Medicaid-Public Health Partnership to Improve Health and Control Costs: Early Lessons from the CDC’s 6|18 Initiative

June 28, 2017

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Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Welcome and Introductions

The Robert Wood Johnson Foundation’s Perspectives on the 6|18 Initiative

Overview of the 6|18 Initiative

States Advancing Prevention Strategies under the 6|18 Initiative
  » Rhode Island’s Road to Securing Medicaid Coverage for an Asthma Control Program
  » South Carolina’s Path to Enhancing Tobacco Cessation Benefits

Q&A
Welcome & Introductions
Today’s Speakers

Hilary Heishman
Senior Program Officer, Robert Wood Johnson Foundation

Maia Crawford
Senior Program Officer, Center for Health Care Strategies

Christina Galardi
Project Manager, South Carolina Department of Health and Human Services

Julian Drix
Asthma Program Manager, Rhode Island Department of Health
Non-profit policy center dedicated to improving the health of low-income Americans
The Robert Wood Johnson Foundation's Perspectives on the 6|18 Initiative

Hilary Heishman, RWJF
The CDC’s 6|18 Initiative

Maia Crawford, CHCS
CDC Strategic Direction

- Improve health security at home and around the world
- Better prevent the leading causes of illness, injury, disability, and death
- Strengthen public health/health care collaboration
Prevention and Population Health Framework

1. Traditional Clinical Prevention
   - Increase the use of clinical preventive services

2. Innovative Clinical Prevention
   - Provide services that extend care outside the clinical setting

3. Community-Wide Prevention
   - Implement interventions that reach whole populations

http://journals.lww.com/jphmp/Citation/publishahead/The_3_Buckets_of_Prevention_.99695.aspx
The 6|18 Initiative

Promote adoption of evidence-based interventions in collaboration with health care purchasers, payers, and providers

High-burden health conditions 6 18 Evidence-based interventions that improve health and save money

CDC.gov/sixeighteen

6|18 Initiative Goals

- **Improve health** and control health care **costs** using specific evidence-based interventions

- **Establish sustainable partnerships** between public health and health care purchasers, health plans, and providers
Six High-Burden Health Conditions

SIX WAYS TO SPEND SMarter
FOR HEALTHIER PEOPLE

- Reduce tobacco use
- Control blood pressure
- Prevent healthcare-associated infections (HAI)
- Control asthma
- Prevent unintended pregnancy
- Control and prevent diabetes

- High-burden
- Costly
- Preventable
- Scalable
- Purchasers and payers
Evidence-Based Interventions

**REDUCE TOBACCO USE**
- Increase access to evidence-based tobacco cessation treatments, including individual, group, and telephone counseling and Food and Drug Administration (FDA)-approved cessation medications (in accordance with the 2008 Public Health Service Clinical Practice Guideline and the 2015 U.S. Preventive Services Task Force (USPSTF) tobacco cessation recommendation statement).
- Remove barriers that impede access to covered cessation treatments, such as cost-sharing and prior authorization.
- Promote increased use of covered treatment benefits by tobacco users.

**CONTROL HIGH BLOOD PRESSURE**
- Implement strategies that improve adherence to blood pressure and other common chronic disease prescription medications, including lipid-lowering and smoking cessation medications. Strategies may include: low-cost medication fills and fixed dose medication combinations; calendar blister packs or other medication packaging; and care coordination by primary care teams.
- Provide to patients with known or suspected hypertension validated home blood pressure monitors and reimburse for the clinical support services required for home blood pressure monitoring.

**PREVENT HEALTHCARE-ASSOCIATED INFECTIONS**
- Require antibiotic stewardship programs in all hospitals and skilled nursing facilities, in accordance with CDC’s Core Elements of Hospital Antibiotic Stewardship and The Core Elements of Antibiotic Stewardship for Nursing Homes.
- Reduce inappropriate antibiotic prescribing by incentivizing providers to encourage them to closely follow CDC’s Core Elements of Outpatient Antibiotic Stewardship.

