

DRAFT

# Arkansas Payment Improvement Initiative

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Perinatal Workgroup Meeting #3

March 14<sup>th</sup>, 2012

*PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE*



# Objectives for today and what's coming up

## Objectives for today

- Review key opportunities to improve perinatal care
- Review version 1.0 design elements specific to Pregnancy episode
- Review historical data for the Pregnancy episode based on version 1.0 design
- Briefly review episode design elements common across episodes (for further discussion in late March)

## What's coming up

- Third round of workgroups for each of the clinical areas underway through March 14
- Late-March: in-depth discussion of design elements common across clinical areas (participants from all workgroups invited to attend)
- May/June: release and review of version 1.0 episode design refined based on stakeholder input

## July 1<sup>st</sup> launch: what to expect

Key milestones	Description	Timing
<ul style="list-style-type: none"> <li>▪ <b>Description of design elements across episodes</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ In-depth discussion of design elements common across clinical areas (participants from all workgroups invited to attend)</li> </ul>	<p>March 26 and 28</p>
<ul style="list-style-type: none"> <li>▪ <b>Program announcement and education</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ Payment design and documentation published</li> <li>▪ Educational workgroups and town halls to answer questions</li> </ul>	<p>May/ June</p>
<ul style="list-style-type: none"> <li>▪ <b>Program launch</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ All analytic/ reporting engines up and running</li> </ul>	<p>July 1<sup>st</sup></p>
<ul style="list-style-type: none"> <li>▪ <b>Reporting period (3-6 months)</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ Principal Accountable Providers (PAP) receive baseline historical performance reports</li> <li>▪ Analytic/ reporting engines track “virtual” performance for each PAP</li> <li>▪ Performance does not yet impact payment</li> </ul>	<p>July 1<sup>st</sup></p>
<ul style="list-style-type: none"> <li>▪ <b>Feedback period</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ Workgroups provide feedback on version 1.0</li> <li>▪ Payors may refine version 1.0 design</li> </ul>	<p>July 1<sup>st</sup> – Sep 1<sup>st</sup></p>
<ul style="list-style-type: none"> <li>▪ <b>Performance period begins</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ New episodes begin to count towards a PAP’s share of risk or gain sharing</li> </ul>	<p>Q4 2012 or Q1 2013</p>

## Recap: 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

## Recap: payment for episode-based care delivery will be based on “episode performance payment”<sup>1</sup>

### How “episode performance payment” will work:

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- A cost threshold is determined for an episode
- One or more providers is designated the Principally Accountable Provider (PAP)
- Providers initially paid separately for the care they deliver, filing claims as they do today
- At the end of the episode, average costs and quality for the entire episode are “virtually bundled” and compared with the pre-determined threshold
- Savings or excess costs are divided between the PAP(s) and the payor or plan sponsor<sup>2</sup>
- While only PAPs directly receive a share of gain or risk from the payor, these providers may in turn choose to share incentives or risk with one or more other participating providers, subject of course to any legal limitations
- While the episode model inherently incents high quality care, PAPs will not be eligible for gain sharing unless certain quality thresholds are met

<sup>1</sup> We have previously described this as a “retrospective reconciliation” method of episode-based payment

<sup>2</sup> Upside and downside risk or gain sharing will be made at period intervals (i.e., at the end of a performance period)

## Recap: Principal accountable providers – overview and criteria

*Two types of providers for an episode of care:*

- **Principal accountable provider (PAP):**
  - Provider with which payor directly shares upside/risk for cost relative to benchmark
  - Receives performance reports, organizes team to drive performance improvement
  - May be physician practice, hospital, or other provider
- **Other participating provider(s):**
  - Any provider that delivers services during an episode that is not a PAP
  - Payors do not directly share in upside/risk for cost relative to benchmark

*Payors will identify one (or two if necessary) principal accountable provider(s) for each episode of care*

- *Focuses accountability*
- *Ensures sufficient upside/downside to motivate behavior change*
- *Simplifies administration*

*Qualifications for a Principal Accountable Provider*

- ✓ **Decision-making responsibility:** provider is principal (not exclusive) decision maker for most care during episode
  - Selects tests/ screenings
  - Determines treatment approach
  - Carries out procedures
- ✓ **Influence over other providers:** provider is in best position to coordinate with, direct, or incent participating providers to improve performance
  - Makes referral decisions
  - Provides infrastructure
  - Organizes quality improvement efforts
- ✓ **Economic relevance:** provider bears a material portion of the episode cost or a significant case volume

