. The Asthma Control Program provided subject matter expertise to the Office of Health Insurance Programs to embed evidence-based asthma remediation as an enhanced HRSN service under NYHER. Launching in 2025, the SCNs will be responsible for screening all Medicaid members for health-related social needs (HRSN) and providing enhanced services addressing these needs to eligible members.

Medicaid beneficiaries in an enhanced population meeting clinical criteria indicating poorly controlled asthma will be eligible for medically necessary asthma remediation services including in-home asthma self-management education, home environmental trigger assessment, and home remediation and provision of supportive products for asthma trigger reduction. Given New York's focus on advancing asthma-related services under NYHER, the Office of Health Insurance Programs opted not to pursue the ILOS with the intention that home-based asthma services will become embedded into New York's Medicaid benefits after conclusion of the waiver.

Lessons from New York's past work advancing home-based asthma services will support effective implementation of these services under NYHER. While some efforts did not result in sustainable asthma home visiting through the original coverage pathways envisioned, what Department leaders learned helped to shape New York's current success. Lynley Siag, who has been with the Department since 2015, shared, "I feel very accountable to the broader policy goal of integrating home-based asthma services under Medicaid and the commitment and persistence across the Asthma Control Program and OHIP teams have been a facilitating factor to success." The Department is now focused on providing technical assistance to both the SCNs and the asthma home visiting health services and home improvement delivery partners.

KEY LESSONS NEW YORK

- Expect to pursue multiple policy tracks and stay persistent. Feasible policy options will change rapidly, but even an unsuccessful attempt can gain important momentum in policy transformation. With every attempt, partners learn necessary details and forge necessary connections without which no policy can be successful. Every step is a building step, knowledge is cumulative towards successful policy change, even if your first policy target is not the pathway your state or community can ultimately make work. Policy is opportunistic, and the prepared team is ready when opportunity presents itself with detailed policy solutions that can fit the opportunities.
- There are multiple policy solutions that can achieve the same outcome. It's important to explore and understand all options and determine which is most feasible for a given place and time.

FLEXIBLE TA AND SUPPORT IS AVAILABLE. CONTACT:

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BUILDING ON YEARS OF COLLABORATION TO ACHIEVE POLICY SUCCESS IN CALIFORNIA

While some organizations across California have offered asthma home visiting services for over 20 years, most had to rely on unstable grant funding, which meant inconsistent access to these services for the people who need them most. In response to pressing need and policy opportunities at the federal level, organizations across the state created the California Asthma Financing (CAF) Workgroup in 2015 with the clear goal to increase access to asthma home visiting services for Medi-Cal beneficiaries with poorly controlled asthma. (Medi-Cal is California's Medicaid program.)

Coordinated by Regional Asthma Management & Prevention (RAMP), CAF's membership includes asthma care providers (licensed and nonlicensed), managed care organizations, home visiting programs, public health departments, children's health champions, healthy housing organizations, and others. CAF members share resources and information, network, and strategize about policy opportunities to support home-based asthma services. Over five years, CAF members directly engaged with the state Medicaid agency, advancing two key pieces of legislation and working through the state's budget appropriations process to embed asthma home visiting in Medi-Cal.

In 2019, CAF and other key partners were almost successful at including asthma home visiting services in Medi-Cal through state legislation. However, instead of approving the legislation, the legislature and governor decided to make a one-time appropriation of $15 million to support asthma home visiting services through grants from a private foundation, which enabled 28 organizations statewide to provide home-based asthma services for three years.

The grant program expanded the capacity of the asthma home visiting workforce and deepened understanding of best practices, and in 2022, California adopted two asthma-related Medi-Cal policies.

The Asthma Preventive Services benefit, enacted through a state plan amendment via the federal Preventive Services Rule, covers asthma self-management education for anyone with an asthma diagnosis and an in-home environmental asthma trigger assessment for people with poorly controlled asthma. Importantly, these services can be provided by qualified nonlicensed professionals like CHWs and *promotoras*.

