

DRAFT

Arkansas Payment Improvement Initiative:

Perinatal
Workgroup Meeting #2

December 7, 2011

3-5 pm

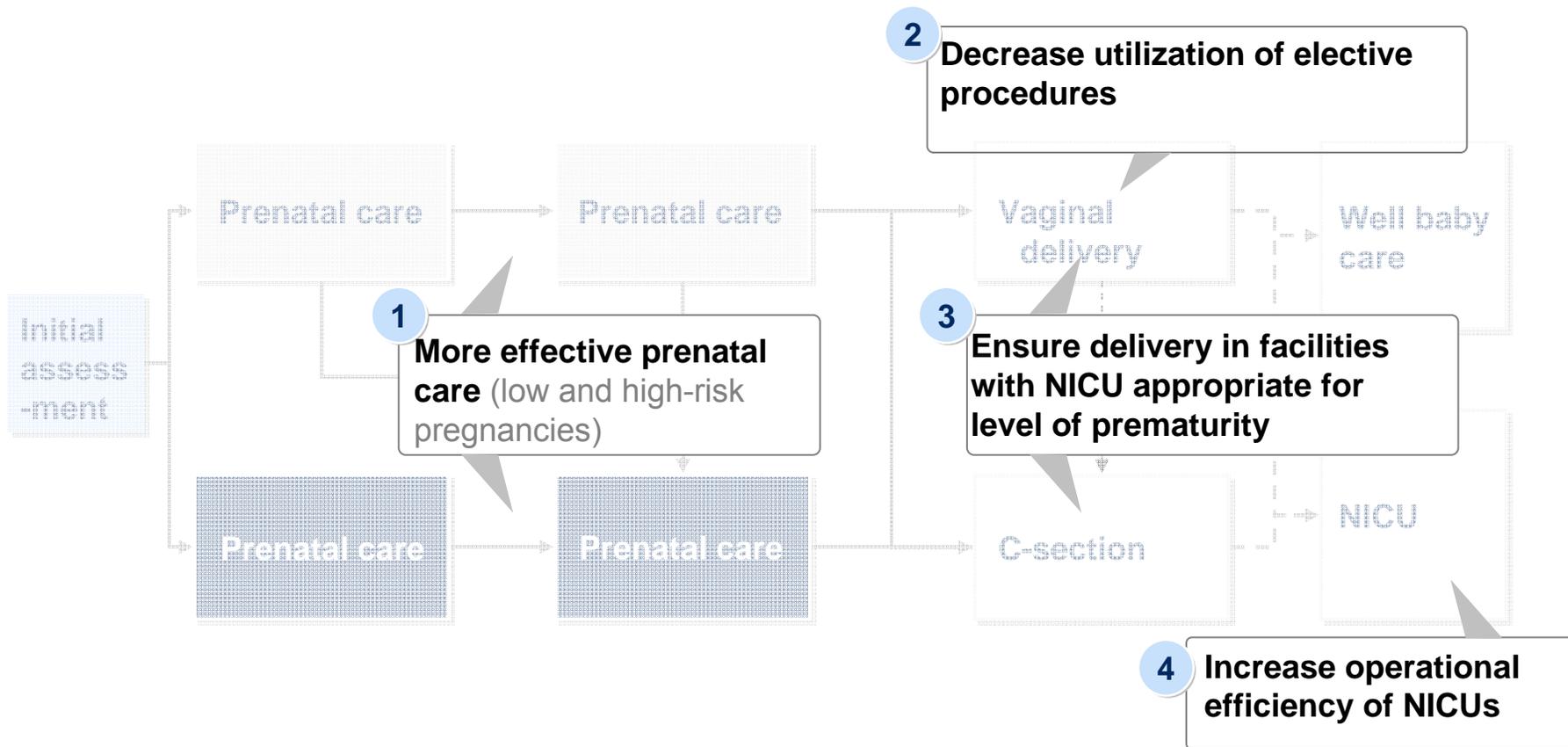


Discussion topics for today's workgroup meeting

- Briefly recap input received from Workgroup Meeting #1 on perinatal care
- Review principles and preferred payment structure for administering episode-based payment
- Discuss perinatal-specific episode design dimensions
- Get input on approaches to ensuring high quality outcomes through episode-based payment

