

Workgroup III: Perinatal Care

The third session of the Arkansas Healthcare Payment Improvement Initiative Perinatal Care Workgroup convened on March 14, 2012 to discuss payment innovation in Arkansas, with an emphasis on episode-based payment for Perinatal care.

Approximately 50 Arkansas healthcare professionals and patients were in attendance, representing perspectives of patients, providers (obstetric-gynecologists, family medicine physicians, pharmacists, nurses), advocacy groups, hospital administrators, nonprofit administrators, and government administrators.

Workgroup materials and an overview of the payment model can be accessed online at <<http://humanservices.arkansas.gov/director/Pages/Pregnancy-andNICU.aspx>>. Key components of the discussion are summarized below.

KEY COMPONENTS OF WORKGROUP III DISCUSSION

- The third workgroup session focused on reviewing:
 - Key milestones for the Payment Improvement Initiative
 - Key opportunities to improve perinatal care
 - Version 1.0 design elements specific to the Pregnancy episode
 - Historical data for Pregnancy episodes based on version 1.0 design
 - Episode design elements common across episodes
- The workgroup reviewed the goals and basic structure of episode-based care delivery
- The workgroup reviewed and discussed opportunities to improve perinatal care in Arkansas
 - The workgroup discussed the current rates of c-sections and variability in c-section rates among providers that perform deliveries
- The workgroup reviewed and discussed several elements of the Pregnancy episode design
 - Workgroup members asked several questions related to the Principal Accountable Provider (PAP)
 - How is the PAP designated for an episode?
 - Enrollment is not needed to become the PAP. The PAP will be identified by the payor retrospectively based on billing for the

delivery services or prenatal services in cases where there are multiple PAPs

- Workgroup leaders noted that each payor will explicitly define the PAP separately, taking the general approach of identifying the provider or providers who (a) has significant decision-making responsibilities; (b) has the most influence over other providers; and (c) bears a material portion of the episode cost
- In the pregnancy episode, this may be the delivering provider; however the delivering provider may share the status in some proportion if another provider delivers substantial prenatal care services
 - How will different practice arrangements (e.g., laborists, cross-covering for other groups, and birthing centers) affect the identification of the PAP?
- The workgroup also asked several questions about the scope of the Pregnancy episode (e.g., what costs are included, how does the episode incorporate the global OB bundle that already exists?)
 - Workgroup leaders noted that the episode will include all pregnancy-related costs incurred during the episode (e.g., referrals to pregnancy-related specialists, hospital costs). Thus, it is broader than just the global OB bundle (which only includes professional claims)
 - NICU care and care for non-pregnancy-related conditions will be excluded from the initial episode design
- Several participants inquired about how the episode design will address non-compliant patients
 - Workgroup leaders noted that this is a common issue in health care and all providers would be affected by issues of adherence
 - The episode model is designed to encourage providers to improve patient compliance
- Participants also asked about how patient preferences as they related to elective procedures were factored into the episode design
 - Workgroup leaders noted that while exceptions are always possible, providers should not routinely accede to patient requests that do not reflect professional norms for care delivery
- The workgroup discussed adjustments and exclusions for the episode
 - Participants asked questions about high-cost cases, particularly when they were incurred by the presence of risk factors

- Workgroup leaders noted an intent to incorporate adjustments for patient severity (e.g., for patients with gestational diabetes) and that some patients with significant risk factors may be excluded from version 1.0 of the episode design (e.g., for patients with severe preeclampsia)
- Workgroup leaders also noted an intent to exclude very high cost cases (those that are “outliers”) from the initial episode design
- Participants also discussed quality metrics for the episode
 - Participants asked how quality thresholds would be set
 - The workgroup leaders noted that quality thresholds would be set by each payor, and noted that the quality measures will be based on national specialty society guidelines and review processes
 - The workgroup also discussed the process for collecting quality metrics for the episode and raised questions over the added administrative complexity of a provider portal
 - Workgroup leaders acknowledged the concern over administrative complexity and emphasized the effort to keep administrative requests as simple as possible
- The workgroup reviewed historical cost data related to the Pregnancy episode; participants asked if that data would be used to set cost thresholds for the episode
 - Workgroup leaders noted that payors would set their own cost thresholds
- The workgroup reviewed cross-episode design elements and discussed the process for implementing the episode performance payment model
 - Participants noted that time is required to adjust to the episode format, with training to understand quality metrics and reporting requirements
 - Workgroup members and leaders noted that provider and public education would be an important component of implementation