Mini Summit XIX: Case Studies in Specialty Medical Homes

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ACAAI Asthma APM Sub-committee Members

Allergists

- Dr. Stephen Imbeau, chair
- Dr. James Tracy, vice-chair
- Dr. Donald Aaronson
- Dr. Michael Blaiss
- Dr. J. Allen Meadows
- Dr. Travis Miller
- Dr. Brian Smart
- Dr. James Sublett
- Dr. Vincent Tubiolo

Consultants and Practice Executives

- Harold Miller, president and CEO of the Center for Healthcare Quality and Payment Reform
- Sandy Marks, AMA
- Bill Finerfrock, lobbyist for Advocacy Council
- Kay Tyler, Chief Executive Officer, Family Allergy & Asthma

Opportunities to Improve Care and Reduce Spending

- Reduce misdiagnosis
- Reduce use of unnecessary tests
- Reduce ED visits and hospitalizations
- Reduce use of unnecessary medications
- Achieve better asthma control

Current Payment Barriers to Optimum Asthma Care

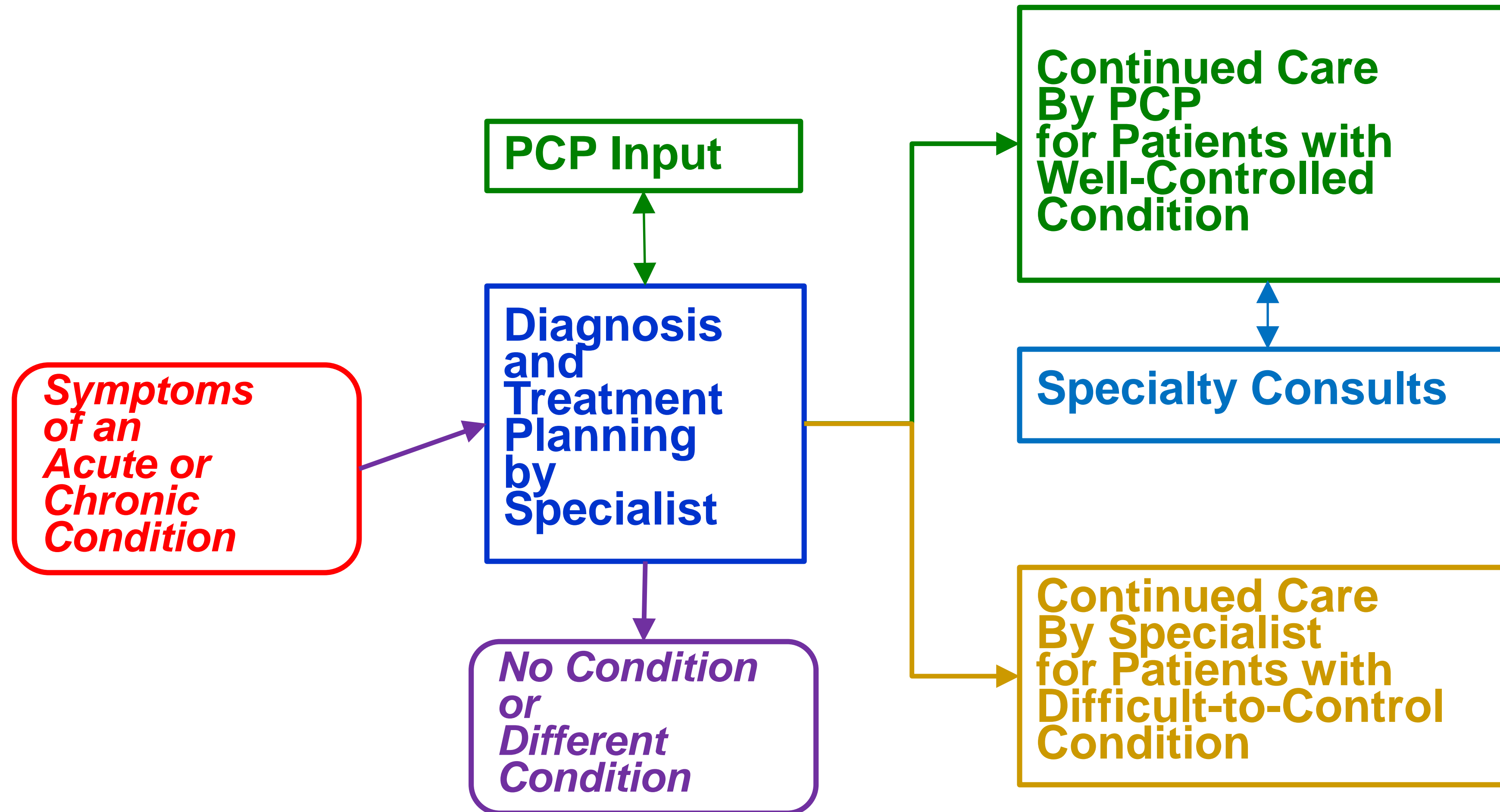
- Inadequate payment for diagnosis
- No payment for patient education
- No payment for telephone support to patients
- No payment for open slots or extended hours to treat exacerbations
- No payment for communications between PCP and allergist
- Restrictions on use of medications
- Poor coverage of Allergy testing and treatment

