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Policy and Reimbursement Issues

# **A COMPREHENSIVE APPROACH TO ASTHMA MANAGEMENT – THE CHANGING CLIMATE**



- Policy and Reimbursement Issues

## FRAMING THE PROBLEM



# Bending the Cost Curve and Improving Quality of Care in America's Poorest City



- In Camden, New Jersey—as in many urban areas—health care costs are concentrated in a disproportionately small number of patients. These “super-utilizers” typically have multiple chronic conditions combined with social barriers that make it hard to access and coordinate the care they need to manage these conditions and stay healthy. Launched in 2002, the Camden Coalition of Healthcare Providers strives to reform the quality, capacity, and accessibility of the health care system for the city’s vulnerable populations.





# THE NEW YORKER

Medical Report

## The Hot Spotters

*Can we lower medical costs by giving the neediest patients better care?*

by [Atul Gawande](#)  
January 24, 2011

*In Camden, New Jersey, one per cent of patients account for a third of the city's medical costs.*





Camden Coalition of  
Healthcare Providers

Community Outreach for Complex Patients:  
*Basics of Care Management and  
Care Transitions in the Field*

Kelly Craig, Director of Care Management Initiatives  
Jason Turi, Clinical Manager of Care Transitions

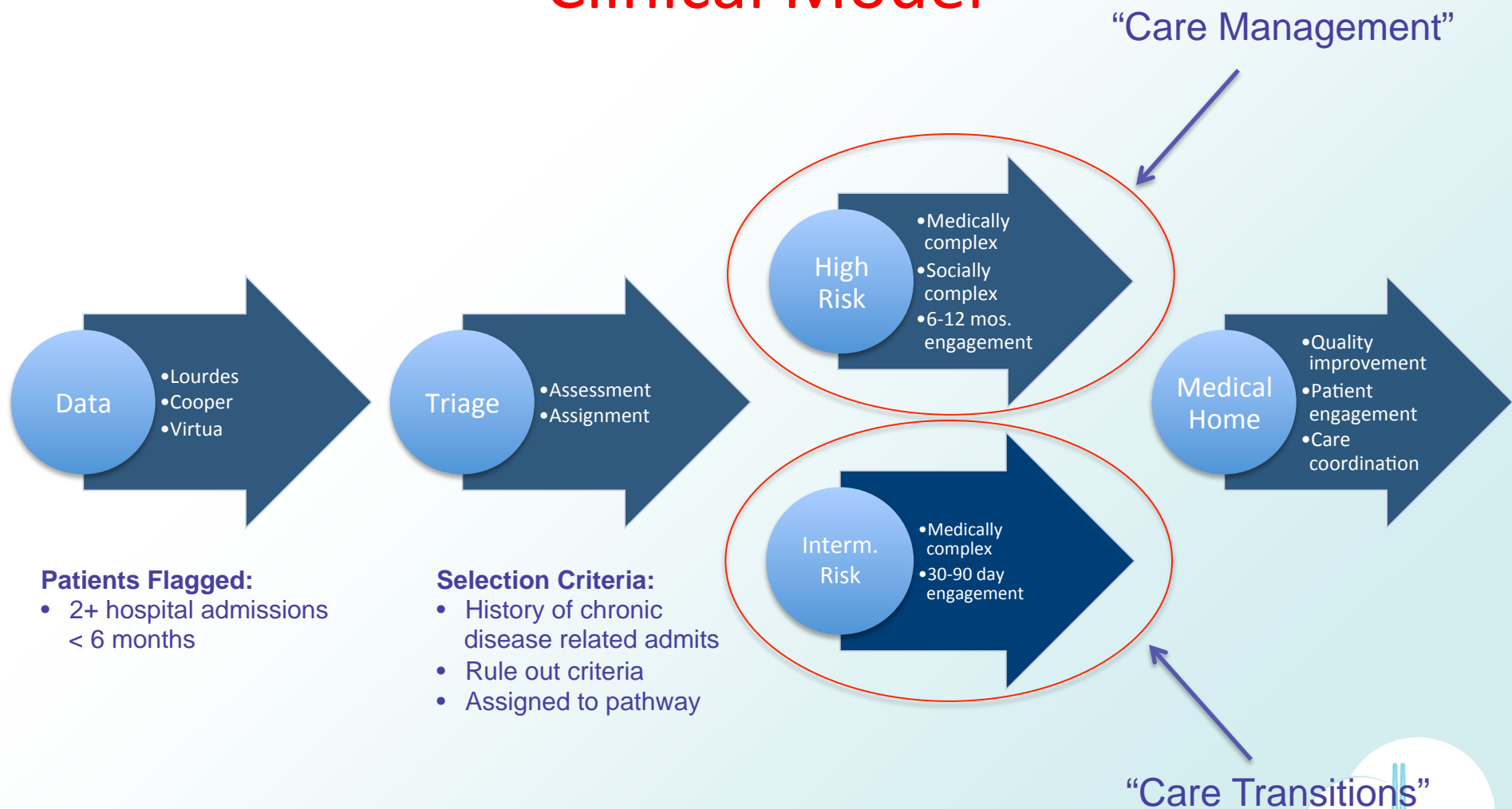
July 20, 2012

[www.camdenhealth.org](http://www.camdenhealth.org)





