2022 Brief on Medi-Cal In Lieu of Services – Asthma Remediation Services and Environmental Accessibility Adaptations

Overview of CMS's focus on SDOH

The Centers for Medicare & Medicaid Services (CMS) released Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH) on January 7, 2021. The State Health Official (SHO) letter describes the potential opportunities under "Medicaid and CHIP to address social determinants of health (SDOH) and support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing SDOH".[i] Many of the 76 million low-income Americans who receive health coverage from Medicaid and Children's Health Insurance Program (CHIP) and experience challenges related to SDOH — "including but not limited to access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social connections, quality education, and opportunities for meaningful employment."[ii] SDOH are contributing risk factors that lead to poor health outcomes and health disparities. There is also strong evidence demonstrating bi-directional causal links between poverty and health; poverty can cause poor health outcomes and those persons in "poor health are more likely to have low income because their health status prevents them from working or lowers their earning ability".[iii] This federal policy shift is a significant step forward in addressing SDOH under CMS. CMS now recognizes the impact that SDOH can have on population health outcomes and has provided guidance on using Medicaid and CHIP funds for services such as in-home education, home modifications, and accessibility to housing.

In Lieu of Services (ILOS) as a Pathway to Health Care Reimbursement for Healthy Housing Interventions

Policy analysis by GHHI entitled "Authority for Services in Lieu: 2016 Managed Care Regulations" identified in lieu of services (ILOS) as a pathway to reimbursement for asthma home visiting programs.[iv] The ILOS policy was established with the revision of the CMS Managed Care Regulations on April 25, 2016. These regulations facilitate negotiations between managed care organizations, states, and the federal government with matters such as determining reimbursements. The 2016 managed care regulations provided a path forward for innovative financing for SDOH by including "services in lieu of state plan services" in the CMS approved contracts between managed care organizations and the state, either directly or as an amendment, and without requiring a specific waiver or State Plan amendment. Generally, ILOS can only be covered if:

(1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service,
(2) Members are not required to use the in lieu of services, and
(3) the in lieu of services are authorized and identified in the managed care plan contracts.[v]

The State of California implemented this pathway starting in January 2022 which opens another innovative healthcare funding mechanism for healthy housing interventions and other services that address SDOH. The revised California Advancing and Innovating Medi-Cal (CalAIM) proposal released on October 29, 2019, was the result of California Department of Health Care Services (DHCS)' collaboration with stakeholders to address SDOH and design a statewide transformation plan for key aspects of the Medi-Cal delivery system.[vi] During the stakeholder engagement process California Healthy Housing Coalition (CHHC), Regional Asthma Management and Prevention (RAMP), the Green & Healthy Homes Initiative (GHHI) and others successfully advocated for housing costs— specifically for asthma remediation— to be part of the new "In Lieu of Services (ILOS) Benefit" section of the waiver submitted to CMS for approval. DHCS CalAIM

housing services proposal was classified under ILOS rather than a 1115 waiver renewal because the former operates under a cost-effective determination made by the State. DCHS determined the 1115 renewal was not viable due to the stricter budget neutral requirements made by CMS.[vii]

On January 1, 2022, the DHCS began implementing CalAIM— a framework that encompasses broad-based delivery system, program, and payment reform across the Medi-Cal program.[viii] "CalAIM recognizes the opportunity to move California's whole-person care approach —first included in the Medi-Cal 2020 Section 1115 demonstration — to a statewide level, with a clear focus on improving health and reducing health disparities and inequities".[ix] CalAIM provides new opportunities for Medicaid managed care program (MCP) to address social determinants of health. In particular, poor quality and unhealthy housing is covered as part of the introduction of a menu of pre-approved in lieu of services (ILOS).[x] Once the CalAIM initiative is fully executed there is flexibility for MCPs to provide benefits—which can include asthma self-management education, in-home assessment, and home modifications. This is achieved when MCP's contract with local service providers to deliver asthma trigger remediation and environmentally accessibility adaptations (EAA) to Medi-Cal beneficiaries and other low-income people in the state.[xi]

CalAIM allows for MCPs, which covers 85% of Medi-CAL enrollees, to provide ILOS as a pathway to deliver services by different providers (e.g., community health workers) or in different settings (e.g., in-home environmental services) that are covered under the State plan. The ILOS are medically appropriate and cost-effective alternatives to services covered under the State Plan and federal regulation allows states to permit Medicaid managed care organizations to offer ILOS as an option to members as a substitute for other covered Medi-Cal benefits - such as hospital care, nursing facility care, and emergency department use.[xii] As a funding pathway ILOS overcomes three obstacles that previously hindered provision of housing services, specifically, through Medicaid[xiii]:

- Legal Requirements. ILOS provides flexibility with legal Medicaid requirements by allowing for MCPs to invest Medicaid funds on housing services.
- Medical Loss Ratio (MLR) Requirements. Cost of housing services for ILOS are counted as incurred claims under the MLR. The 2016 CMS Final Rule on Medicaid Managed Care Regulations that provided legal clarity on ILOS also codified non-medical services may be counted in the numerator of the MLR as well.
- Rate-Setting Requirements. Also, under federal regulation MCP are allowed to account for any ILOS' cost and utilization when states are determining capitation rates.