Many asthma patients benefit from long-term management by Allergy/Asthma Specialists

- By NHBLI guidelines all patients with moderate to severe or poorly controlled asthma should be evaluated for allergy triggers
- Patients requiring management with oral or inhaled steroid usage
- Patients requiring allergy diagnosis and treatment with allergen immunotherapy
- Patients who have been hospitalized or with more than one Emergency Room visit per year

Sources: NIH NHBLI Asthma Guidelines, August 2007
ACAAI *Asthma Management and the Allergist: Better Outcomes at Lower Cost,* 2015
Hankin CS, Cox L, Wang Z, Bronstone A. *Allergy immunotherapy: reduced health care costs in adults and children with allergic rhinitis.* J Allergy Clin Immunol 2013; 131:1084–1091 (Tab 10).

Phases of Care for a Condition by PCPs & Specialists



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Asthma APM Payment Categories

1. Diagnosis and Initial Treatment for Patients with Poorly Controlled Asthma-Like Symptoms
   - Bundled monthly payment for up to 3 months instead of E&M payments
   - Supports evaluation, testing, diagnosis, and initial treatment for a new patient experiencing asthma-like symptoms.
   - Also supports re-evaluation for an established asthma patient who was previously well-controlled but experiences a significant increase in the frequency or severity of asthma symptoms.

2. Continued Care for Patients with Difficult-to-Control Asthma
   - Bundled monthly payment instead of E&M payments
   - Supports ongoing care for patients with difficult-to-control asthma

3. Continued Care for Patients with Well-Controlled Asthma
   - Payment for telephone or email communications in addition to traditional E&M services
   - Supports continued successful care of patients with well-controlled asthma

Asthma APM Accountability

Minimum Quality Standards

- 1 face-to-face visit every six months
- 1 patient follow up contact per month via phone or email
- Annual spirometry test
- Asthma action plan

Performance on Service Utilization and Spending

- Payment reduced if practice is above average on standardized total spending per patient for allergy testing, asthma meds, E/D visits & hospitalizations related to asthma

Performance on Care Quality and Outcomes

- Payment reduced if practice is below average on measures:
  - % of patients improved (moving from “very poorly controlled” to “not well-controlled”, etc.)
  - % of patients worse (moving from “not well-controlled” to “very poorly controlled”, etc.)
  - % of patients rating access as “very good” or “excellent”

ACAAI Asthma APM

- APM is based on partnership with PCPs to provide care to asthma patients. Goal is to improve diagnosis and treatment for asthma patients and provide specialty care for patients who need it.

- Payments for all three APM categories are stratified by patient characteristics such as diagnosis, frequency and severity of symptoms, and comorbidities
  - Payments are higher for patients with more severe symptoms or comorbidities
  - Physicians are not penalized for poorer outcomes from higher complexity patients

- Broader payment bundles are a possibility after we gain experience with payment amounts and accountability measures
  - Option A: Inclusion of Medication Costs
  - Option B: Inclusion of ED Visit Costs
  - Option C: Inclusion of All Asthma-Related Services
  - Option D: Population-Based Payment for Asthma Care

Current Status and Plans

- Asthma APM Implementation Workgroup created in September 2016
- Goals
  - Find pilot medical practices to test and refine the model
  - Develop financial models to justify Asthma APM
  - Get buy-in from primary care physicians and pulmonary specialists
  - Get approval from multiple commercial payers and CMS