# Clinical Model

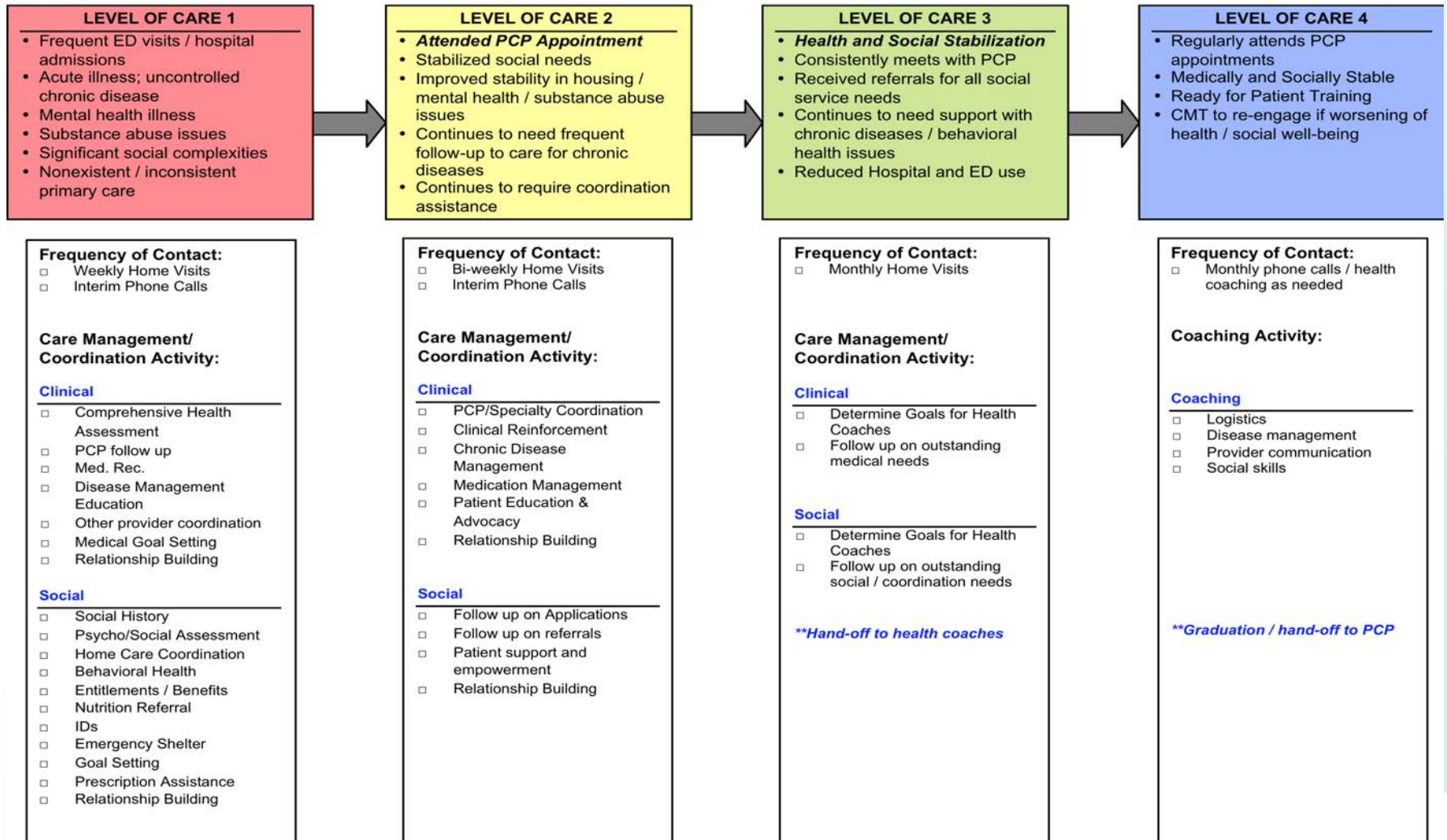


## Care Management: High Risk

- Hospital utilization in the city
  - Appropriate vs. inappropriate
- 2 or more chronic health conditions
- Low socioeconomic status
- Homeless or unstable housing
- Lack of social supports
- Low-literacy, lack of HS diploma
- Behavioral health issues
- Generational poverty/urban violence



# Care Management Workflow





## Care Transitions: Intermediate Risk

- History of 2 + admissions within past 6 months
- History of chronic disease-related admits
- Socially stable
- Rule-out criteria
  - Oncology
  - Pregnancy-related
  - Trauma
  - Psych-only diagnosis



# Care Transitions Workflow

**Intervention  
Leader**

## Nurse Provider

Lead – Nurse Provider

- Clinical Assessment performed within 48 hours of assignment
  - Verify patient plan for discharge (location of discharge, insurance needs, etc); begin coordination
  - Relationship Building
  - Home Care Services established if needed
- First Home Visit performed within 48 (72 hours if weekend) of discharge from hospital
  - Goal Setting
  - Med Rec
  - Durable Goods / Equipment Evaluation
  - Psychosocial Assessment