Where available, the asthma remediation option means Medi-Cal will cover minor to moderate environmental remediation for beneficiaries with poorly controlled asthma. Asthma remediation can include supplies like mattress and pillow dustcovers, HEPA-filtered vacuums, dehumidifiers, or air cleaners, or services like minor mold removal and remediation services, ventilation improvements, or integrated pest management.

The asthma remediation option under the Community Supports program is the second Medicaid policy. Enacted through the Medicaid waiver process, Asthma Remediation uses the federal "in lieu of services" rule to allow certain nonmedical services to be provided in lieu of traditional medical care to help avoid other costlier interventions. In California, Community Supports provides a menu of 14 services that Medi-Cal managed care plans can integrate into their programs; asthma remediation is one of them. Where available, the asthma remediation option means Medi-Cal will cover minor to moderate environmental remediation for beneficiaries with poorly controlled asthma. Asthma remediation can include supplies like mattress and pillow dustcovers, HEPA-filtered vacuums, dehumidifiers, or air cleaners, or services like minor mold removal and remediation services, ventilation improvements, or integrated pest management.

RAMP Director Anne Kelsey Lamb noted, "Together, the two policies support comprehensive asthma home visiting services for the people who need them most. The Asthma Preventive Services benefit helps licensed and nonlicensed providers engage people with asthma wherever they encounter them with proven preventive services, including asthma self-management education,

and home environment assessments. When people with asthma are living in home environments that may make their asthma worse, the asthma remediation option under Community Supports allows the providers to remediate environmental asthma triggers through supplies and services."

California's successes resulted from broad and committed partnerships over many years to move policies forward. The range of partnering organizations was a tremendous strength that served the effort. For example, early in the process, RAMP secured a meeting with the head of Medi-Cal and was able to convene stakeholders who understood everything from the details of home visiting, the evidence base for asthma home visiting, the Medi-Cal reform process, and priorities of the Medi-Cal director. This "bench strength" continued through the development of the Asthma Preventive Services benefit and asthma remediation under Community Supports, where CAF members provided insights and experience to help craft policies that reflect the array of the asthma home visiting professionals and communities across the state.

Passing policies is only one step toward getting services to people who need them. Today, California's asthma partners are focused on increasing effective implementation. For example, RAMP provides technical assistance (TA) to health plans and asthma home visiting programs, and facilitates a peer learning community of 30 organizations that are providing asthma home visiting services through Medi-Cal. The peer learning community provides opportunities to discuss program improvements, like how to increase referrals, and to identify needed policy improvements that RAMP shares with the state agency on behalf of the network of providers.

KEY LESSONS CALIFORNIA

- Broad and committed partnerships—developed over many years and with a range of partnering organizations—are a tremendous strength to support both state and local efforts.
- After policy development and passage, policy implementation requires ongoing dialogue between policymakers and implementers to be successful.

Workforce development is also critical for policy implementation. Launched in 2018, the California Department of Public Health manages the Asthma Management Academy, a no-cost training for CHWs and other health educators. The Academy provides live, virtual, and in-person training in both English and Spanish, facilitated by CHWs and a Certified Asthma Educator, and has trained over 700 asthma educators. Completion of training prepares participants to provide asthma self-management education (ASME) and home trigger assessments with payment from Medi-Cal.

California State Senator Melissa Hurtado (right) introduces legislation to expand asthma home visiting services to low-income families.

