

# **Moving Health Care Upstream: Making the Case to Medicaid and other health payers**

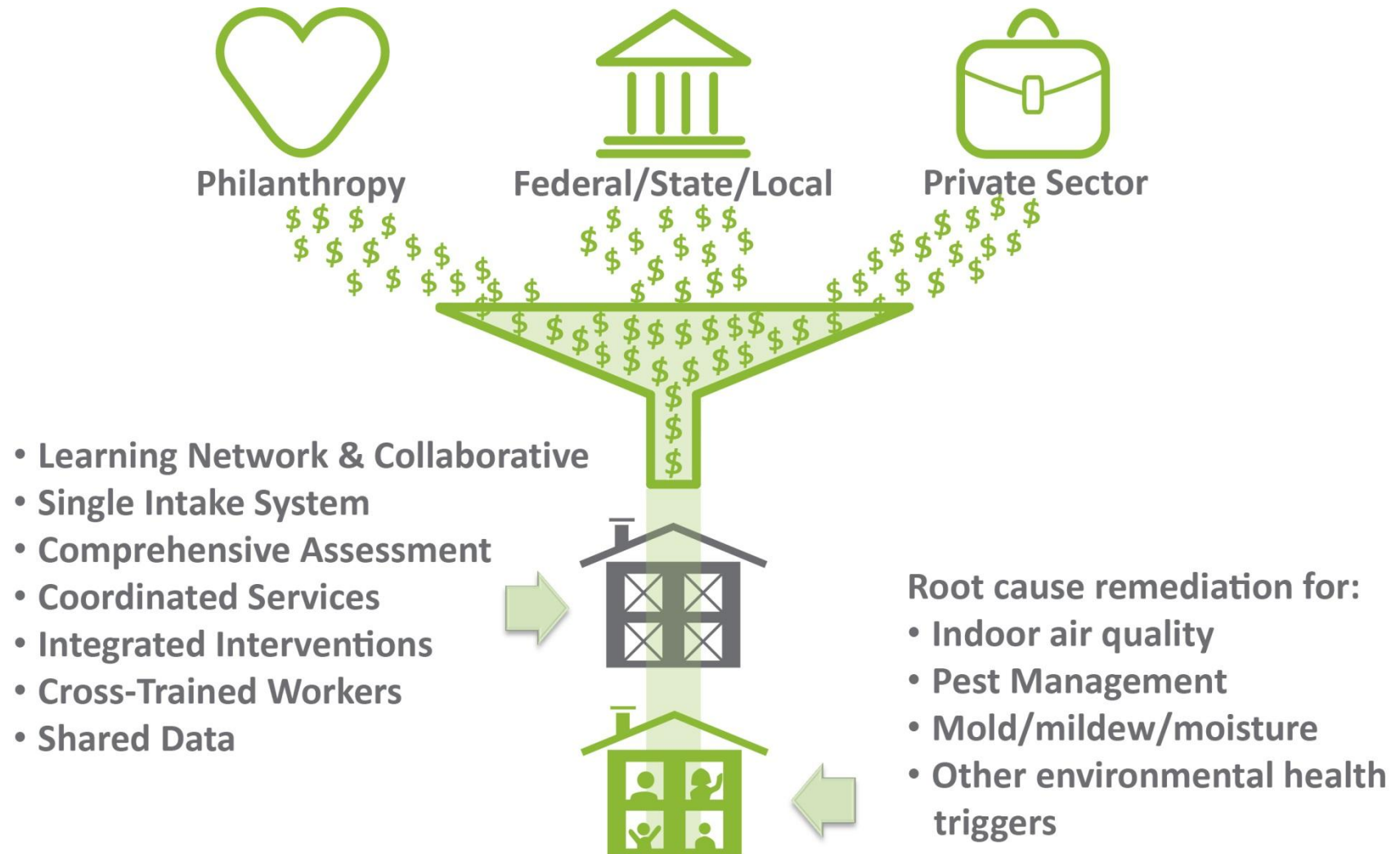
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Green & Healthy Homes Initiative

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# Agenda

- Considerations when engaging Medicaid and other healthcare payers
- Payment models
- Avenues for healthcare funding
- Examples of healthcare related reimbursements/payments
- Exercise: Mapping out next steps
- Internal activities to prepare to engage Medicaid and other payers
- Exercise: Outcomes Template