  - Identify Health Coaching Needs for first 30 days
- Nurse Provider discusses needs with health coaches 24-48 hours from first home visit
- PCP Appointment attended within 7 days of discharge
- Specialist(s) Appointment(s) within 14 days of discharge
- Patient Education begun by second visit
- Identify Health Coaching Needs for days 30-90

## Health Coach

- Logistics
  - Patient can make and keep appointments
  - Patient can Arrange Transportation
  - Patient is able to arrange for a referral to a specialist
  - Patient can arrange for nutrition / food security
- Disease Management
  - Chronic Disease Management Education as directed by Nurse Provider
  - Patient can communicate well with physicians and knows how to ask questions and negotiate an agenda
- Social Skills
  - Patient knows how to find available resources
  - Patient has been introduced to life management skills as necessary (budgeting, etc.)
  - Patient can meet and set goals
- Health Coach Provides Ongoing Support

**Intervention  
Secondary  
Team**

## Health Coach

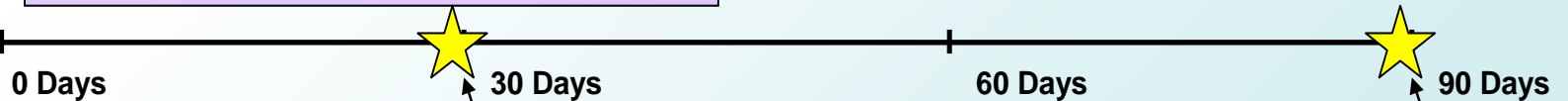
- Housing Appointments
- Transportation Appointments
- Nutrition Support
- Social Support
- Mobility

