Health Resources in Action
Advancing Public Health and Medical Research

Promoting Sustainability for CHW-led Asthma Home Visiting: Engaging Medicaid Payers in the Process

Lessons from the New England Asthma Innovations Collaborative

Presented at the Regional Summit on Sustainable Funding for Asthma In-Home Interventions

Icahn School of Medicine at Mount Sinai
Stacey Chacker

November 20, 2015

NEIAC is an initiative of Health Resources in Action's Asthma Regional Council of New England

New England Asthma Innovation Collaborative

Controlling Asthma, Controlling Costs

NEAIC is a project of the Asthma Regional Council of New England, a program of Health Resources in Action

- Established in July 2012 with a $4.2 million Award from Center for Medicare and Medicaid Innovation.

The project (NEAIC) described is supported by **Grant Number 1C1CMS331039 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services**. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

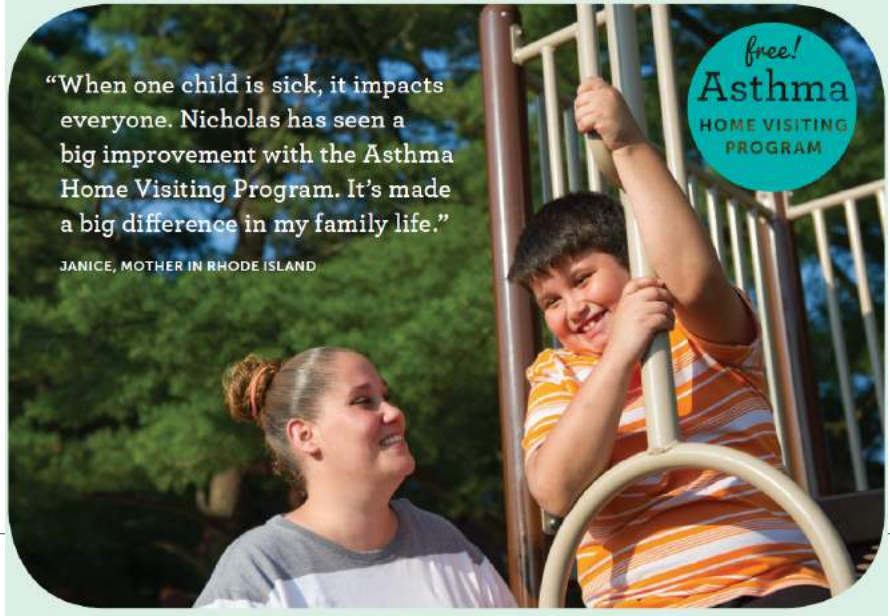
"Payers are from Mars, Providers are from Venus"

- Harold Miller, Center for Healthcare Quality and Payment Reform

NEAIC Goals and Partners

For children with poorly controlled asthma:

- Improve quality of care
- Improve health and quality of life outcomes
- Decrease health care utilization costs
- Advance sustainable payment systems



- 9 Health Care Providers
  - served 1145 patients
- Policy and Training Partners
- Seven Medicaid Payers
  - MMCOs
  - State Medicaid Offices

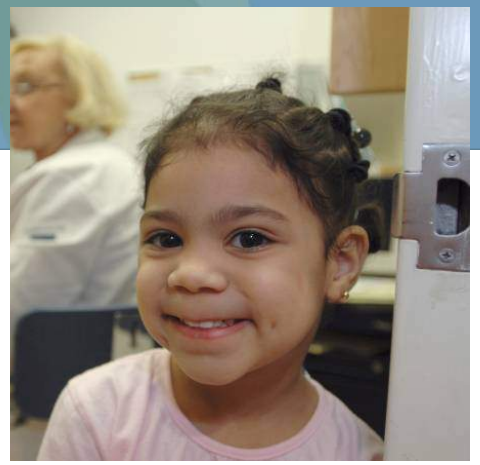
NEAIC Intervention: CHW- Led Asthma Home Visits

- **Assess** patients' needs and home environment
- **Provide** asthma self-management education
- **Deliver** cost-effective environmental supplies
- **Improve** quality and experience of care:
  - Client-centered, use of motivational interviewing
  - Promote asthma action plans
  - Promote connections to primary care & prevention
  - Referrals for social services

Target Population

- Aged 2 – 17 years old
- Medicaid or CHIP beneficiary
- A diagnosis of asthma from an authorized clinician
- Poorly controlled asthma

Inviting Payers as Partners



- **Invite/recruit asap**
- **Reach out to key decision makers**
- **Outline problem and program goal**
- **Emphasize possible benefits – e.g.**
  - Members receive high-quality services, reducing utilization
  - Capacity built in payer's service area
  - May compliment payer's case management services
  - Payer gets data on health outcomes, quality of life and cost
  - Recognition
- **Specify the "ask" – e.g.**
  - Meetings
  - Claims data
  - Referrals
  - Committing to pay pilot, test new payment model
  - With ROI, consider policy change.

Securing Claims and Encounter Data

- **Health economist:** specify data needed & time period.
- Assure **HIPAA compliant** environment
- Develop **data transfer protocols**
- **Patient Consent Forms** – specifying purpose for data sharing and whom
- **Payer Compliance Offices - necessary agreements**
- **Remind payers** in advance for data draw
- **Review all data for completeness**
- Be prepared to **negotiate and problem solve**.

NEAIC 2015 Payer/Provider Summit

- Overview of results from **NEAIC Payer Assessment.**
- Preliminary **findings -** data from asthma home visiting intervention.
- Preliminary **cost analysis -** preliminary claims and encounter data.
- **Payment models** from CHW-led asthma home visiting programs:
- C**aregiver perspective** on the value of the intervention.
- Discussion on **how to sustain** these important services.

Participants included: Public and Private Health Payers; Federal and State agencies; and NEAIC Providers and workforce development specialists

Challenges

- Need to “braid” funding
- MMCO’s committed to pay if ROI and improved health outcomes. But full cost analysis - 2016. Grant ended – intervention ended or capacity decreased
- Turnover at payer organizations = changes in commitment.
- Challenging to pay for within Fee for Services
- Developing contracts – when not all payers on board
- Moving from a FFS to a bundled payment or global payment system may require new contracting system/mechanism
  - NEAIC intervention not big enough to be influencing factor
  - Patient churning makes new models less appealing.
  - For global payment, providers need to have financial wherewithal and infrastructure to assume risk
  - ACOs a few years off. Programs ahead of health care reform.

Promoting Sustainability – Opportunities

- CMS Ruling (2014) allows payment for preventative services by non-licensed individuals when recommended by licensed clinician
- 1115 Waivers
- MCO's have flexibility: Short term contracts, pilot projects, policy change.
- Accountable Care Organizations
- Community Benefits funding
- Payment models: a) bundled payment or enhanced FFS payment; b) "case rate"; c) partial Accountable Care Organization/FFS model (shared risk – as part of global or capitated payment); d) global payments.
- State Innovation Model discussions
- Chronic Care Teams (VT)

Questions and Thank You!

- Stacey Chacker, Project Director schacker@hria.org
- Heather Nelson, PhD, MPH, Senior Research Scientist hnelson@hria.org
- Annie Rushman, MSPH, Program Associate arushman@hria.org

The project described is supported by Grant Number 1C1CMS331039 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.