**CONTROL ASTHMA**
- Use the 2007 National Asthma Education and Prevention Program (NAEPP Guidelines) as part of evidence-based clinical practice and medical management guidelines.
- Implement strategies that improve access and adherence to asthma medications and devices.
- Expand access to intensive self-management education by licensed professionals or qualified lay health workers for patients whose asthma is not well-controlled with the medical management approach outlined in the 2007 NAEPP Guidelines.
- Expand access to home visits by licensed professionals or qualified lay health workers to provide both targeted, intensive self-management education and the reduction of home asthma triggers for patients whose asthma is not well controlled through use of both 2007 NAEPP Guidelines’ medical management and asthma self-management education.

**PREVENT UNINTENDED PREGNANCY**
- Reimburse providers for the full range of contraceptive services (e.g., screening for pregnancy intention; client-centered counseling; insertion, removal, replacement, or reinsertion of long-acting reversible contraceptives [LARCs, such as intrauterine devices and implants] or other contraceptive devices, and follow-up) for women of childbearing age.
- Reimburse providers or provider systems for the actual cost of FDA-approved contraception, including LARC or other contraceptive devices in order to provide the full range of contraceptive methods.
- Reimburse for immediate postpartum insertion of long-acting reversible contraceptives (LARC) by unbundling payment for LARC from other postpartum services.
- Remove administrative and logistical barriers to LARC (e.g., remove pre-approval requirement or step therapy restriction and manage high acquisition and stocking costs).

**PREVENT DIABETES**
- Expand access to the National Diabetes Prevention Program (the National DPP), a lifestyle change program for preventing type 2 diabetes.
Key 6 | 18 Focus Areas

**Coverage**
Medicaid agencies and Medicaid health plans - State plan amendments, legislation/regulatory changes, and contract modifications

**Utilization**
Providers - Education, incentives, trainings, and behavior change

**Uptake**
Consumers - Awareness, engagement, and incentives
## The Medicaid-Public Health Partnership: Complementary Skills

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<th>Medicaid</th>
<th>Public Health</th>
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<td>- Authority over benefits and coverage</td>
<td>- Disease-specific expertise and epidemiologic evidence</td>
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<td>- Expertise in health care payment and delivery</td>
<td>- On-the-ground knowledge of access and utilization barriers</td>
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<td>- Establish health quality goals</td>
<td>- Population health focus</td>
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<td>- Collaborate with federal/state policymakers, and health plans</td>
<td>- Expertise in intervention design and implementation</td>
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<td>- Access to and analysis of state/federal data</td>
<td>- Experience with knowledge dissemination and provider training</td>
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Benefits of Participation

- Build/enhance cross-agency partnerships
- Implement concrete interventions that align with state payment reform activities and goals
- Improve health and control costs using evidence-based interventions
- Receive targeted technical assistance
- Learn from and share experiences with other states
Examples of 6|18 Accomplishments

- Baseline coverage and utilization assessment
- State Plan Amendments to enhance Medicaid benefits
- Changes in billing
- Managed care organization contractual negotiations
- Payment pilots
- New scope of practice legislative authority
- Provider and member education and outreach
Additional Information about 6|18

Visit [cdc.gov/sixeighteen](http://cdc.gov/sixeighteen) for more information; there you will find:

- Evidence summaries
- FAQs
- 6|18 At-a-Glance
- Links to relevant resources

Visit [www.chcs.org/618](http://www.chcs.org/618) for additional related resources, including webinars and blogs.
States Advancing Prevention Strategies under the 6|18 Initiative

Julian Drix, Rhode Island Department of Public Health
Christina Galardi, South Carolina Department of Health and Human Services
Controlling Asthma: RI’s Road to Benefit Change Approval and Implementation

June 28, 2017
6|18 National Webinar
Progress and Early Successes
PROPOSED PAYER INTERVENTION

Expand access to home visits by licensed professionals or qualified lay health workers to improve self-management education and reduce home asthma triggers for individuals whose asthma is not well-controlled with the 2007 National Asthma Education and Prevention Program (NAEPP Guidelines) based medical management and intensive self-management education.