□ Hand Off Meeting  
Nurse Provider –  
Health Coach

## Nurse Provider

- Follow up on Outstanding Labs
- PCP / Specialty Coordination
- Meds
- Chronic Disease Maintenance
- Handles Readmissions
- Schedule hand off appointment with PCP

□ Hand Off  
To PCP

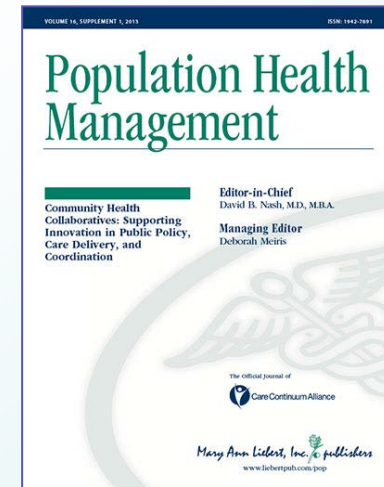


## Outreach & Intervention

- Enrollment & begin outreach at bedside
- Clinical assessment and first home visit within 24 hours of d/c
  - Care plan, resource building, goals, medical records, etc.
- Schedule PCP appt within 7 days (target)
- Schedule specialty appointments within 14 days (target)
- Planned 30-90 day engagement



# The Camden Coalition: Summary



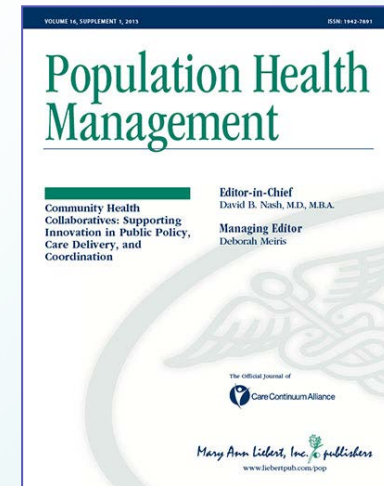
- Clinical Redesign: Enhancing primary care through care coordination for medically and socially complex patients, peer education, support groups, and practice transformation activities at clinics across Camden.
- Community Engagement: Working closely with its member organizations and Camden residents to identify common goals and ensure broad participation in community-wide interventions. **Miller A, Cunningham M, and Ali N. *Population Health Management* 2013;16: S-17–S-19.**





# The Camden Coalition: Keys to Success

- Data: Maintaining 3 significant data holdings that support its programs and initiatives:
  - A citywide health database that contains claims data from the 3 Camden hospitals to support population-level analyses of emergency department (ED) and inpatient utilization.
  - The Camden Health Information Exchange (HIE) that allows providers to access detailed clinical data about their patients at the point of care.
  - A customized care coordination tracking tool that is used to monitor and evaluate Coalition interventions.



**Miller A, Cunningham M, and Ali N. *Population Health Management* 2013;16: S-17–S-19.**



# Difficult asthma: assessment and management

- Patients with severe asthma have considerable morbidity related to their asthma and are at risk for serious, life-threatening exacerbations.
- Their management requires an intensive and comprehensive approach, including:
  - attention to reducing exposure to environmental inciters of airway inflammation and triggers of symptoms,
  - patient education (including an asthma action plan), and
  - opportunity for close patient-provider communication.

**Fanta CH, Long AA.** *Allergy Asthma Proc*  
2012 Jul-Aug;33(4):313-23.

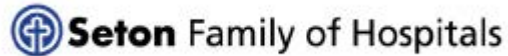


## Asthma in children and adolescents: a comprehensive approach to diagnosis and management

- Non-pharmacological management strategies include:
  - allergen avoidance,
  - environmental evaluation for allergens and irritants,
  - patient education,
  - allergy testing,
  - regular monitoring of lung function,
  - and the use of 1) asthma management plans, 2) asthma control tests, 3) peak flow meters, and 4) asthma diaries.
- Challenges in management include evaluation of the child's ability to use inhalers and peak flow meters and the management of exercise-induced asthma.



