Massachusetts Medicaid Pediatric High-Risk Asthma Bundled Payment Pilot

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Confidential Information

• Process to procure primary care practices to participate in this pilot is under development and some details have not yet been shared publicly
• Pilot is awaiting CMS approval
• Design is still subject to change
• Please keep details confidential until the Request for Responses (RFR) is released (expected October - November, 2011)
Statutory Mandate – Key Provisions

FY11 Budget outside section (St. 2010, C.131, S.154)

• EOHHS “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.”

• “The global or bundled payments shall reimburse expenses necessary to manage pediatric asthma, including, but not limited to, **patient education, environmental assessments, mitigation of asthma triggers and purchase of necessary durable medical equipment**.”

• “The global or bundled payments shall be designed to **ensure a financial return on investment** through the reduction of costs related to hospital and emergency room visits and admissions not later than 2 years after the effective date of this act.”
What is a bundled payment?

MA Division of Health Care Finance and Policy explains: *

• A bundled payment is a method of reimbursing a provider, or group of providers, for the provision of multiple health care services associated with a defined episode of care under a single fee or payment.

• Episodes of care can be either acute or chronic, and
  • include clinically related services, such as: hospital admission, ambulatory care, pharmacy, and other clinical and professional services,
  • over a defined period of time with a clear beginning and ending (acute conditions) or annually (chronic conditions).

• Multiple goals: Achieve better coordinated and higher quality care at lower total costs

*Source: DHCFP Overview of Bundled Payment Methodologies, 2/28/11
Goal and Objectives

Goal: To evaluate the degree to which a bundled payment and flexible use of funds enhances the effects of delivery system transformation, as demonstrated by improved health outcomes at the same or lower cost.

Objectives:

• **to develop a bundled payment system** for members with high-risk pediatric asthma enrolled in selected MassHealth Primary Care Clinician Plan Practices, designed to support a comprehensive chronic disease management approach to asthma in order to prevent the need for hospital admissions and emergency department visits and to improve health outcomes;

• **to demonstrate whether a financial return on investment** can be achieved through the reduction of costs related to hospital admissions and emergency department visits in order to justify and support the sustainability and expansion of the model;

• **to help pediatric providers** begin developing skills and infrastructure they will need to **manage global payments as accountable care organizations**; and

• **to help children and their families learn practical and actionable methods for managing asthma** in the context of their lives and for optimally controlling asthma symptoms to minimize asthma’s impact on their health, wellbeing and quality of life.
Design Process

• Established an **internal program design team**, including 3 MDs, 1 RN, 1 PharmD, program and policy experts, data analysts, and legal counsel; met weekly for 6 months

• Internal team:
  • Developed program design through an iterative process
  • Reviewed relevant literature and model programs
  • Analyzed Medicaid claims and eligibility data to determine:
    • number of children and practices that might be eligible to participate in the pilot under various proposed criteria
    • cost to Medicaid for asthma care in hospitals for eligible children in prior years (baseline cost)
  • Collaborated closely with DPH asthma prevention staff
  • Obtained expert advice from Advisory Committee (next slide)
Advisory Committee

• External Advisory Committee includes 20 members, each with expertise in:
  (1) treating high-risk pediatric asthma patients, and/or
  (2) designing and implementing clinical programs to prevent and manage high-risk pediatric asthma, and/or
  (3) designing and implementing global or bundled payment structures

• Advisory Committee members are physicians, nurses, pharmacists, researchers, representatives of professional organizations, and health care administrators

• Advisory Committee provided input on topics including:
  (1) Providers’ qualifications for participation
  (2) Eligible patients (including definition of high-risk asthma)
  (3) Scope of services: clinical as well as financial/operational
  (4) Bundled payment methodology and services to include in bundle
  (5) Data submission and evaluation plan
Eligibility to Participate in Pilot

