Law and the Public's Health

One of the most important questions in health law concerns how the law can be used as a tool to improve the public's health. This article by Malcarney et al. focuses on this question, providing a detailed overview of how the legal changes in the Affordable Care Act might be employed in a comprehensive strategy to reduce the burden of asthma.

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USING INSURANCE LAWS TO IMPROVE ACCESS TO COMMUNITY-BASED ASTHMA PREVENTION

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Asthma symptoms are triggered and exacerbated by many risk factors found in homes and community environments. Interventions designed to reduce or eliminate these triggers—such as patient self-management education, home visits and care coordination by asthma educators and community health workers, and supplies to mitigate environmental asthma triggers—can greatly decrease asthma morbidity. However, many of these evidence-based interventions and services fall outside of traditional clinical health-care interventions included in care delivery systems and reimbursed by insurers. This installment of *Law and the Public's Health* reviews the role Medicaid, the Children's Health Insurance Program (CHIP), and private insurers can play to promote public health through community-based asthma prevention.

BACKGROUND

Asthma is among the most common chronic diseases. According to the Centers for Disease Control and Prevention (CDC), in 2011, almost 26 million people in the United States—approximately 9.5% of children younger than 18 years of age and 8.2% of adults aged 18 years and older—had asthma.^{1,2} Asthma is the single most common chronic condition among children in the U.S.,³ and the incidence is rising significantly: in 2009, more than one in 12 people had asthma compared with just one in 14 (about 20 million) in 2001.⁴ Asthma can be a fatal disease if not properly managed,

claiming the lives of almost 3,500 Americans each year.⁵ Researchers estimate the economic burden of asthma on the U.S. at \$56 billion annually, representing \$50.1 billion in costs to the health-care system (in increased emergency department [ED] visits and hospitalizations) and \$5.9 billion in indirect costs from lost productivity (asthma accounts for 14.4 million lost school days and 14.2 million lost work days).^{5–7} Thus, curbing the epidemic and reducing costs is a public health priority.

The complexity of the disease means that clinical care is necessary, but not sufficient. Teaching patients and their families to administer asthma medication correctly and to mitigate environmental exposure—such as cigarette smoke, certain allergens (e.g., dust mites, pests, and pets), and other environmental irritants—is a central component of effective asthma management.^{8–11} Expert guidelines released in 2007 by the National Asthma Education Prevention Program (NAEPP) emphasize the importance of community patient education for self-management, along with control of environmental asthma triggers.¹² However, clinical providers typically lack the capacity to assume the extensive educational role envisioned by NAEPP guidelines. CDC reports that in 2008, fewer than half of patients with asthma reported being taught how to avoid home asthma triggers.⁴

Community-based asthma education programs work to fill this void and are considered fundamental to the success of any asthma-control program.^{13,14} Such programs extend NAEPP guidelines in nontraditional settings, such as homes, schools, and community centers, and augment clinical care by working in coordination with action plans and other aspects of asthma treatment. Studies show the positive effects of asthma home visitation programs on asthma management, use of urgent care, allergen reduction, missed school days, and caregiver stress.^{15–19} School settings represent an additional opportunity for effective asthma

education.²⁰⁻²⁴ Rigorous evaluation has shown the benefits of community asthma education in controlling symptoms, improving medication adherence and quality of life, and reducing medical costs,^{12,25} with savings of \$5.30 to \$14.00 for each dollar spent.²⁶ Other studies show similar results for children and adults when community interventions are combined with clinical care improvements.^{25,27,28} In one study, implementation of a school-based health center intervention for children with asthma resulted in decreased health-care utilization, bringing net savings of nearly \$1,000 per child per hospitalization.²⁹

HOW INSURANCE DESIGN AFFECTS COMMUNITY-BASED ASTHMA INTERVENTIONS

The results of community-based asthma intervention studies have prompted some private insurers to modify coverage and payment principles to reach home- and community-based asthma education. For example, Optima Health Plan's Asthma Life Coach program deploys nurses and respiratory therapists to patients' homes to carry out education, medication review, and instruction on environmental asthma triggers.³⁰ Optima estimates a return on investment of \$4.40 for every \$1.00 spent.^{31,32} Priority Health Plan's program, which includes asthma management and trigger avoidance education and mitigation of environmental risk factors, has improved medication use and significantly reduced ED visits and hospitalizations, generating net per-child savings of \$800 per year.²⁷ Priority Health Plan estimates project total savings of more than \$1.7 million. The Neighborhood Health Plan runs a similar asthma program, estimating more than a 30% reduction in hospitalizations and ED visits since the program's inception.³⁰