Workgroup 1: strong agreement that there is opportunity to improve perinatal care

- Pregnancy with no major clinical complications
- Pregnancy with significant clinical complications



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Goals of Payment Initiative compared with fee-for-service

-  Reward high-quality care and outcomes
-  Encourage clinical effectiveness
-  Promote early intervention and coordination to reduce complications and associated costs
-  Encourage referral to higher-value downstream providers

Principles of payment design for Arkansas

Patient-centered

Focus on improving quality, patient experience and cost efficiency

Clinically appropriate

Evidence-based design with close input from Arkansas patients and providers

Practical

Consider scope and complexity of implementation

Data-based

Make design decisions based on facts and data

Complementary approaches to achieve these goals

	What is it?	When is it used?	Why use it?
Episode-based payment	<ul style="list-style-type: none"> ▪ Pay for an episode based on quality and cost targets reflecting total value of clinically appropriate care 	<ul style="list-style-type: none"> ▪ Conditions where range of services provided are clearly for a given condition (e.g., acute/ post-acute care) 	<ul style="list-style-type: none"> ▪ Rewards high-quality care and outcomes ▪ Promotes effective care, encourages reduction in unnecessary care
Population-based approach	<ul style="list-style-type: none"> ▪ Pay for care provided to population over extended period of time ▪ Models include medical homes and health homes 	<ul style="list-style-type: none"> ▪ Prevention/ management of chronic disease across population (healthy, at-risk and with chronic conditions) 	<ul style="list-style-type: none"> ▪ Promote care coordination ▪ Reward effective prevention and management of chronic diseases
Ongoing support to meet individual needs	<ul style="list-style-type: none"> ▪ Combination of approaches above: <ul style="list-style-type: none"> – Episode-based payment matched to assessed need – Population-based care coordination payment 	<ul style="list-style-type: none"> ▪ Individuals requiring ongoing support matching individualized needs (e.g., DD, LTC) 	<ul style="list-style-type: none"> ▪ Ensure appropriate and efficient ongoing care matching individual need ▪ Promote care coordination

What defines episode payment?

- An **episode of care** includes all clinically relevant services associated with a desired clinical outcome(s), e.g.,:
 - A chronic disease remains under control
 - A healthy baby is delivered
 - An acute procedure is free of complications
- **Payment** for the episode should be based on quality and cost targets that reflect the total value of clinically appropriate delivery of care
- One or more **providers** is made accountable for delivering the episode with desired outcomes within this cost target

Three episode design dimensions to discuss today

1 Payment streams

- What should be the payment structure for administering episode-based payment?
 - Ex: single bundled payment vs. retrospective reconciliation

2 Episode definition/ scope of services

- When does the episode start and stop?
- Should the accountable provider be responsible for direct costs only or direct and indirect costs?

For today's discussion

3 Approach to ensuring high-quality care

- How should the model be augmented to ensure patient-centered, high-quality care?

Other design elements

- Patient severity adjustments and exclusions
- Accountable providers
- How to set a clinically fair target price
- Transition approach

For upcoming workgroup discussions

1 Payment streams: range of options available

 Favored option for (most) episode payment initially, based on feasibility and stakeholder feedback

Individual performance bonuses	Episode-based retrospective reconciliation	Single bundled payment for episode
<ul style="list-style-type: none">▪ Fee for service payments to individual providers▪ Defined bonus payments for defined process/ outcome measures	<ul style="list-style-type: none">▪ During period, providers paid separately for care delivered▪ Total episode costs retrospectively compared to target price▪ Accountable provider(s) or team shares portion of upside/ downside for costs below/ above target price	<ul style="list-style-type: none">▪ Single bundled payment (target price) paid to accountable provider or team▪ Accountable provider(s) or team must pay other providers for care within the episode▪ Most individual providers no longer receive payments from the payor (no fee schedules or contracted rates)

1 Explaining the retrospective reconciliation model: three steps

Before start of reporting period

During period

At end of period

A Establish target price for episode

- Set a clinically fair target price for the episode
- Share targets with providers

B Determine actual total cost of episode

- Reimburse each provider based on a fee schedule for services rendered
- Calculate total cost of episode, inclusive of all relevant services and providers