THERE ARE MULTIPLE MEDICAID POLICY MECHANISMS FOR COVERING HOME-BASED ASTHMA SERVICES

- **STATE PLAN AMENDMENTS (SPAS):** SPAs make permanent amendments to the benefits covered by a state Medicaid agency. Some states have used SPAs to allow Community Health Workers, promotoras, or other qualified nonlicensed professionals to provide asthma self-management education and other services. This approach takes advantage of the federal Preventive Services rule, which provides state Medicaid agencies with the option to pay for preventive services provided by professionals that may fall outside of a state's clinical licensure system (e.g., certified asthma educators, healthy homes specialists and other community health workers) upon the recommendation of a physician or licensed practitioner. Check out examples from Missouri and California.
- **IN LIEU OF SERVICES (ILOS):** ILOS is an option states may consider employing in Medicaid managed care programs to improve health outcomes and address unmet health-related social needs, such as housing instability and nutrition insecurity, through the use of a service or setting that is provided to an enrollee in lieu of a service or setting (ILOS) covered under the state plan. Some states have used ILOSs to pay for the remediation of environmental asthma triggers in homes. In those states, Medicaid managed care plans can opt to offer the ILOS service to their members. Check out California's Community Supports program, which uses the ILOS option. For more background information on ILOS, see this guidance from the Centers for Medicaid and Medicare Services.
- **SECTION 1115 WAIVERS:** In the case of asthma, services like pest management or supplies like air cleaners may be essential for a patient to manage asthma triggers in their home, but these supplies/services are not reimbursable under Medicaid rules. State Medicaid programs can seek a waiver of Medicaid rules to test new ways to deliver and pay for health care services in Medicaid. This is typically done via a Section 1115 waiver, which gives states additional flexibility to design and improve their Medicaid programs by using innovative delivery and payment systems or by providing services not typically covered. Waivers are time-limited, typically expiring or renewing after five years. Check out New York's Social Care Networks, funded through a 1115 waiver.
- **HEALTH SERVICES INITIATIVES (HSIS):** A longstanding but underutilized provision in the Children's Health Insurance Program (CHIP), HSIs give states a flexible opportunity to leverage federally matched funds to design, implement, and finance asthma interventions for children in low-income households. States can draw down federal matching funds at an enhanced CHIP rate for expenditures not related to the direct provision of covered benefits. These funds, which may equal up to 10% of the state's total spending on covered benefits, can be used to fund administrative work and HSIs. States must first fund the operating costs for the core CHIP program; any remaining funds can then be used to finance an HSI. Check out this brief, Health Services Initiatives: Using a CHIP State Plan Option to Address Asthma Among Children in Low-Income Households, which provides more information and highlights Maryland's HSI.
- **MANAGED CARE PLAN ADMINISTRATIVE BUDGETS:** Medicaid managed care organizations have a portion of their budget devoted to administrative costs, separate from medical services. While the size of the budget is typically limited, plans can use their administrative dollars to provide home-based asthma services, even if there are only enough funds to run a pilot project. For one example, check out this partnership between a health plan and asthma home visiting program in Michigan.

Reach out to us for technical assistance and/or share what your state or community is pursuing!

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BUILDING THE GROUNDSWELL TOWARD CHANGE

When state Medicaid policy change is not a near-term feasible goal, there are still ways to make meaningful progress for people with poorly controlled asthma in a way that lays the groundwork for future policy change. Local partnerships, pilot programs, and other innovations can create a groundswell that ultimately leads to statewide change and serve as models for communities across the country.

Snapshots of recent progress are described in the following examples.

ADDRESSING ASTHMA AND HOUSING QUALITY IN ALEXANDRIA (VA)

The efforts to address asthma and housing quality in Alexandria, Virginia, reflect a deep understanding that the multiple causes of substandard housing require multiple solutions—and Alexandria's progress through new programs, system changes, and expanding partnerships have indeed been substantial.

Launched in late 2021 as a pilot and then as a permanent program in 2023, the Alexandria Health Department's (AHD) ALX Breathes program provides home-based education and trigger remediation services for English- and Spanish-speaking residents with asthma and/or COPD. The program recently served its 50th participant, and most new clients come from word-of-mouth referrals, which speaks to the impact and value of the program.