**Members** must:

- Be between the ages of 2-18;
- Be MassHealth eligible;
- Be enrolled in the MassHealth Primary Care Clinician (PCC) Plan with the selected Practice;
- Have a clinical diagnosis of asthma and have at least one of the following in the last 12 months:
  - Inpatient hospital admission for asthma;
  - Observation stay for asthma;
  - Emergency Department visit for asthma; and
  - Oral systemic corticosteroid prescription for asthma.
- Have poorly controlled asthma: a score of 19 or lower on the Quality Metric's Childhood Asthma Control Test (ACT)
Eligibility to Participate in Pilot

Practices must:

• participate as a Primary Care Clinician in the MassHealth PCC Plan;
• treat pediatric patients for asthma;
• possess broadband Internet access; and
• **not** participate in the Massachusetts Patient Centered Medical Home Initiative (PCMHI) at this practice site location
Staffing

Practices must:

- Designate a financial/operational project leader
- Designate a clinical project leader
- Employ or contract for the services of at least one full-time or part-time Community Health Worker (CHW) or train an existing staff member to become a CHW
- Assign a clinical supervisor for the CHW
- Designate members of an interdisciplinary clinical care team, including at a minimum the member’s primary care provider, a CHW, and the CHW’s clinical supervisor
Scope of Services – Minimum

Participating Practices MUST:

• **Assess and monitor asthma control** at least every 6 months;
• Administer the **Asthma Control Test** (ACT) at every visit;
• Ensure the member has an up-to-date **Asthma Action Plan**;
• Provide asthma **self-management education** to the member and family in the office;
• Offer and encourage families to accept a **home visit by a CHW** or nurse to provide supplemental family education and conduct an initial environmental assessment;
• Share the member’s Asthma Action Plan with the member’s **school and/or childcare provider** and offer to explain the plan (with parental permission);
• Provide or arrange for the member to receive an inactivated **flu vaccine** when seasonally appropriate; and
• **Contact families each August** in order to: review medications, request updated school and childcare contact information and, with permission, share the member’s Asthma Action Plan with new school and childcare personnel.
Scope of Services – Optional

Participating Practices MAY also provide:

• **Additional home visits** by a CHW or nurse to provide supplemental family education and a full home environmental assessment;

• **Supplies to mitigate environmental triggers**, such as hypoallergenic mattress and pillow covers, vacuum, HEPA filter, air conditioner units, and integrated pest management, as well as training by a CHW to use these supplies correctly; CHWs may also support families’ advocacy with landlords and property managers to promote healthy environmental conditions in the home;

• **Care coordination**, provided by a CHW, case manager, or clinician, to help patients and caregivers access needed health care and community-based services, such as: allergen testing, flu vaccine, dietary modification, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child’s asthma; and

• **Clinical care management** of multiple co-morbidities provided by a licensed clinician, including communication with all clinicians treating the patient, as well as medication review, reconciliation and adjustment.
Implementation Proposal for this Pilot

Phase 1 bundled payment includes:

- Non-covered services to manage high-risk pediatric asthma: community health worker home visits, environmental mitigation supplies
- May include stipend to implement the infrastructure required to manage a bundled payment: systems to coordinate services provided by other entities, as well as the financial, legal and information technology systems required to accept and redistribute the bundled payment. Pilot providers may contract with a fiscal intermediary to handle the latter set of functions.

Phase 2 bundled payment includes:

- All Phase 1 services
- Other Medicaid ambulatory services required for both the effective treatment and management of pediatric asthma for high-risk patients: primary and specialty care office visits, care management, DME, etc. (Rx tbd)
Outcome Measures

Key measures include:

- Difference, relative to other children with high-risk asthma enrolled in the MA Medicaid PCC Plan, in:
  - Hospital admissions and observation stays for asthma
  - Emergency department visits for asthma
  - Cost of asthma care
- Change in asthma control (shortness of breath, waking at night, need for rescue medication, and interference with normal activities)
- Return on investment
- Qualitative evaluation of provider experience managing bundled payments; lessons learned
DRAFT Project Timeline

Note: Dates are approximate and may be moved forward or back.

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