Despite these results, innovative asthma programs are not in widespread use, and coverage of and payment for community education is not typical.^{18,27} As a result, most of the community-based interventions in the field today rely on limited funding from CDC's National Asthma Control Program or from private foundations. Community benefit support from nonprofit hospitals might be an additional source of such funding, but no data exist on how frequently hospitals make investments in community-based asthma interventions.^{33,34} Maintaining community programs is a challenge, and few communities are able to maintain these interventions when funding dollars run dry.³⁵

USING INSURANCE LAWS TO ADVANCE COMMUNITY-BASED ASTHMA INTERVENTIONS

The fact that some insurers participating in public programs and private insurance markets do offer broader coverage and payment for community-based asthma interventions while others do not underscores that the exclusion of community-based interventions is largely the result of insurer discretion rather than legal limitations on coverage and payment. Examining how existing insurance sources might be better deployed to advance community prevention thus emerges as a public health policy priority, particularly as the expanded insurance markets created by the Affordable Care Act (ACA) begin to emerge.

Medicaid

Medicaid policy is central to this discussion because of the association among asthma prevalence, poor asthma management (as measured by higher ED use),³⁶⁻³⁸ and poverty.^{3,39} Medicaid can play a significant role in bringing effective community asthma programs to low-income and medically underserved populations.

Preventive benefits for children as part of EPSDT. Preventive benefits are optional for traditionally eligible adult populations (e.g., caretakers and parents, pregnant women, and adults with disabilities) but are required for beneficiaries younger than 21 years of age as a result of Medicaid's special Early and Periodic Screening Diagnosis and Treatment (EPSDT) entitlement, which encompasses not only screening and diagnostic services, but all treatments recognized under federal law, including preventive services.^{40,41} Proposed federal regulations issued in 2013 clarify that the statutory term "preventive services" encompasses not only preventive care *furnished* by licensed professionals, but also services *recommended* by physicians and other licensed practitioners of the healing arts, even if performed by others.^{42,43} Thus, if these regulations are finalized, it will be lawful for Medicaid (either directly or through its managed care contractors) to cover and pay for a community-based asthma intervention even when carried out by health educators or other community health workers. Although not considered licensed health-care professionals, these personnel may still have to meet a state's training and, where applicable, certification standards. Furthermore, federal Medicaid law already gives states discretion over the settings in which care is furnished. As a result, coverage for preventive services is permissible even when the intervention happens outside the clinical setting. Essentially, a physician can prescribe a health educator home visit, and Medicaid can cover and pay for the service as a form of "medical assistance."⁴²

Community-based interventions as part of Medicaid “health homes.” The ACA creates a new state Medicaid option to create “health homes” for individuals with one or more chronic conditions, specifically including asthma.⁴⁴ Since this Medicaid option became available in January 2011, seven states have established Medicaid health homes that include as eligible beneficiaries both children and adults with asthma.⁴⁵ Under the law, health homes are responsible for providing or coordinating all patient care, as well as a specific set of health home services: comprehensive care management, care coordination and health promotion, patient and family support, and referral to community and social support services.⁴⁴ Federal guidelines emphasize that health homes must contain sufficient providers to deliver a “whole-person approach to care,” which includes access to health education and promotion of disease self-management, in coordination with community-based services.⁴⁶ The guidelines also emphasize state discretion over the range of participating preventive service providers and treatment settings. Oregon has used this authority to include community health workers and peer wellness specialists among its health home participating providers when they meet criteria established by the Oregon Health Authority.⁴⁷

Contracting with managed care providers. As noted, Medicaid agencies have the legal power to cover and pay for medical assistance either directly or through participating managed care organizations (MCOs). Today, managed care enrollment accounts for more than 70% of Medicaid beneficiaries.⁴⁸ Under their contractual agreements, states can specify community-based asthma interventions; MCOs also have the authority to use their revenues to supplement what the state’s fee-for-service Medicaid program may cover. Community-based asthma interventions bear a striking similarity to the disease-management strategies used by MCOs to manage chronic conditions, and some MCOs include asthma in their disease-management arsenals. For example, in 2002, Monroe Plan for Medical Care—a Medicaid MCO plan in New York State—launched a program for children with asthma, providing specialty clinical care, case-management services, educational materials, home environmental assessments, and supplies for reducing exposure to environmental triggers. For every \$1.00 spent, \$1.48 was saved in direct medical costs through a 60% reduction in hospitalizations and 78% fewer ED visits.^{27,49} Other MCOs implementing similar community asthma interventions have yielded comparable results.^{30,50}