They also developed a Healthy Homes Action Plan in 2022 and facilitated the launch of the Healthy Homes Network, a coalition of public and community organizations that would serve as the primary forum in which to share information, better coordinate efforts, and plan future activities to address housing quality. Interested groups are much more on the same page, and efforts move ahead in a coordinated, far less patchwork, fashion. Action Plan 2.0 will be released in early 2025. Recognizing the community demand for action on home conditions, other city agencies are also now working toward healthy housing. The Office of Climate Action is starting to address healthy homes in its work, and when the Office of Housing updates its housing master plan, it will have a stronger emphasis on housing quality.

In addition to substantial programs, system changes, and partnerships, Alexandria is seeing a perhaps equally important change in *language*: "Hearing how much people are using key phrases like 'healthy homes' even more in our community has been incredibly gratifying," notes Natalie Talis, MPH, the population health manager for AHD. City Council members now regularly talk about housing quality in addition to housing affordability, and residents who have raised housing quality concerns for years now feel more seen and heard. The collective planning and action facilitated by AHD staff and other government and community partners has instilled a sense of hope for both short- and long-term solutions.

Meaningful and continual community engagement "from day one" lies at the core of Alexandria's progress, and staff wanted to approach healthy housing work with a human-centered design approach where the people directly experiencing the issues are foundational contributors to the solutions.

Meaningful and continual community engagement "from day one" lies at the core of Alexandria's progress, and staff wanted to approach healthy housing work with a human-centered design approach where the people directly experiencing the issues are foundational contributors to the solutions. This approach has been woven throughout all work starting with the development of their Healthy Homes Action Plan 1.0 in 2022 and the launch of the Healthy Homes Network.

While the Healthy Homes Network has community partner representation, staff knew it wasn't sufficient, so AHD and partners launched a resident survey that netted over 900 responses. That feedback led to nine different community

conversations focused on different populations, including different racial/ethnic and language groups, people with disabilities, property managers, and the general population.

Talis shared that the solutions from residents "are the core of what's going into our next Healthy Homes Action Plan [2.0]. They are resident-generated solutions based on lived experience, refined by the organizations doing work in this field. That's how we're using the expertise on both sides—[at] the organization level but also the individual level to turn it into something that hopefully will have a lot of impact. As we implement this work, we'll be going back to community to make sure we got it right."

2024 Meeting of the Alexandria Healthy Homes Network

The effective use of data has been another core component of Alexandria's progress. Building on work done in collaboration with the National Center for Healthy Housing to review local healthy homes policy, programs, and data assets and gaps in Alexandria, Action Plan 1.0 focused extensively on developing metrics so that community, organizations, and decision-makers could better understand the issue and see if and how they're making a difference. A subcommittee within the Healthy Homes Network also worked to develop a local definition of healthy housing, heavily informed by resident feedback.

This data-centric approach prompted new understanding and opportunities; for example, AHD epidemiologists and student interns combined 311 data, the Office of Code Administration's data, and resident feedback to systematically identify hot spots the office's staff that its pest abatement contractor could prioritize. This "victory" for data-driven decision-making that is responsive to residents' concern isn't a one-off, as the Healthy Homes Network will track this data moving forward to see what progress is made. Additionally, staff at the city's Alex311 office are using this data and community feedback to refine their complaint reporting portal, which will improve the experience for residents and provide different departments with more actionable information.

Of course, no one is resting on their laurels, and there's much more work to do. Action Plan 2.0 makes that clear given its focus on a wide range of issues, including mold, smoking, pests, and extreme clutter/hoarding. As much as asthma and respiratory issues like COPD have often been seamlessly mixed in with other housing quality issues, AHD staff are still motivated to better sustain and expand the ALX Breathes program, possibly by attempting to tap into Medicaid financing.