OPPORTUNITIES FOR PAYERS AND PROVIDERS

Payers can consider expanding patient access to home visits by licensed professionals or qualified lay health workers to improve patients’ ability to self-manage their asthma and reduce home asthma triggers.

KEY HEALTH AND COST EVIDENCE MESSAGES FOR PAYERS AND PROVIDERS

Home-based educational and environmental intervention delivered by non-physician teams (nurses, certified asthma educators, community health workers) can improve asthma symptom control, particularly in inner-city children with asthma, and may have cost savings for payers.
Asthma, Poverty, and Housing in RI

Legend

- Percent of Children Ages 2-17 with an Asthma Claim*: 2010-2012, Three-Year Average, with Percent of Children Under 18 Living Below Poverty
- Density of Children Ages 2-17 with an Asthma Claim*, 2010-2012, with Low-and-Moderate-Income Affordable Housing

* Asthma diagnosis in diagnosis fields 1-4 (UHC) or 1-4 (BCBSRI and WPRI) on any claims form, ICD-9-CM 493.xx

Rhode Island’s Asthma Intervention

The Home Asthma Response Program (HARP)

HARP is an evidence-based asthma intervention designed to reduce preventable asthma emergency department visits and hospitalizations among high risk pediatric asthma patients. The HARP model utilizes a Certified Asthma Educator (AE-C) and a Community Health Worker (CHW) to conduct three intensive sessions that:

- Assess patients’ asthma knowledge and trigger exposure
- Provide intensive asthma self-management education
- Deliver cost-effective supplies to reduce home asthma triggers
- Improve quality and experience of care

Launched in 2011, HARP is a mature evidence-based intervention with well-defined and tested partnerships, roles and responsibilities, curriculum, service delivery infrastructure, eligibility criteria, and evaluation framework.
Partnerships and TA

Pre-Existing Partnerships
- Hasbro Children’s Hospital
- Saint Josephs Health Center
- Thundermist Health Center
- Health Resources in Action

6|18 Initiative support and TA
- Closer working relationship with RI Medicaid
- CDC and CMS expertise
- Technical support: CHCS and Georgia Tech

Healthcare Reform landscape
- MCOs, ACOs (“accountable entities”), SIM, Statewide Population Health Goals, Pay for Success feasibility study
Data and Analysis

Multiple data sets and evaluations available

- Participant survey data (asthma control test, quality of life, missed school/work, symptoms)
- Observed data (asthma triggers, behaviors)
- Claims data (utilization, costs, pharmacy, office)

Separate funding → Separate data and analysis

- CDC-funded (initial HARP launch)
- CMMI-funded expansion (regional New England Asthma Innovation Collaborative)

Challenges: combining data, keeping it concise
Combined claims data showed:

- Consistent reductions in ER and hospital costs
- Higher (% and total) reductions for high utilizer group
- Participant results out-performed expected reduction (regression to the mean)
HARP has a positive return on investment. This means that every dollar invested into reducing preventable ED/hospital visits gets returned, with additional savings earned. Overall, HARP participants had a 33% ROI on ED/hospital costs ($1 investment returned with extra 30 cents saved). The subset of high utilizers had an ROI of 126%. Including overall asthma costs which showed increased medication costs, HARP was still cost effective (i.e., investment equal to savings) and the high utilizer subgroup still had an overall ROI of 65%.

DEMONSTRATED OUTCOMES:

Quality Improvement: The asthma medication ratio HEDIS score for participants increased from 32% to 46%.

Improved Asthma Control: Patient population went from 20% well controlled to 51.5% well controlled.

Improved Quality of Life: Caregiver quality of life improved 17% on validated surveys.

Reduction of Environmental Triggers: Observed reductions in the presence of mold, dust, pests, pets, tobacco smoke, and chemicals.