Medicaid demonstration authority. Although states have all the flexibility they need to expand coverage and pay-

ment to incorporate community-based asthma services without special waivers, some states have incorporated asthma care into their demonstration waivers to target the communities in which such additional services will be available. For example, states may seek a waiver to the statewideness rule—a Medicaid rule that requires medical assistance coverage to be available to all state residents—to direct interventions toward specific localities and populations.⁵¹ Demonstration authority (found in Section 1115 of the Social Security Act⁵²) also may enable states to cover supplies not otherwise considered medical assistance, such as allergen-proof mattress covers or air humidifiers.

Through its special MassHealth §1115 demonstration, Massachusetts has developed a pediatric asthma pilot program to provide more flexibility for coverage of community prevention services not traditionally covered by Medicaid, including home visits, care coordination by community health workers, and supplies to mitigate environmental triggers.⁵³ This pilot also tests an innovative payment methodology, using a bundled per-member, per-month payment for services not traditionally covered by MassHealth. The Center for Medicare and Medicaid Innovation (CMMI), whose establishment was authorized under the ACA to test new efficient delivery and service arrangements, also has approved innovative projects in New England, Delaware, and Tennessee that support the provision of services and the inclusion of providers not traditionally covered under Medicaid.⁵⁴ For example, the Nemours/Alfred I. duPont Hospital for Children is partnering with Medicaid and public health officials as well as community-based organizations to address asthma triggers in schools and homes, use certified community health workers as patient navigators who provide case-management services to high-need families, and develop an asthma population health initiative in specific neighborhoods.

CHIP

The types of flexibilities outlined under Medicaid apply equally to CHIP. Thus, states with separately administered CHIPs might consider revisions to the scope of child health assistance, as well as modifications of purchasing agreements with CHIP issuers, to incorporate preventive, community-based asthma interventions that use health workers who meet state-established performance criteria.

Including community-based preventive asthma intervention as a qualified health plan performance standard. As the nation moves closer to full implementation of the ACA, coverage under qualified health plans (QHPs) will become available to millions of lower- and

moderate-income individuals and families through health insurance marketplaces, known under the law as Exchanges. As of January 2013, 19 states are moving toward operating state-based marketplaces, while another seven will participate in a state Partnership with a federal marketplace.⁵⁵ In both cases, states will have the authority to design the certification criteria for QHPs. One criterion is offering essential health benefits that include services for children as well as preventive, disease-management, and rehabilitative services. While federal law sets minimum standards governing these requirements, states retain the flexibility to establish performance standards for QHPs that measure their performance by how well they deliver community-based asthma intervention services to patients with diagnosed asthma as part of their disease intervention and preventive services activities. Financing community prevention through QHPs thus becomes a basic measure of plan performance.

IMPLICATIONS FOR PUBLIC HEALTH PRACTICE AND POLICY

This brief review underscores the important role that both public and private health insurance can play in financing community-based asthma interventions for patients with asthma. Insurance generally does not finance group treatments; that is, it would not be possible for an insurer to treat as a covered benefit an award of funding to a school, for example, to run a health education program. But an insurer, public or private, could pay for the services received by individual children in such settings, and third-party payments, coupled with grants from public programs or hospital community benefit investments, might be used to help sustain such an effort. In terms of home visits for individual patients, this article emphasizes that such patient-specific treatments fall well within the meaning of coverage under Medicaid and CHIP and should be an important quality improvement performance standard for QHPs, which are expected to operate effective preventive programs that return good value for the investment.

What is perhaps most needed is a public health community that gains sufficient familiarity with the flexibility made possible by modern insurance products to effectively advocate for these types of design and performance modifications as a core element of public health practice. Plenty of examples exist; the task becomes translating these examples into policy of general applicability. For policy translation to occur, public health expertise on program content and performance

measurement will be key, along with active efforts to convince payers of the wisdom of such modifications.

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