# The GHHI Model

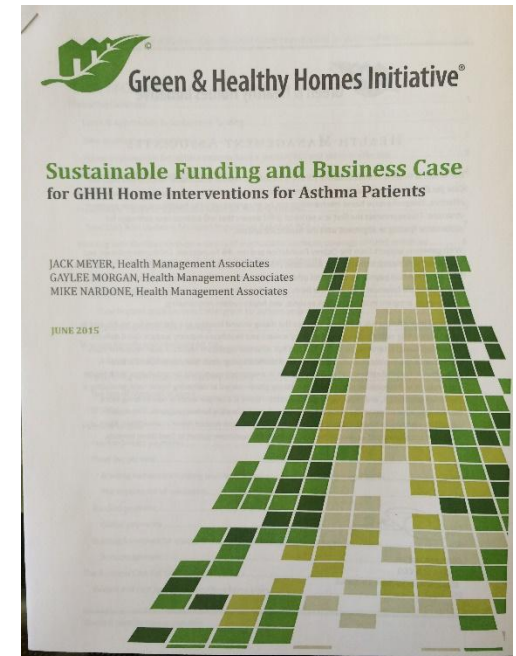


# Policy Goals

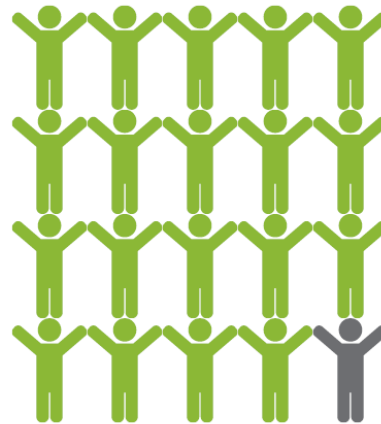
- CMS and other health payers covering evidenced-based healthy homes services
- Physicians commonly writing prescriptions for healthy homes services
- Housing professionals being utilized as a new front line for healthcare
- Hospitals utilizing community benefits to keep people healthier, rather than paying for undercompensated care
- Increased use of data around the broad impact of healthy homes

# Considerations

- State Medicaid programs and other healthcare payers and providers all looking at the Triple Aim, but have different flexibilities and authority
- Effective strategies will vary by state structure (HMA paper for GHHI in Maryland)
- Need a champion – build relationships
- Importance of credentials
- Understanding and aligning incentives