Requirements for providing ILOS begin with MCP, pursuant to 42 CFR §438.3, applying to the State and obtaining State approval to follow the ILOS Model of Care are met.[xiv] MCPs are strongly encouraged to elect to offer some or all of these preapproved ILOS and are expected to detail their ILOS offerings in their Model of Care submitted to the state for approval. If certain interventions are not allowed as in lieu of services then a MCP may voluntarily agree to provide any service to a member outside of an approved ILOS model of care, but the cost of any such voluntary services may not be included in determining MCP rates.

Among the pre-approved ILOS there are two types of healthy home interventions - Environmental Accessibility Adaptations (EAAs - Home Modifications) and Asthma Remediation – which can now be funded by MCPs. Both EAAs and asthma remediation are payable up to a total lifetime maximum of $7,500 and the only exceptions to the $7,500 total maximum are if the Medi-CAL member's place of residence changes or if the condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the member or to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.

Environmental Accessibility Adaptations (Home Modifications)[xv]

Service description: Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual or to enable the individual to function with greater independence in the home, without which the Member would require institutionalization. Examples of environmental accessibility adaptions include:

- Ramps and grab bars to assist Members in accessing the home
- Doorway widening for Members who require a wheelchair
- Stair lifts
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower)
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies
- Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed)

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

Eligibility: Individuals at risk for institutionalization in a nursing facility.

Allowable providers: Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based Providers and organizations

Asthma Remediation[xvi]

Service description: Environmental asthma trigger remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual or to enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers
- High-efficiency particulate air (HEPA) filtered vacuums
- Integrated pest management (IPM) services
- Dehumidifiers
- Air filters
- Other moisture-controlling interventions
- Minor mold removal and remediation services
- Ventilation improvements
- Asthma-friendly cleaning products and supplies
- Other interventions identified to be medically appropriate and cost-effective

The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver.

Eligible population: Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care Provider has documented that the service will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Allowable providers: The Medi-Cal managed care plan may manage these services directly, coordinate with an existing Medi-Cal Provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The policy requires providers to have experience and expertise with providing services in conjunction with culturally appropriate asthma self-management education. The policy guidelines list a few examples of the types of Providers that Medi-Cal managed care plans may choose to contract with for services.

- Lung health organizations
- Healthy housing organizations
- Local health departments
- Community-based providers and organizations

Discussion

The new ILOS policy in California is an exemplary model which allows the use of health care funding to address social determiants of health – such as unhealthy and unsafe housing- to improve the health outcomes for low income households . There are two immediate next steps that need to occur to make best use of the new ILOS policy: implementation in California by MCPs and the replication or adaptation of the ILOS policy in other states interested in providing green and healthy housing services.

Implementation in California is critical to ensure that good policy turns into actions that reduce health disparities related to poor quality housing. Specifically, managed care programs along with asthma home visiting programs and housing service providers need to form equitable business partnerships to work collaboratively to address housing quality needs of Medi-CAL members allowed for by this ILOS policy. Referral pathways, program design, information and data sharing, and evaluation frameworks all need to be established to ensure services are delivered effectively. There are 16 managed care plans (MCPs) that have elected to offer either Asthma Remediation or EAAs in 64 of 78 counties providing Medi-CAL members the potential to access green and healhy housing services in their communities.[xvii] Of these 16 MCP's, there are 15 individual programs that offer Asthma Remediation, 10 of which offer EAA and 9 that offer both. Some of the MCP's that offer the mentioned services include health plans that recognize the pivotal role of SDOH on population health; such as Anthem Blue Cross Partnership Plan, Aetna Better Health of California and Blue Shield of California Promise Health Plan.[xviii]

In 2022 California is paying for Managed Care Plans to pursue both strategies—providing access to essential health care and addressing the social determinants of health. As a result, additional MCP's such as Health Net Community Solutions and San Francisco Health Plan will start to cover EAA effective July 2022.[xix] The recognition by California of the significant effects of SDOH and its chronic impact on population health sets the precedent for other states to implement similar strategies. However, due to the comlexity of implementation, ILOS has not been uniform across the state. To limit in-state variation of ILOS, DHCS proposes state-wide offerings of a set of ILOS interventions to Medi-Cal benefeciaries by

incorporating it into managed care contracts. In addition to standardizing ILOS, "DHCS seeks to fully implement ILOS by building network capacity that meets the needs of the residents. This may come in the form of partnerships to develop the physical infrastructure as well as collaborations with new provider types who have not worked with Medi-Cal in the past".[xx] Lastly, in order to ensure relevant and necessary changes to meet resident needs, stakeholder feedback to identify additional cost-effective infrastructure as well as identifying the appropriate provider types to deliver these services will be implemented. Full integration of ILOS will be executed by 2027.