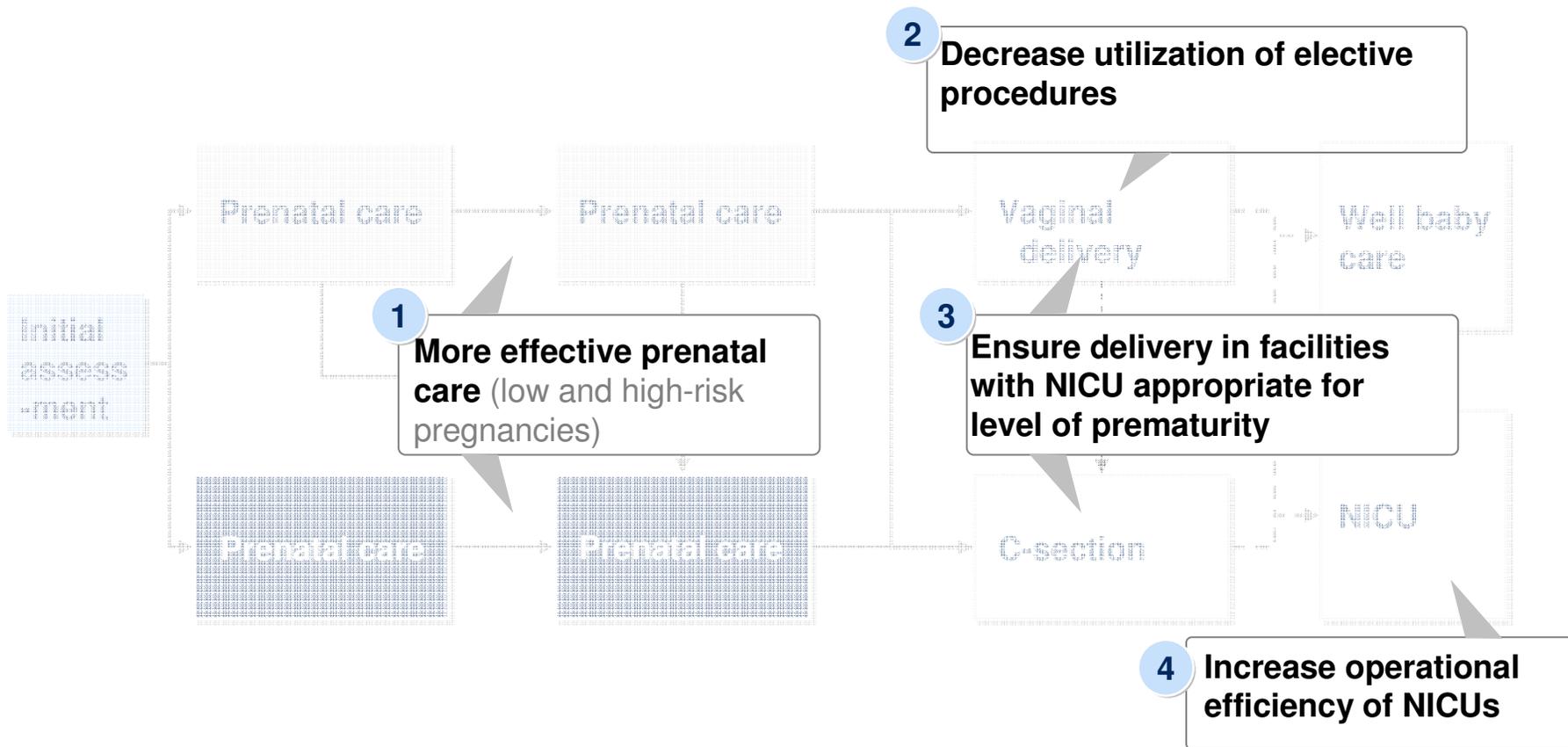
# Contents

## Review key opportunities to improve perinatal care

- Review version 1.0 design elements specific to Pregnancy episode
- Review historical data for the Pregnancy episode based on version 1.0 design
- Briefly review episode design elements common across episodes (for further discussion in late March)