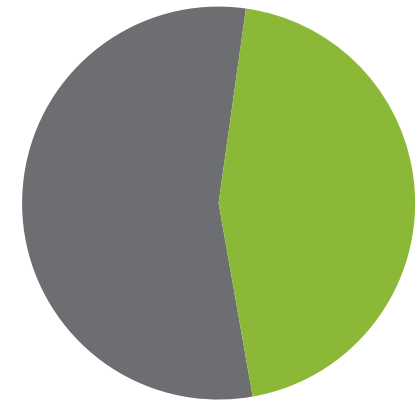
# Reimbursement Opportunities



5% of patients

=

Super-utilizers



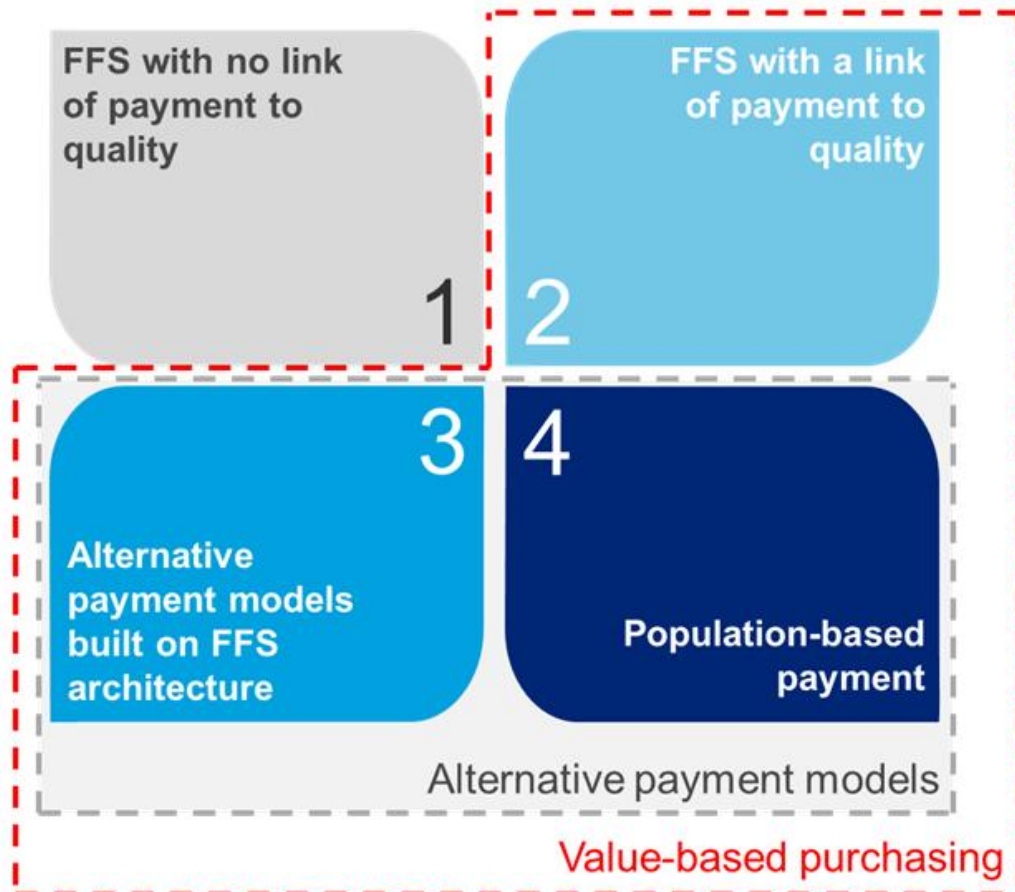
More than 50% of  
healthcare costs

# Payment models

- Fee for service
- Fee per visit (fixed)
- Bundled payments (suite of services)
- Blending of funds (combination of healthcare-based funding and other funding streams such as philanthropic grants and HUD-based grants)
- Global payments (interventions budgeted with total costs of care and prevention activities)
- Outcome based payments (measured by quality indicators or medical utilization measures)

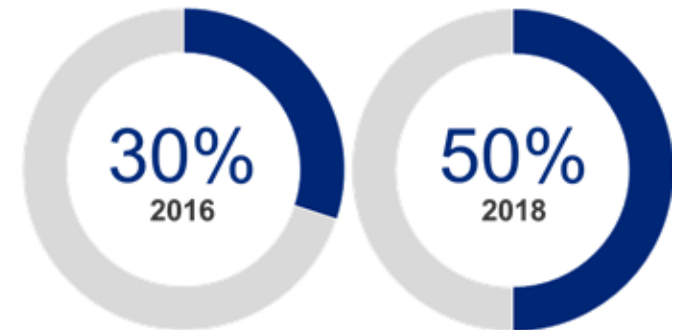
# Payment Models – HHS goals

## HHS payment taxonomy framework

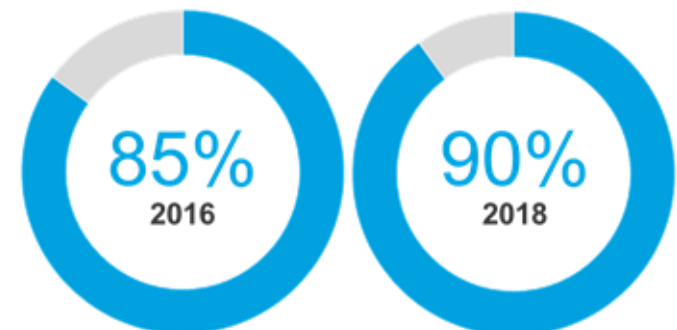


## HHS goals

Payments through alternative models  
Categories 3 and 4



Fee-for-service linked to quality and value  
Categories 2 through 4





# Avenues for healthcare financing

- Medicaid Rule Change
- Waivers
- Hospital Community Benefits
- Readmission Reduction Program
- Social Impact Bonds / Pay for Success
- Administrative Claims
- Examples from states

# Medicaid Rule Change

- Opening up Reimbursement for non-clinical professionals
- Services must be recommended by a licensed clinical provider (physician or RN), but could be performed by other professionals such as certified asthma educators in the home
- To take advantage, each state has to submit a State Plan Amendment (SPA) to CMS laying out what services would be offered, the costs for those services, and what certification will be used for those professionals
- **Changes “Who” but not “What” for the services that are eligible**
- Education, case management, community health worker services



# Medicaid Waivers

## Section 1115 Demonstrations

- Purpose is to pilot or demonstrate projects that
  - Expand eligibility,
  - Provide services not typically covered by Medicaid,
  - Use innovative delivery systems
- Submitted by a state to CMS (Centers for Medicaid and Medicare Services)
- Approved for 5-year period typically, must be “budget neutral”
- Affordable Care Act requires public comment for any proposed waiver before approval by CMS, and ensures timely review of any requests

# Hospital Community Benefit Investments under ACA

- ACA revised requirements to assure that hospitals' community benefit investments are transparent, concrete, measurable, and responsive to community needs
- A Community Health Needs Assessment (CHNA) is conducted every 3 years by the hospital, which then adopts an implementation plan
- Community benefit investments can encompass “physical improvements and housing” and “environmental improvements.”