The other critical next step is adoption and implementation of similar ILOS policies in other states. There has been an increase spending on Medicaid dollars from the federal outlay— from 11 percent in 2000 to 15 percent in 2014 but most of these dollars are not addressing the root causes underlying health disparities in this country.[xxi] The amount the U.S. government spends on healthcare is grossly disproportionate to the population health benefits received; a stark indication of the inefficiences of our health care system. Most of Medicaid/Medicare spending is spent on end-of-life treatment or spent on acute conditions rather than disease prevention that result in disparate health outcomes. However, a more efficient allocation of financial resources that address the SDOH will not only create costs savings but will result in better population health outcomes. Now, more than ever, states must follow suit of California and implement similar strategies to address SDOH.

In recent years, states have recognized the potential savings and better health outcomes driven by ILOS in Medicaid. Currently there are 33 states that are using "In lieu of authority" with Medicaid which gives MCO's the authority to provide alternative services rather than ones specified under the state's medicaid plan.[xxii] Many of these services focus on psychiatric services which include crisis residential services as well as federal matching for capitation payments for adults who receive inpatient psychiatric or drug abuse treatment services.[xxiii] However, states have increasingly started implementing policy for healthy housing services to address the keen impacts of the social determinants of health on population health outcomes. Although California is one of the first states to use ILOS for EAA, asthma remediation and other home-based services, states are increasingly recognizing how social needs impact health outcomes. To implement healthy housing services within ILOS or initiate ILOS as an alternative to the standard care offered by CMS, states must collaborate with CMS and regional stakeholders to design such a plan. Once the plan is complete, it must be submitted to CMS for approval. The adoption of similar policies must be initiated in other states to ensure low income communities throughout the United States are provided green and healthy housing services to reduce health and racial disparities related to housing.

Other CMS Pathways to cover healthy homes services

State Plan Amendments

Services similar to the services that ILOS covers can be covered in some instances by direct medicaid benefit coverage. For instance, DHCS is considering the submission of a State Plan Amendment (SPA) to allow for reimbursement of asthma preventive services, specifically asthma education and home assessment, as a covered benefit. Medicaid offers mandatory benefits, but states have leeway to provide other services such as "targeted case management" which allows access to facilities that address SDOH.

Waivers

Medicaid can also provide housing-related services through section 1915 (c) or state-plan options in section 1915 (i) and 1915 (k) Medicaid Managed Care "value added services": For example, Texas has implemented the Community First

Choice Option under a 1915 waiver. Services include personal assistance and home-based services that ensure sanitary household conditions, enable mobility throughout the home as well as transportation and and escort services.[xxiv]

Value-Added Benefits

States can also provide SDOH services through managed care contracts such as value-added benefits. In Lousiana Medicaid's most recent managed care RFP, applicants were required to respond around how they would implement value added benefits that included home repairs and home-based asthma measures.

Value-Based Payments

The fee-for-service model in the US healthcare system has created a consumer based demand for medical services. The incentive to overuse services creates not only economic ineffeciencies in the health care system but also poses a health hazard for the population. The transition from fee-for-service per volume to a value-based payment model is an adequate solution which states have started to incentivize. States are now seeking to contract with managed care organizations (MCO's) as a vehicle to implement value-based payments (VBP). States are using a few approaches to facilitate MCO adoption of VBP. For example, some states are requiring MCO's to adopt a standard VBP model developed by the state Medicaid agency. This creates standardization of provider elgibility requirements, payment methods and quality measures; ultimately facilitating provider participation and allows for faster adoption of the VBP. States are also requiring a certain percentage of provider payments be through VBP arrangements such as bundled payments or global payment programs. Lastly, the state may also require MCO's to launch VBP models subject to state approval. This would entail MCO's to "submit VBP proposals for input, review, and approval".[xxv] This would allow the state to work directly with MCO's to develop implementation strategies for specific VBP models as well as evaluate quality during development. The adoption of VBP is not only a strategy to prevent moral hazard but will allow services such as home-based asthma interventions and fall prevention services to work more effectively and efficiently.

Health Homes

Currently, 20 states have the Medicaid state option to enroll in Medicaid Health Home Programs. The program focuses on care coordination for patients with physical and behavioral health conditions and serves as an avenue to connect patients to social services such as housing and community-based programs.

Collaborations with Local Social Services that Address SDOH

These formal and informal agreements with social service providers have helped ameliorate poor social conditions. For example, EAA implementations such as creating accessible kitchens, bathrooms, stair elevators and grab bars have been funded through these partnerships. Programs from HUD, DOE, and HHS have been aligned at a local level to address hazards that Medicaid is not directly funding to resolve. CMS launched the Accountable Health Communities (AHCs) which screens beneficiaries for social and medical needs and links them to local community services. Many of the AHCs are now looking to build on the screening and referral networks that have been established to also include funding and resources to address the identified social needs.

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