Successful relationships will continue to be at the core of Alexandria's work, and investing in constructive relationships is a pathway Talis believes can advance work in other communities across the country. AHD in particular didn't go in thinking it had all the answers or could tell others what they needed to do, especially since their partners had been working on these issues for years. It was a collaborative conversation from the beginning. "Finding that joint ground is something communities all over can do. It doesn't cost a lot of money—it takes time, it takes bandwidth to build those relationships." And Alexandria's progress to date has clearly demonstrated it's worth it.

KEY LESSONS ALEXANDRIA, VA

- Authentic community engagement leads to stronger foundation for future policy change.
- Data-driven interventions increase impact, foster new understandings, and highlight potential opportunities.
- Constructive partnerships and individual relationships are a connective tissue that can support work in any community.

PROGRAM REPLICATION AND SCALING LEAD TO SUSTAINABILITY SUCCESS IN MICHIGAN

The Ingham Health Plan Corporation (IHPC), a community-based organization in Michigan provides home-based asthma services through the Managing Asthma Through Case Management in Homes (MATCH) program. IHPC offers the MATCH services to children with new and/or uncontrolled asthma in Ingham, Eaton and Clinton Counties, and benefits participants through improved asthma control, avoidance of costly healthcare visits, and fewer interruptions to daily activities.

Over the years, IHPC has received grant funding for their MATCH services from a local community foundation and a Preventive Health and Health Services Block Grant from the Michigan Department of Health & Human Services' Local Health Services Division. Not wanting to rely solely on grant funding, IHPC staff also worked with Medicaid health plans to further improve IHPC's sustainability. While IHPC was successful in establishing a contract with two health plans, Michigan's Medicaid program went through a rebid process, and one of the two partner plans is no longer contracted to provide Medicaid services.

The staff of IHPC are embracing this change as an opportunity. While they've had grant funding, they have collected data to demonstrate the impact of their program and began outreach to the new plans in their community. IHPC's strategic and thoughtful approach to implementing MATCH prepared them well for meeting with health plans as they could articulate the "value add" of their work. This included not just providing data related to costs, but also focusing on their assets in terms of:

- *Services provided: T*hey offer clients a wide range of trigger-reducing supplies, including vacuums, asthma-friendly cleaning supplies, air purifiers, mattress and pillowcase covers, humidity gauges, and more.
- *Program experience:* They have been implementing the MATCH model since 2013.

"

We know the MATCH program improves the lives of children and families, and we're lucky to be part of a network of partners committed to making these services available to children across the state.

"

Lori Noyer
Executive Director, IHPC

- *Their ability to be flexible in terms of staffing:* They are working on ways to integrate CHWs as Asthma Educators, in addition to the Certified Asthma Educators (AE-Cs) who have been core to the MATCH program since its inception.
- *Their improvement on services offered:* They have integrated social drivers of health into their curriculum.
- *Their potential for growth:* They are ready to scale up and serve more members.

Due to their track record and strategic preparation, IHPC immediately had success! They had their first meeting with one of the new health plans in October, 2024 and left with a commitment from the health plan to establish a contract. IHPC staff are now reaching out to the other health plans and hope to replicate the success so that all children with Medicaid coverage will be eligible for these important services.

In addition to IHPC's track record and preparation, their partnerships have been instrumental to achieving their success. IHPC is not the first nor the only organization in Michigan to provide MATCH services. The Asthma Network of West Michigan developed the MATCH model in 1996 and since then, MATCH has become an evidence-based program that has been replicated in other communities. The Michigan Department of Health & Human Services' Asthma Program provides technical assistance to support the implementation, replication, and sustainability of MATCH programs within the state, and IHPC has worked with those programs to establish coordinated strategies for managed care plan outreach; they are working with the State on an analysis of cost data, too.