# Hospital Readmissions Reduction Program

- Established by ACA
- Reduced payments for excess readmissions
- First three conditions were  
AMI (heart attack), pneumonia, and congestive heart failure
- COPD (chronic obstructive pulmonary disease and THA/TKA (total hip and total knee arthroplasty) added in 2014
- ACA also encourages the formation of Accountable Care Organizations for Medicare, incentivizing providers to keep patients healthy
- Maryland has new global waiver for hospitals (per capita payments)



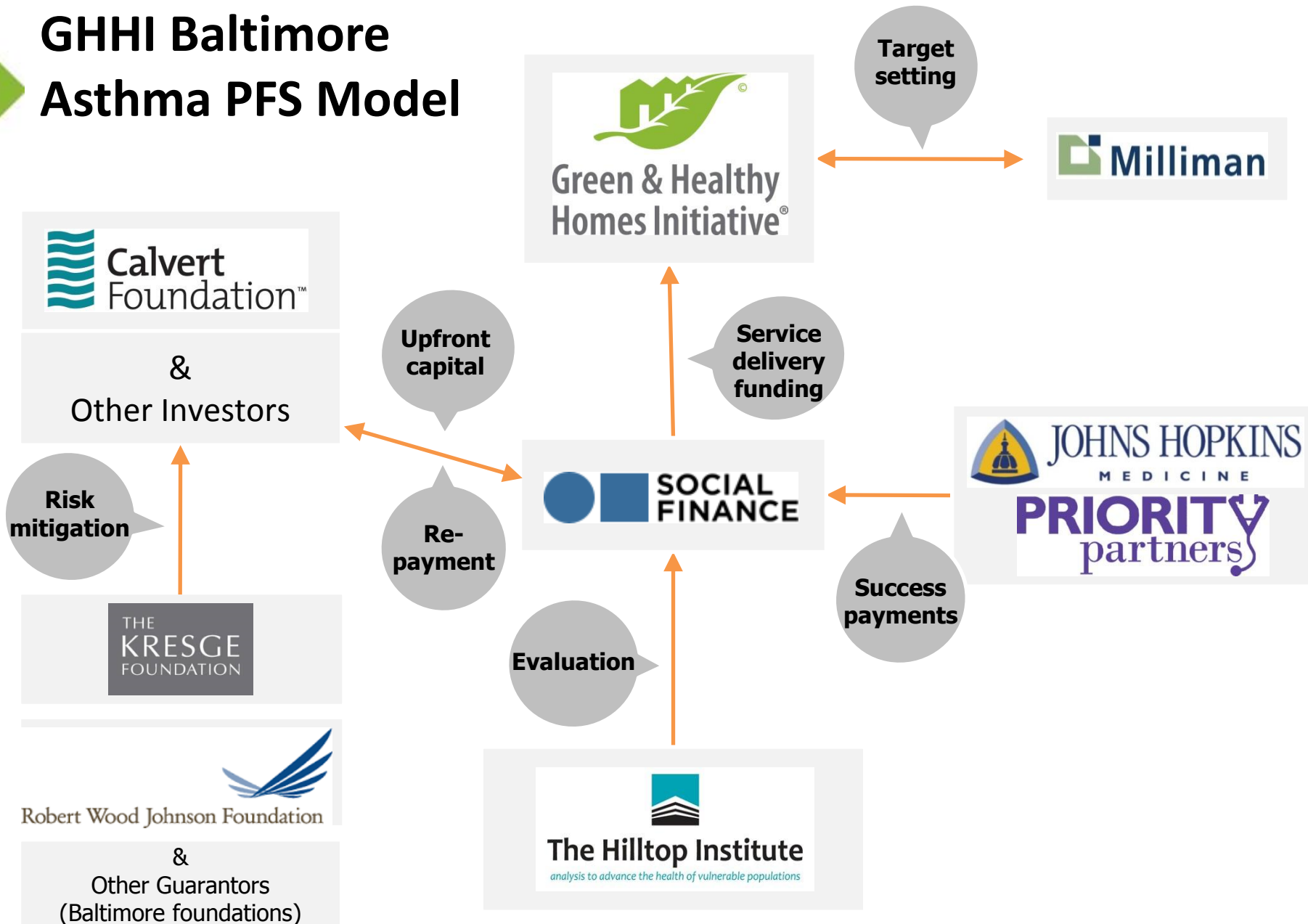
# Health Homes – Sec. 2703 of ACA

- New Medicaid option to permit individuals with one or more chronic conditions to seek care through a health home
- Health home is responsible for providing or coordinating all patient care, as well as a specific set of “health home” services, including:
  - (i) comprehensive care management;
  - (ii) care coordination and health promotion;
  - (iii) comprehensive transitional care;
  - (iv) patient and family support;
  - (v) referral to community and social support services; and
  - (vi) use of health information technology to link services
- States receive an enhanced 90% federal matching payment for the first 8 quarters of operation of the Medicaid Health Home. The enhanced matching payment is tied to the Health Home’s operation, not to individual beneficiaries.

# Pay for Success

- Pay for Success (PFS) is an innovative new method of paying for social programs based on outcomes
- Program funding comes from private investors who are paid back by government or healthcare orgs *only* if pre-determined outcomes are met
- Ideally, PFS interventions:
  - Are evidence-based ✓
  - Are preventative ✓
  - Generate cashable savings ✓

# GHHI Baltimore Asthma PFS Model





# Medicaid Administrative Claiming

- Texas Childhood Lead Poisoning Prevention Program (TxCLPP) began receiving reimbursement in 2011 for administrative claims
- Environmental lead investigations (ELIs) by TxCLPP are covered at a rate of \$327.31 per ELI
- Under the Texas Medicaid Administrative Claiming (MAC) program, state-affiliated public agencies may submit claims for reimbursement for administrative activities supporting the Medicaid program.
- TxCLPP Annual claim = (FFP)(Proportion of Medicaid enrollees)(Total salaries)

# Examples of payments/reimbursements

## Multnomah County Environmental Health Services (MCEHS)

- Began with HUD Healthy Homes program for in-home nursing care management, environmental assessments, education, and supplies to reduce asthma triggers.