C Distribute gains or costs to accountable providers

- Compare actual episode cost against the target price
- Distribute additional payment or reduction to accountable providers

Each episode will have an accountable provider(s) or team who:

- Have substantial influence over the majority of clinical decisions in the episode
- Are best positioned to be responsible for coordinating care

1 Explaining the retrospective reconciliation model: illustrative example

	 Accountable Provider Team A	 Accountable Provider Team B
Average cost per patient	\$14,500	\$16,500
Relevant measures of quality	Satisfactory	Satisfactory
Clinically fair target price for the episode¹	\$15,500	\$15,500
Amount above or below target price	\$1,000 in savings shared between payor and accountable provider team	(\$1,000) in excess costs paid by payor and accountable provider team

- The payor initially distributes payments to each provider according to an established fee schedule
- After the episode, the total cost of services is reconciled against a clinically fair target price
- Any savings or excess costs relative to the target price are divided among the payor and the accountable provider team

¹ May be risk-adjusted. For simplicity of illustration, all patients in this example are of the same level of severity

1 Most applicable model for Arkansas today: retrospective reconciliation

 Favored option for (most) episode payment initially, based on feasibility and stakeholder feedback

Rationale

Individual performance bonuses

- Does not achieve quality and coordination aims of episode-based payment
- (May be a valuable component of population-based model for chronic episodes)

Episode-based retrospective reconciliation

- Rewards development of clinical relationships that have impact on total cost of care without requiring providers to develop financial relationships with one another
- Well suited for Arkansas today where providers:
 - May not have financial relationships with each other
 - May not have capabilities to sub-contract with other providers

Single bundled payment for episode

- Effectively encourages providers to form stronger business relationships that integrate clinical and financial aspects of care
- Well suited for delivery systems with high levels of integration and established financial relationships

Discussion

- Questions and points to clarify on how the two episode-based payment models work?
- Feedback on selection of the retrospective reconciliation model as the preferred model for Arkansas?
- Feedback on what's attractive and challenges to consider with the retrospective reconciliation model?

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2 Overall episode design concepts for the perinatal episode: version 1.0

- **Episode begins with the initial assessment of pregnancy and ends with the completion of postpartum care** (e.g., 60 days after delivery)
- **V1.0 includes maternal care for low and medium-risk pregnancies**
- Principal accountable provider is the **provider overseeing prenatal care** (e.g., OB/GYN, family practice physician who delivers, nurse midwives)
- Payment model will be **retrospective reconciliation**
- **Principal accountable provider will also be rewarded or held responsible for certain modifiable neonatal outcomes**
 - Encourages accountable care (e.g., delivery <39 weeks only when clinically justified, progesterone treatment, plan delivery at appropriate site)
- Fair target price of episode will be set based on **clinically effective performance** (e.g., target rate for c-sections)