# Seton Family of Hospitals Health Initiative: Asthma Disease Management

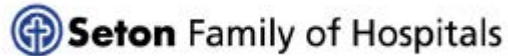


- Overarching Goals
  - Improved access to care
  - Decreased cost of health care
- Quantitative Measures
  - Fewer hospitalizations
  - Fewer emergency room visits
  - Fewer health disparities
  - Better health status indicators
  - Improve patient quality of life indicators





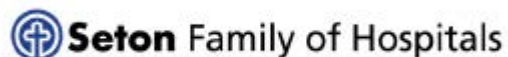
# Seton Family of Hospitals Health Initiative: Asthma Disease Management



- Services provided and/or processes implemented:
  - Asthma education via standardized curriculum
  - Asthma Action Plan/Individualized Care Plan
  - Case Management/Care Coordination
  - Financial Screening/program application assistance
  - Quality of Life Analysis
  - Primary Care Physician placement
  - Partnership for Pharmaceutical Assistance
  - Quarterly telephonic Follow-up



# Seton Family of Hospitals Health Initiative: Asthma Disease Management



Age Range	%Population
<2	3%
2-4	12%
5-10	40%
11-13	12%
14-17	8%
>18	25%

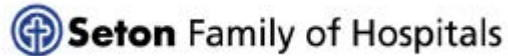
Race/Ethnicity	%Population
Hispanic	62%
Caucasian	17%
African American	18%
Native American	1%
Middle Eastern	1%
Asian	1%

Payer	%Population
Commercial	8%
Medicaid	57%
Medicare	1%
Uninsured	18%
Other Public	17%

Gender	%Population
Female	51%
Male	49%



# Seton Family of Hospitals Health Initiative: Asthma Disease Management



- Qualitative & Quantitative outcomes:
  - 39.5% reduction in ED utilization (12-month pre/post)
  - 94.5% reduction in hospitalizations (12-month pre/post)
  - 40% increase in days without symptoms
  - 13% increase in nights without symptoms
  - 99.4% patient satisfaction score
  - Annual cost avoidance \$1105/enrollee
  - Program ROI 5.5



# A Comprehensive ASTHMA Program\*

## Summary

- University of Michigan Health System
  - Comprehensive asthma management program that includes:
    - a registry of all patients with asthma,
    - standardized patient education and self-management asthma action plans,
    - periodic home visits from nurses, and
    - specialized programs for children with asthma who are at high risk for emergency department visits or hospitalizations.
- \*Received EPA's 2008 National Environmental Leadership Award in Asthma Management





# A Comprehensive ASTHMA Program

- **Results**

- **More asthma action plans:** 6-mo effort in 2005 educating staff about the importance of creating action plans
  - Info provided in 6/2013 indicates the number has continued to grow, with 42% of adults and 74% of pediatric patients with a documented asthma plan. (up from 7% overall)
- **Fewer asthma-related hospitalizations:** 7/2005-6/2007, asthma-related admissions at the health system fell by 50%, in part due to programs focused on high-utilization populations. (trend has continued through 6/2013)



# A Comprehensive ASTHMA Program

- **Results**

- **Significant improvements in pediatric care:** All in the Children's Asthma Wellness Program (for higher acuity patients) have action plans and many are referred to the home visitation program (6/2006-6/2007)
  - ED visits for kids receiving periodic home visits fell 60%
  - Hospitalizations declined by 85%
  - Continued and sustained improvements thru 2009
    - 99% enrolled for  $\geq 6$  months did not visit the ED during enrollment
    - 96% were not hospitalized during this same period



# A Comprehensive ASTHMA Program

- ***Resources Used and Skills Needed***
  - **Staffing:** a full complement of asthma specialists, including:
    - physicians,
    - respiratory therapists,
    - nurses certified as asthma educators, and
    - nurses who make home visits.
  - **Costs:** data not available (one key cost is the expense associated with measuring and reporting on the care received by patients with asthma)



# A Comprehensive ASTHMA Program

- **Funding Sources**

- The program is funded internally and through payments from third-party payers.
- The Children's Asthma Wellness Program is supported by clinical dollars generated from health care visits to physicians and the asthma educator;
  - *these payments are the result of new programs begun by Blue Cross Blue Shield of Michigan and Blue Care Network, the managed care portion of Blue Cross Blue Shield of Michigan.*
- These different funding sources ensure the sustainability of the program.