- Expanded to the Community Asthma Inspection and Referral (CAIR) program. Community Health Nurse and Community Health Worker conducts 7 visits.
- In 2010 MCEHS negotiated with OR Department of Medical Assistance Programs and CMS to develop **Healthy Homes targeted case management**, allowing for Medicaid reimbursement.
- Receiving over \$330 / visit.
- With OR move towards Coordinating Care Organizations, currently working on bundled payment plan

# Asthma Network of West Michigan (ANWM)



- Provides comprehensive home-based case management, environmental assessment, trigger identification, and education and asthma control strategy by certified asthma educators and licensed medical social workers (LMSW)
- Health outcomes and net cost savings of \$800/year per child led to partnership with MCO Priority Health
- Priority Health reimburses at standard Medicaid rate for a skilled nursing visit, revenue code 551, for both asthma educators and LMSW
- 6 to 18 home visits are authorized
- 83% reduction in hospitalizations, 60% reduction in ER visits
- PCMH pilot in 2008 called First Steps

# Hennepin Health - Minnesota

- Hennepin Health is a Medicaid ACO pilot
- State plan amendment
- Partners include Hennepin County Medical Center, NorthPoint Health and Wellness Center (FQHC), Metropolitan Health Plan, and the Human Services and Public Health Department.
- The partners have a risk-sharing agreement and share in any cost savings. This payment model aligns incentives among the provider partners, and provides the financial rationale to decrease expensive preventable inpatient and ED by funding care coordination services.
- Hennepin Health has partnered with the Hennepin County Medical Center Coordinated Care Clinic, which serves as a Patient Centered Medical Home for high cost patients (5% of patients account for 64% of costs)



**Hennepin Health**  
County Health Care Reform

# Missouri Legislation

- Plan started in response to CMS bulletin to state Medicaid programs regarding strategies to target super-utilizers
- Medicaid reimbursement for specialists to visit the homes of low-income patients with severe asthma to identify asthma triggers in those homes.
- Medicaid also provides reimbursement for face-to-face sessions to educate severe asthmatics
- Eligible patients identified as frequent users of ER, prior hospitalizations, or frequently prescribed oral steroids for asthmatic emergencies.
- Plan costs Missouri \$524,033 in the first year with the federal government chipping in another \$4.7 million in Medicaid dollars.