2 By design, episode-based payment rewards high quality care

Example for a perinatal episode

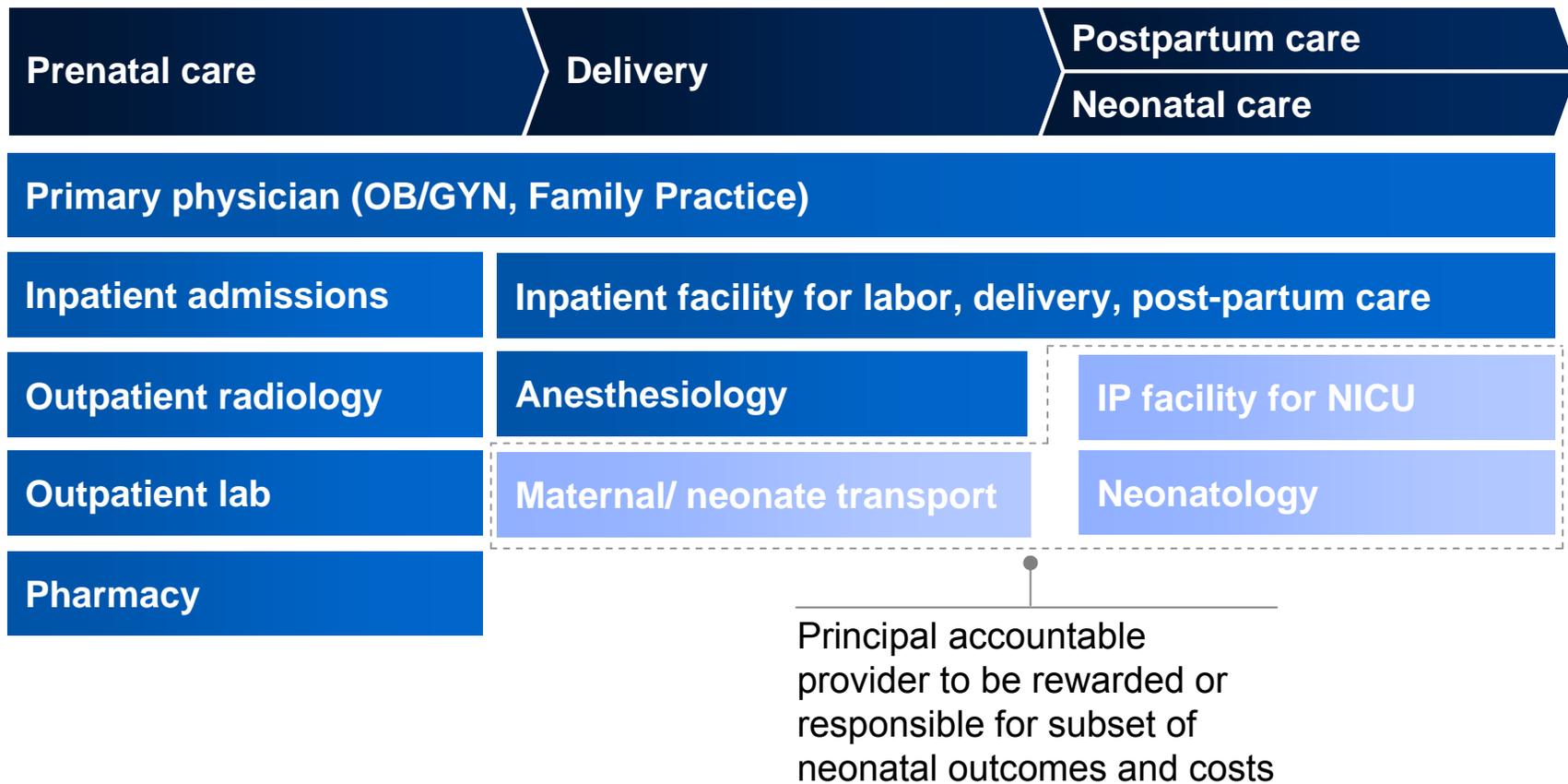
Episode-based payment rewards providers for maternal and neonatal outcomes and therefore:

- Motivates the OB/GYN to perform clinically indicated prenatal screens and ultrasounds to identify risk factors
- Rewards the OB/GYN for resolving identifiable and modifiable risk factors
- Encourages the provider to select the optimal labor delivery method (e.g. vaginal vs. c-section) and plan delivery for appropriate date
- Ensures that provider performs delivery in appropriate setting when possible

Episodic payment inherently rewards quality care by holding providers accountable for downstream outcomes and costs

2 Perinatal episode definition

- Fully included
- Rewarded for subset of outcomes



2 Discussion – Patient inclusion/ exclusion

Example pregnancy risk factors

- Placental disorders
- Severe pre-eclampsia
- Multiple gestation
- Gestational diabetes/ Diabetes mellitus
- History of preterm birth (PTB)
- Cervical shortening
- Mild hypertension/ pre-eclampsia

- Which pregnancy risk factors should be **excluded** from the episode?
- Which risk factors should be included with an **adjusted target price**?
- What other risks should be considered for potential **exclusion** or **adjustments**?
- Which of these risks can be **accurately tracked** via claims data?

2 Rationale for provider accountability over select neonatal outcomes

- There is a weak association between prenatal interventions and prematurity, which accounts for ~70% of neonatal costs
- Episode should, however, include maternal and neonatal outcomes that are attributable to provider performance
- Episode will reward or hold principal accountable provider responsible for performing clinical actions that can potentially improve neonatal outcomes

SOURCE: American College of Obstetricians and Gynecologists. ACOG Practice Bulletin. Assessment of risk factors for preterm birth. Clinical management guidelines for obstetrician-gynecologists. Number 31, October 2001.; ACOG practice bulletin. Management of preterm labor. Number 43, May 2003. Int J Gynaecol Obstet. Jul 2003;82(1):127-35.