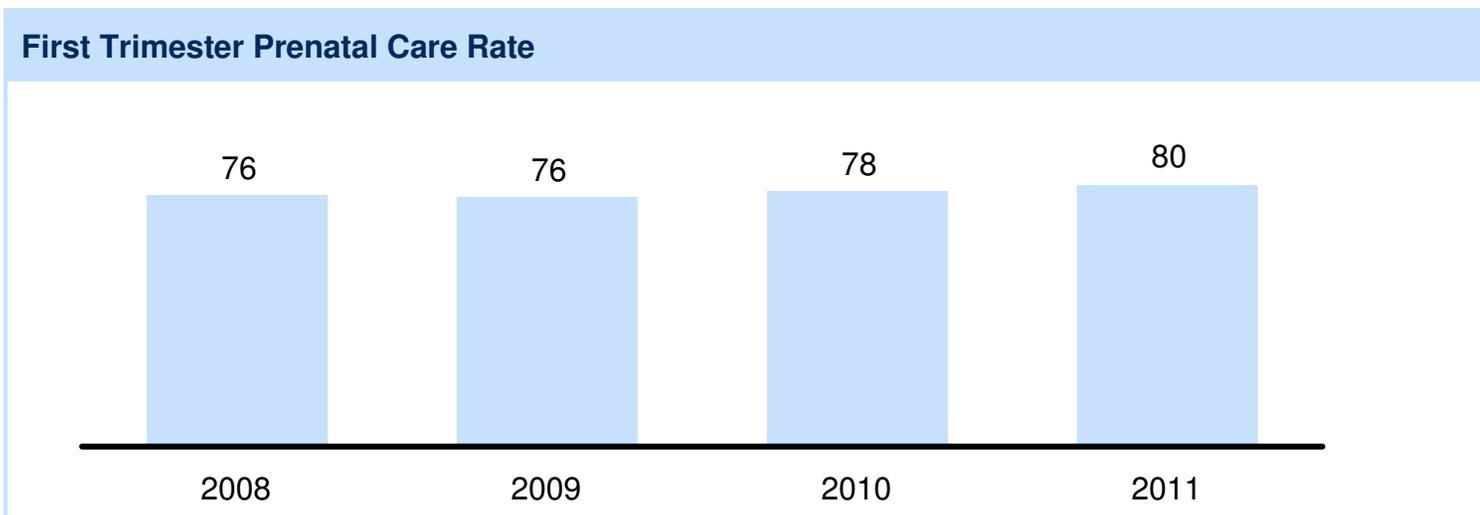
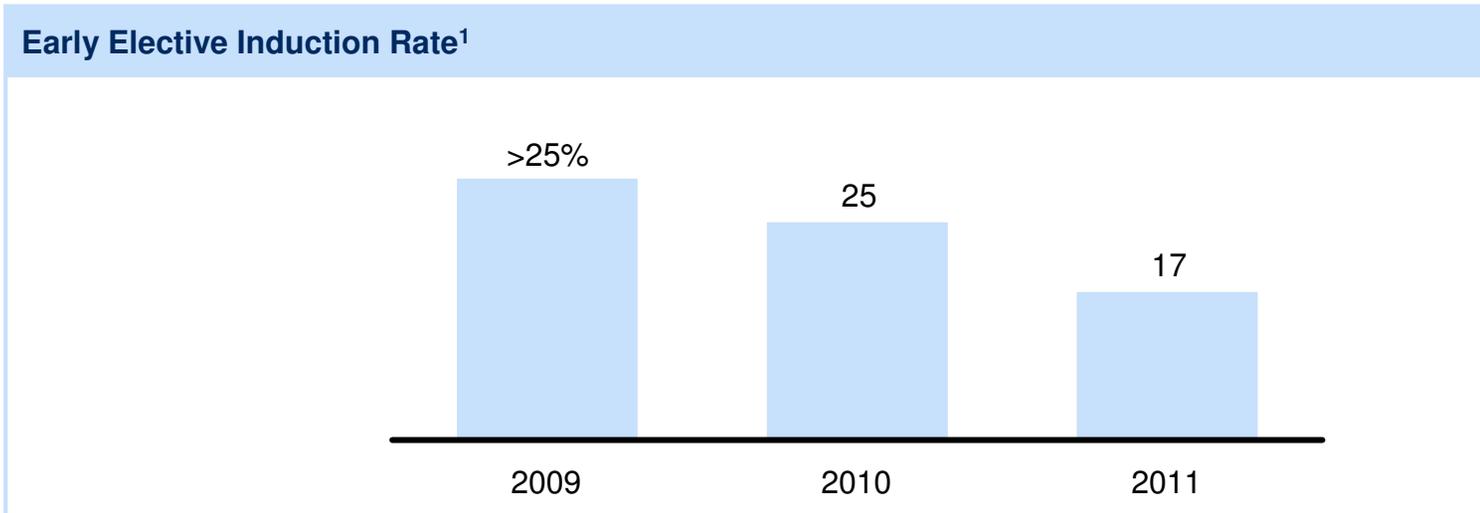
# Previous workgroups: strong agreement that there is opportunity to improve perinatal care