# Monroe Plan (New York)



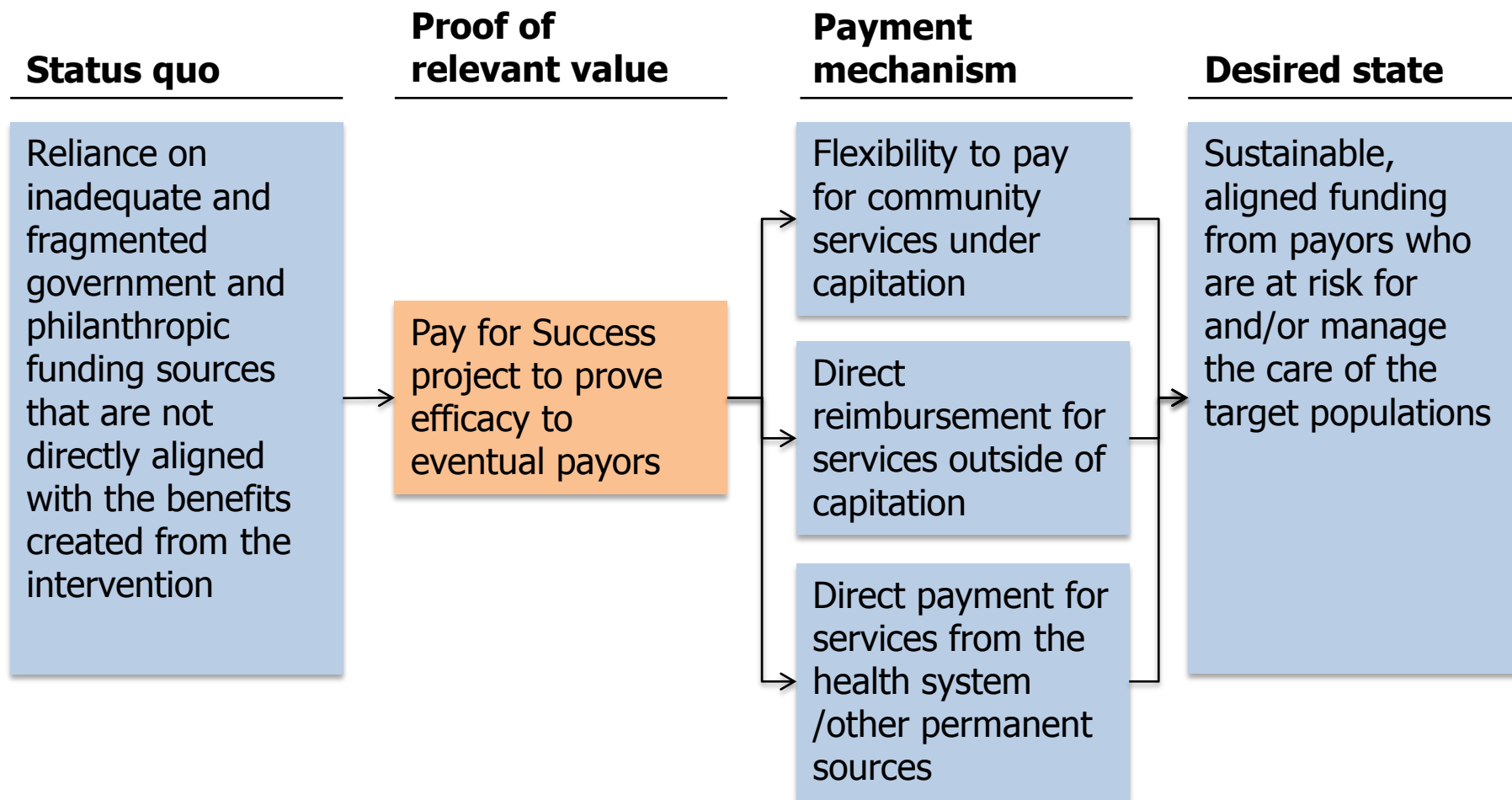
- Monroe Plan for Medical Care, an EPA Asthma Leadership Award winner, launched a program that included educational materials, home environmental assessments, and supplies.
- Initially funded through Robert Wood Johnson Foundation grant, but ROI led to the board funding the program in-house
- For every \$1 spent, \$1.48 was saved in direct medical costs through a 60% reduction in hospitalizations and 78% fewer ED visits.