2 Methods for addressing modifiable drivers of neonatal complications

- Use of elective delivery <39 weeks without clinical justification
- Failure to identify mother with shortened cervix/ history of PTB and administer progesterone treatment
- Not using tocolytic agents to delay PTB onset and administer corticosteroids to promote lung development
- Not delivering neonate in appropriate facility when possible

A Nonpayment for incomplete episode of care

- Reimbursement contingent on provision of clinically-indicated prenatal care and delivery
- Example: OB/GYN not reimbursed if there are neonatal complications from elective delivery <39 weeks

B Provider accountable for “never-events”

- Provider accountable for select costs of newborn care
- Example: OB/GYN responsible for \$30,000 of NICU costs if there are complications from elective delivery at <39 weeks

2 Discussion – Episode definition

- What level of **tolerance** should Arkansas have for neonatal complications that could be prevented via accountable care in prenatal period and delivery?
- What **additional risk factor reduction measures** do you believe are critical to enforce in Arkansas?
- Which of these are **feasible to begin integrating** into clinical practices in Arkansas today?
- **What model for provider accountability will most effectively reward providers** who drive better neonatal outcomes from quality upstream care?

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3 In some cases, the model may be further augmented with additional quality objectives

Objectives	Options available
<p>Ensure model will not result in underuse of care</p>	<ul style="list-style-type: none"> ▪ Payment contingent on delivery of care universally agreed as critical/ necessary (e.g., at least 1 ultrasound for pregnancy) ▪ Select “audits” to understand abnormally low utilization (e.g., for very low number of visits/year for CHF patients)
<p>Encourage evidence-based medicine and practices¹</p>	<ul style="list-style-type: none"> ▪ Require reporting of select quality + process metrics, (e.g., % of CHF patients on an ACE or ARB) ▪ Increase transparency of quality metrics (e.g., to other providers)
<p>Encourage outcomes not directly related to costs within episode</p>	<ul style="list-style-type: none"> ▪ Identify select quality metrics to track (e.g., degree of knee flexion 60 days after knee replacement) ▪ Increase transparency of performance (e.g., to providers, public) ▪ Consider linking to incremental payments or “bonuses”

¹ Avoid directly linking performance on specific measures to payment as episodic payment already incents this

3 Discussion - Potential perinatal quality measures

- **Prenatal screening for HIV**
- Prenatal Anti-D Immune Globulin
- Prenatal Blood Groups (ABO), D (Rh) Type
- Prenatal Blood Group Antibody Testing
- Appropriate Use of Antenatal Steroids
- Diabetes and Pregnancy: Avoidance of Oral Hypoglycemic Agents
- Pregnant women that had syphilis screening
- Pregnant women that had HBsAg testing
- Low birth weight (PQI 9)
- Severity-Standardized ALOS – Deliveries
- Healthy term newborn
- **Elective delivery prior to 39 completed weeks gestation**
- Incidence of Episiotomy
- **Cesarean Rate for low-risk first birth women (aka NTSV CS rate)**
- Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision or at the Time of Delivery – C-section
- **Appropriate DVT prophylaxis in women undergoing cesarean delivery**
- Birth Trauma Rate: Injury to Neonates
- **Under 1500g Infant Not Delivered at Appropriate Level of Care**
- Late sepsis or meningitis in neonates (risk-adjusted)
- Late sepsis or meningitis in Very Low Birth Weight (VLBW) neonates (risk-adjusted)
- Birth Dose of Hep B Vaccine and Hepatitis Immune Globulin for newborns of mothers with chronic Hep B

- **Which quality metrics are critical to supplement the incentives inherent in perinatal episode design?**
- **Which metrics are feasible to begin tracking and rewarding in Arkansas by July 2012?**

Next steps

- Synthesize and incorporate feedback from today's discussion
- Upcoming workgroup meetings: discuss additional design dimensions and review supporting analyses
- Schedule for upcoming workgroup meetings in 2012 will be posted as soon as dates and locations are confirmed