- Policy and Reimbursement Issues

## PAYING FOR RESULTS



## Accountable Care Organizations

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together to provide coordinated, high-quality care to their patients.
- The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves.
- Governance of an ACO involving primary care must include equitable representation of both primary and specialty care.



# Payment Strategies for Comprehensive Asthma Management

- From the Asthma Regional Council of New England
  - *Insurance Coverage for Asthma: A New England Gap Analysis - December 2010*
    - surveys collected from 25 public (Medicaid) and private (commercial) payers across the six New England states.
    - report provides a general analysis of the responses and identifies where there are gaps in coverage.
    - ARC and its partners can knowledgeably collaborate with health payers to work towards reimbursement policies which will:
      - serve to improve health outcomes
      - reduce expensive, preventable, urgent care visits.



<http://asthmaregionalcouncil.org/uploads/Asthma%20Management/Asthma%20Insurance%20Analysis.pdf>



# Payment Strategies for Comprehensive Asthma Management

- *Insurance Coverage for Asthma: Reimbursement*
  - Payment Mechanisms
    - Fee-for-Service
    - Capitation
    - Pay-for-Performance
    - Outpatient Prospective Payment System
    - Bundled payments for “packaged” services
  - Reimbursements for Clinical Services
    - Pay for discrete asthma education sessions in the clinic
      - primarily for individual sessions;
      - group asthma education sessions less frequently approved
    - Reimbursement for a variety of provider types
    - Paid asthma home visits, either clinical education or environmental interventions, or both





# Payment Strategies for Comprehensive Asthma Management

- ***Reimbursements for Environmental Trigger Mitigation Supplies and Services:***
  - Abundant evidence suggests that offering environmental interventions, on a tailored basis, are justified for patients with chronic, poorly-controlled asthma and allergic sensitivities.
  - A 2009 comprehensive literature review from the CDC notes that the combination of environmental remediation in the home with an educational component provides good value for the money invested, based on improvements in symptom-free days and savings from averted urgent care costs. (*Medicaid payers were more likely than commercial to do so*)
  - Mattress and pillow covers, as well as air purifiers, were the most likely to be covered, but vacuum cleaners and air conditioners could also be considered in specific cases.





# Payment Strategies for Comprehensive Asthma Management

- From the Asthma Regional Council of New England
  - *Investing in Best Practices for Asthma: A Business Case - August 2010 Update*
    - Summarizes the third National Asthma Education Prevention Program (NAEPP) Expert Panel Report and the Centers for Disease Control and Prevention's Task Force on Community Preventive Services (CDC Task Force) review - including economic evaluations of the research on asthma education and environmental interventions



Describes 6 evidence-based programs which are achieving their goals of bringing asthma under control cost-effectively.

<http://asthmaregionalcouncil.org/uploads/Asthma%20Management/Investing%20in%20Best%20Practices%20for%20Asthma-A%20Business%20Case%20%20August%202010%20Update.pdf>



# Payment Strategies for Comprehensive Asthma Management

- From the Asthma Regional Council of New England
  - *Asthma: A Business Case for Employers and Health Care Purchasers*
    - The report details three strategies employers can pursue to cost-effectively bring asthma under control:
      - 1) Aligning employee health benefits with recommended best practices for asthma;
      - 2) Supporting employees in overcoming barriers to self-management of asthma; and
      - 3) Ensuring healthy work environments.