# Optima Health (Virginia)



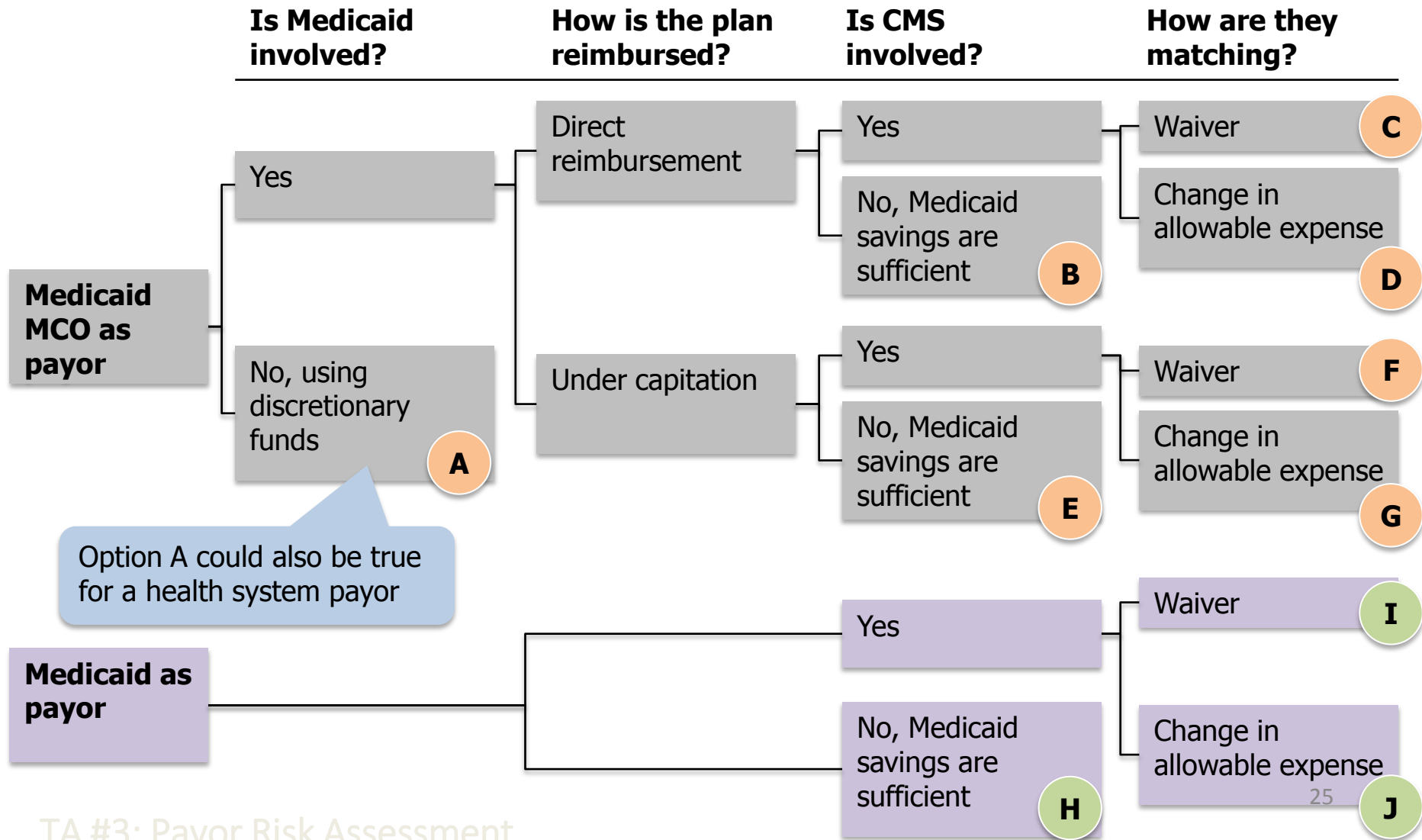
- Managed care system offering Medicaid and commercial HMO, PPO plans
- Launched home visiting pilot, based on asthma severity. For at risk patients, combines education with asthma environmental strategies, 4 visits by nurses
- Hospitalizations decreased by 54% in commercial plans, 32% in Medicaid plans
- Overall costs for patients at high risk and received environmental interventions decreased by 35%
- Optima estimates \$4.40 return for \$1 spent on program