Reduction in Missed School/Work Days: Caregivers report reducing missed work work days due to asthma by 62%. Patients cut missed school days almost in half.

Increased Asthma Action Plans: Availability and patient use of asthma action plans created by providers increased from 20% to 80% of participants.
The Home Asthma Response Program (HARP)

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ECONOMIC CASE: COST SAVINGS AND RETURN ON CLAIMS DATA: COST SAVINGS

HARP has consistently demonstrated reductions in asthma costs, driven by large decreases in hospital and emergency department asthma claims. Claims data comparing one year pre-HARP to one year post-HARP shows that participants had a 75% reduction in asthma-related hospital and ED costs. High utilizers showed even greater reductions close to 80% and average savings of $2,700.

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Infographic

ELIGIBLE CHILDREN IN MANAGED CARE

796 children had at least one asthma emergency room visit or hospitalization, costing Medicaid over $1 million at an average of $1,358 per person.

A subset of 265 “high utilizers” had 2+ asthma ER visits at a total cost of $695,000 and average per person cost of $2,624.

2015 Medicaid data, Dx asthma
Progress in a Shifting Landscape

- RI Medicaid intends to make HARP a covered benefit for high utilizers (2+ asthma ER visits or an inpatient asthma hospitalization)
- Statewide budget difficulties impacted approval
- Multiple options: out of plan coverage, integrate with MCO contracts, value-based purchasing, pay for success arrangement
- Flexible adaptation and collaboration continue to be keys to success
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South Carolina’s Path to Enhancing Tobacco Cessation Benefits

Christina Galardi
Project Manager, SC Department of Health and Human Services (SCDHHS)
June 28, 2017
381,000 adults with full-benefit Medicaid coverage

>70% covered by 5 managed care organizations (MCOs)

33-40% of MCO members identified as current smokers (2016 CAHPS)
Payer Interventions for Reducing Tobacco Use:

1. Expand access to evidence-based tobacco cessation treatments, including individual, group, and telephone counseling and FDA-approved cessation medications.

2. Remove barriers that impede access to covered cessation treatments, such as cost-sharing and prior authorization.

3. Promote increased use of covered treatment benefits by tobacco users.
Existing Challenges for SCDHHS

- Inconsistent coverage of tobacco cessation services across MCOs
- Unknown fiscal impact of coverage changes
- Buy-in needed from relevant stakeholders
6|18 Jumpstarts Partnership

Public Health
- Surveillance data
- SC Tobacco Quitline

Health Care
- Claims data
- MCO and provider network
**Partners Develop 2016 Action Plan**

*Improve access and remove barriers to evidence-based tobacco cessation treatment*

1. Enhance tobacco cessation medication and counseling benefits through MCOs
   - Conduct policy scan and identify gaps
   - Request actuarial analysis for cost offsets

2. Leverage CMS funding match for Medicaid beneficiaries using Quitline
   - Establish data sharing agreement
   - Develop MOA for reimbursement
• Treatment options for all full-benefit Medicaid members:
  • All 7 FDA approved medications
    • No prior authorization
    • No co-pays
    • Medically appropriate combination therapies
  • Referral to the S.C. Tobacco Quitline for free counseling strongly encouraged
  • Individual or group physician counseling
2017: The Path Ahead

- Tobacco cessation benefit and funding match implementation
- MCO promotion and utilization of cessation services
- Monitoring and evaluation of utilization and costs
- Pivot focus to other 6|18 health conditions
DHEC Provides Support for Putting SCDHHS Policy into Practice

Promote increased use of covered treatment benefits

- CME training for providers on brief tobacco intervention
- Sample communication materials for MCO outreach
- Linking EMRs to track Quitline referrals
Framework for Tracking Results

- **Data sources**
  - Behavioral Risk Factor Surveillance System (BRFSS)
  - Adult Tobacco Survey (ATS)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Medicaid claims data
  - Quitline call data
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Question & Answer
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