[http://asthmaaregionalcouncil.org/uploads/Asthma%20Management/Business\\_Case\\_Employers\\_Health\\_Care\\_Purchasers%20\\_2010.pdf](http://asthmaaregionalcouncil.org/uploads/Asthma%20Management/Business_Case_Employers_Health_Care_Purchasers%20_2010.pdf)



- Policy and Reimbursement Issues

## EXPANDING SERVICES AVAILABLE FOR REIMBURSEMENT



## Beginning to think (and pay) outside the box

- Centers for Medicare & Medicaid Services (CMS) released new CPT codes for education and training for patient self-management of chronic diseases (including asthma):
  - 98960 - Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
  - 98961 - Two to four patients; each 30 minutes
  - 98962 - Five to eight patients; each 30 minutes
  - 94664 - Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB
  - And others...





# global payment system for high-risk pediatric asthma patients



- “Notwithstanding any general or special law to the contrary, the executive office of health and human services shall develop a global or bundled payment system for high-risk pediatric asthma patients enrolled in the MassHealth program, designed to prevent unnecessary hospital admissions and emergency room utilization.”
  - 2011 Commonwealth of Massachusetts Budget Summary





# Telemedicine

## (a benefit of Texas Medicaid)

- “Telemedicine” is initiated by a physician who is licensed to practice medicine in Texas or provided by a health professional acting under physician delegation/supervision.
- Telemedicine provides patient assessment by a health professional, diagnosis, consultation or treatment by a physician, or transfers medical data that requires the use of advanced telecommunications technology, other than phone or fax technology, including:
  - Compressed digital interactive video, audio, or data transmission;
  - Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
  - Other technology that facilitates access to health care services or medical specialty expertise.



# Telehealth (another benefit of Texas Medicaid)

- “Telehealth” is defined as a health service, other than telemedicine, and is delivered by a licensed or certified health professional acting within the scope of the health professional’s license or certification, and who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including:
  - Compressed digital interactive video, audio, or data transmission;
  - Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
  - Other technology that facilitates access to health care services or medical specialty expertise.



# Home telemonitoring services (may be a new benefit of Texas Medicaid)

- Home telemonitoring requires scheduled remote monitoring of data related to a patient's health, and transmission of the data to a licensed home health agency or an OP hospital.
- Telemonitoring is [*currently proposed to be*] available only to patients who are diagnosed with either of the following conditions:
  - Diabetes
  - Hypertension



# Home telemonitoring services as proposed in Texas Medicaid

- Home telemonitoring patients must have two or more of the following risk factors:
  - $\geq 2$  hospitalizations in the prior 12-month period
  - Frequent or recurrent emergency department admissions
  - A documented history of poor adherence to ordered medication regimens
  - Documented history of falls in the prior six-month period
  - Limited or absent informal support systems
  - Living alone or being home alone for extended periods of time
  - A documented history of care access challenges





# More Than 60% of Providers See Opportunity in Bundled Payments

- >60% of providers believe bundled payments could improve quality and reduce costs of care provided to patients.
- KPMG polled 190 providers on 10/4/13. Most respondents were hospitals, health systems and large-scale physician groups.
  - 38% of respondents said they are "already working with bundled payments,"
  - 24% said they are planning to do so,
  - 36% remain undecided on bundled payment developments, and
  - only 2% said that had no intention to offer bundled payment plans.
- "Based on our study, providers are generating 15-60% or more of their revenues from risk-based methods, such as bundling. This is much more than even one year ago. We expect those numbers to grow further as providers see how bundling can strengthen relations with physician groups and take steps toward becoming preferred partners with the payer community."

BECKER'S  
**Hospital Review**





## In Summary

- The increasing demands of chronic diseases, like asthma, upon the fiscal health of our healthcare system demand that we develop new and varied ways to reimburse for comprehensive management and care.
- Major new categories developing for healthcare reimbursement include expanding the types of care considered for coverage, the types of providers reimbursed, adding new places of service, including the home, alternative methods of providing those services and, ultimately, novel methods of payment to providers/groups which take into account the individual patients needs and health outcomes.