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



# Perinatal care has been improving in some areas

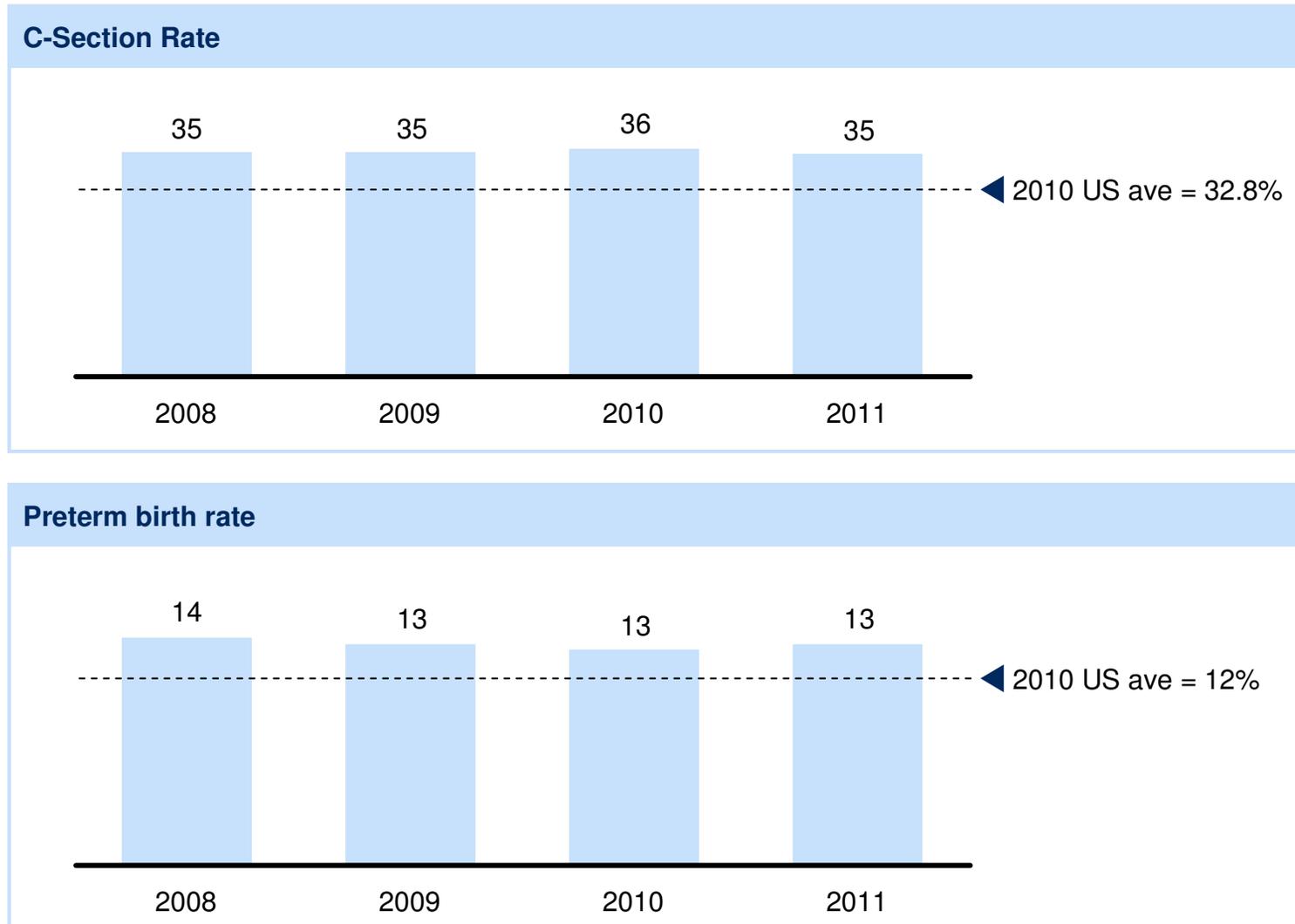
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<sup>1</sup> 2011 data is preliminary and based only on Q3 2011

SOURCE: AR Department of Health, Current Birth Data, December, 2011; AR Medicaid IQI program