Establishing contracts with health plans is a huge step toward sustainability, as it will allow IHPC to transition their MATCH program from grant funding to healthcare system financing. Strengthening partnerships and sharing successes with the State and other MATCH programs is also an important step toward sustainability, as the ultimate goal is to provide access to these services statewide. Lori Noyer, Executive Director of IHPC, reflected on their success, "We know the MATCH program improves the lives of children and families, and we're lucky to be part of a network of partners committed to making these services available to children across the state.

KEY LESSONS MICHIGAN

- Relationship-building is central to sustainability work.
- Broadly articulating the value add of asthma home visiting programs is a key step toward sustainability.
- State capacity building ensures local programs have the support needed to be successful.

FLEXIBLE TA AND SUPPORT IS AVAILABLE. CONTACT:

TA@rampasthma.org
or
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TECHNICAL ASSISTANCE AND TOOLS AVAILABLE

Regional Asthma Management & Prevention (RAMP) and the National Center for Healthy Housing (NCHH) provide free technical assistance and training to expand and sustain in-home environmental asthma interventions through support from the U.S. Environmental Protection Agency.

Our approach to TA prioritizes responsiveness and flexibility over a prescriptive approach by meeting TA participants "where they are," building on their organizational and community strengths and needs, and understanding the broader policy and systems context in which they work.

Examples of our TA include the following:

- Providing strategic guidance on program and policy development.
- Serving as a thought partner in establishing and achieving goals.
- Sharing best practices from other programs across the country.
- Strategizing to overcome challenges and continue progress.
- Facilitating peer-to-peer learning.
- Supporting fundraising by identifying opportunities and supporting proposals.
- Sharing examples of tools developed by programs across the country.
- Helping to develop new tools by providing content and providing feedback.
- Conducting presentations to build capacity of TA recipients and their partners.
- Highlighting TA partners' successes to advance the field.

In addition to providing direct TA, we facilitate peer learning opportunities and develop tools in response to identified needs. Just a few examples of those tools include:

- **Building Systems to Sustain Home-Based Asthma Services** is an e-learning and technical assistance platform to support the launch and growth of large-scale, evidence-based, sustainable asthma home visiting programs. With guidance on topics such as Medicaid reimbursement opportunities and other financing options, developing a business case, scaling up, referrals and eligibility, staffing and training, supplies and services, community resources, and evaluation and reporting, each of the primary e-learning modules offers a deeper look into some of the topics and strategies to consider while working to design and implement home-based asthma services.
- **Unlocking the Power of Home-Based Asthma Services: Model Health Benefit Packages** is a tool for managed care plans and allies describing the scope, staffing, and services associated with home-based asthma services that identify and address environmental asthma triggers in the home environment. The tool includes tiers of services to provide a range of options for payers at different levels of readiness and includes recommendations to support action from critical stakeholders.
- **Roadmap to Sustainable Asthma Home Visiting** is an interactive tool to support action to provide in-home asthma services. Nine rearrangeable, primary waypoints are provided along with one possible route as an example for those who want a premade path.

FOR MORE INFORMATION, CONTACT:

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REGIONAL ASTHMA
MANAGEMENT & PREVENTION

National Center for
HEALTHY HOUSING

Regional Asthma Management & Prevention (RAMP) and the National Center for Healthy Housing (NCHH) are working together to improve the capacity of states and communities to expand and sustain home-based asthma services. We support organizations in: using data to prioritize in-home asthma interventions; developing infrastructure; building collaboration across sectors; supporting the access to, delivery and financing of in-home asthma interventions; and making these interventions more sustainable. We aim to support organizations and advance the field by providing individualized TA, facilitating opportunities for peer learning, producing tools in response to needs, and sharing stories about successes, challenges, and lessons learned.

For more information, visit:

www.rampasthma.org
www.nchh.org

This project has been funded wholly or in part by the United States Environmental Protection Agency under assistance agreement #84099001 to the Public Health Institute. The contents of this document do not necessarily reflect the views and policies of the Environmental Protection Agency, nor does the EPA endorse trade names or recommend the use of commercial products mentioned in this document.

May 2025