# We are trying to shift funding to pay for effective community-based preventative services





# We first want to understand the potential options for the PFS payment mechanism



# Exercise – Medicaid Engagement Worksheet

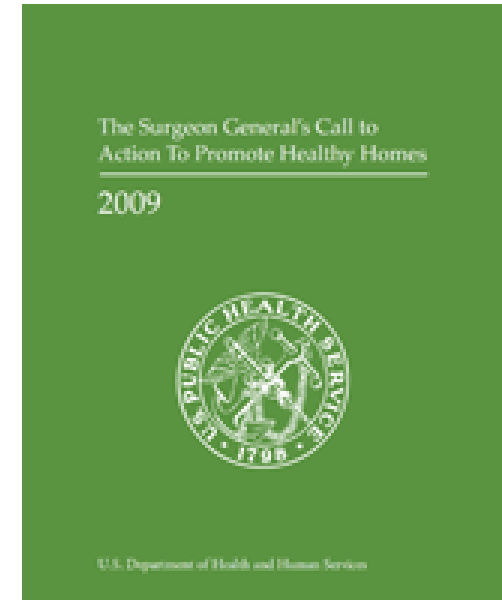
- Who should be involved?
- Which pathways seem most feasible?
- Who has the incentives?
- What are the known challenges?
- What are the expected outcomes?
- Who else may deliver these services?
- What payment structure makes sense?
- What are the political implications?

# Preparing for engagement

- Documenting services (narrative, flow, case studies)
- Evidence Base
- Outputs, outcomes and metrics
- Defining the population served (characteristics / demographics / inclusion and exclusion criteria)
- Cost effectiveness / Business Case / ROI
- Capacity / Scaling considerations

# Evidence Base for Healthy Homes

- NAEPP Guidelines-based care calls for
  - 1) Assessment of disease severity;
  - 2) Medication;
  - 3) Patient education; and
  - 4) **Environmental control**
- HHS's Community Preventive Services Task Force found **“strong evidence of effectiveness of in-home environmental interventions”** in improving asthma management and overall quality of life for asthmatics.
- Cost benefit studies show a return of **\$5 to \$14 per \$1.**



Surgeon General's Call to Action to Promote Healthy Homes (2009)

# GHHI Healthy Homes Program

- Direct Healthy Homes Program services began in 2000
- Program targets asthma diagnosed children ages 2-14 in Baltimore City; priority on children with prior asthma related ED visit or hospitalization; family income  $\leq$  80% AMI
- Primary Referral Sources - MCOs, health care providers, Health Department, GHHI Baltimore partners
- Units Completed - 1,660 families enrolled and 1,480 Healthy Homes interventions completed by the program to date using tiered intervention strategy and in-house GHHI Baltimore Hazard Reduction Team

# Impact: Building a Business Case

*Green & Healthy Homes Initiative: Improving Health, Economic and Social Outcomes Through Integrated Housing Intervention*

- **66%** reduction in asthma-related client hospitalizations
- **28%** reduction in asthma-related client ED visits
- **50%** increase in participants never having to visit the doctor's office due to asthma episodes
- **62%** increase in participants reporting asthma-related perfect attendance for their child (0 school absences due to asthma episodes)
- **88%** increase in participants reporting never having to miss a day of work due to their child's asthma episodes

*Environmental Justice*, Vol 7. Number 6, 2014

# Reduced Costs = Cashable Savings

- Reduction in asthma-related client hospitalizations – **1 hospital stay on average costs \$7,506 in Baltimore City. Reductions in hospitalizations produces cashable savings**
- Reduction in asthma-related emergency room visits - **1 emergency room visit on average costs \$820 in Baltimore City. Reduction in ER visits produces cashable savings**
- Key questions: Who financially benefits? Who loses revenue?

# Analyzing Target Population

Year 1

Year 2

Year 3

**Analysis #1:**  
All affected  
populations over a  
three year period



**Analysis #2:**  
The affected  
population in year  
one, tracked over  
three years



## Demographic criteria

- Health plan member (if applicable)
- Lives in catchment area
- Age as of first year of observation (to be defined in each locale)

## Health criteria

- Hospitalized with asthma as first diagnosis
- Seen in the ED with asthma as first diagnosis
- Hospitalized or seen in ED with asthma as first diagnosis



# Defining the cost of the program

- FTE analysis
- New efficiencies and leveraging greater integration with current care services
- Management and decision making
- Capacity / Scaling considerations
- Specific services, what needs to be added and what can be dropped

# Exercise – Preparing for engagement

- Output and Outcomes Worksheet

# Questions?

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