## However, perinatal care metrics still lag in certain important areas



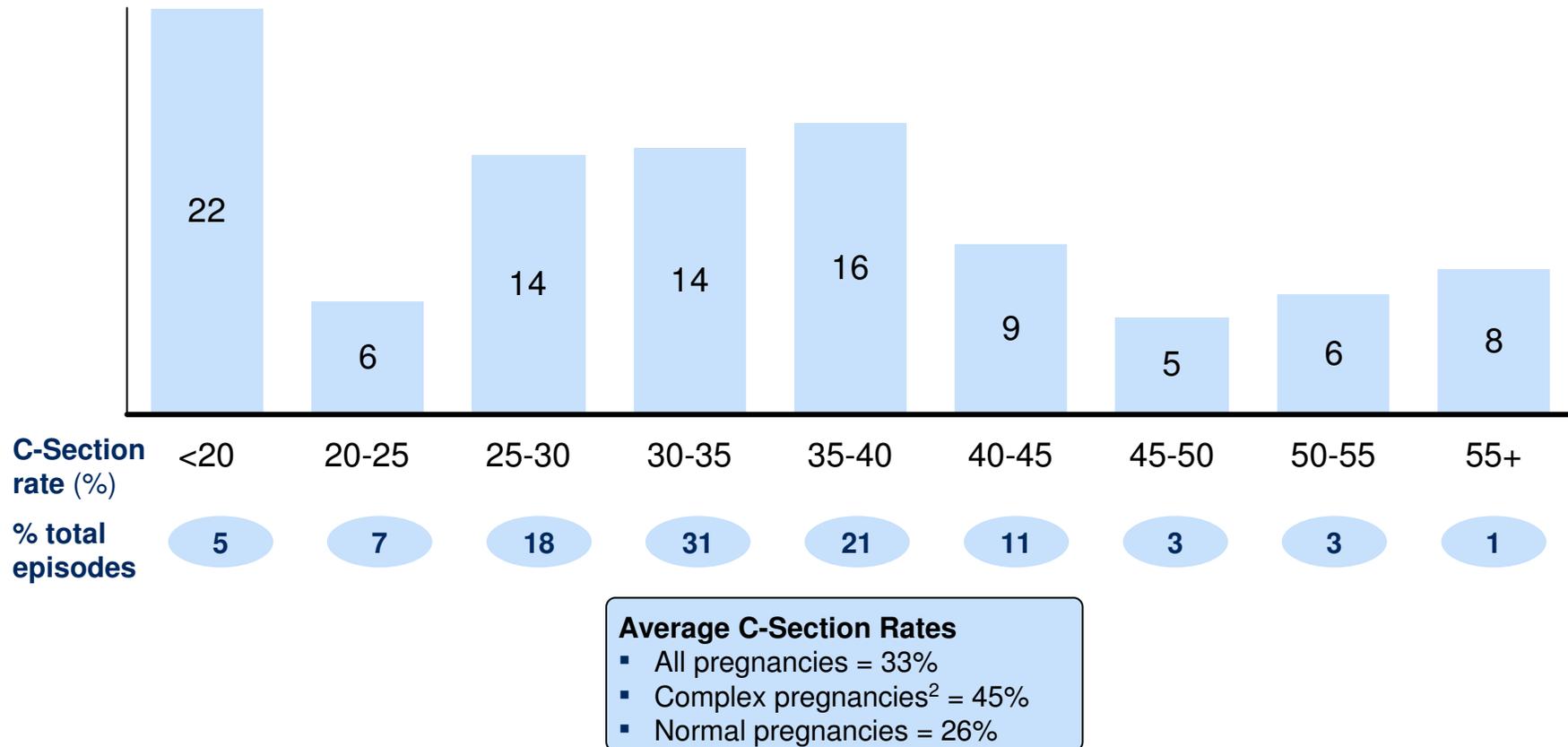
SOURCE: AR Department of Health, Current Birth Data, December, 2011; National Vital Statistics Reports, Births: Preliminary Data for 2010, November, 2011

# And high variation exists in the utilization of procedures among providers (Medicaid example)

PRELIMINARY ESTIMATES

**Average C-Section rate by provider**  
Percent of providers<sup>1</sup>

N = 21,199 births, 231 providers



1 Providers that performed delivery

2 If have at least one risk factor: severe preeclampsia/eclampsia, DM-I or DM-II, placenta previa, shortened cervix, history of PTB, etc.; ~1/3 of pregnancies classified as complex for this analysis

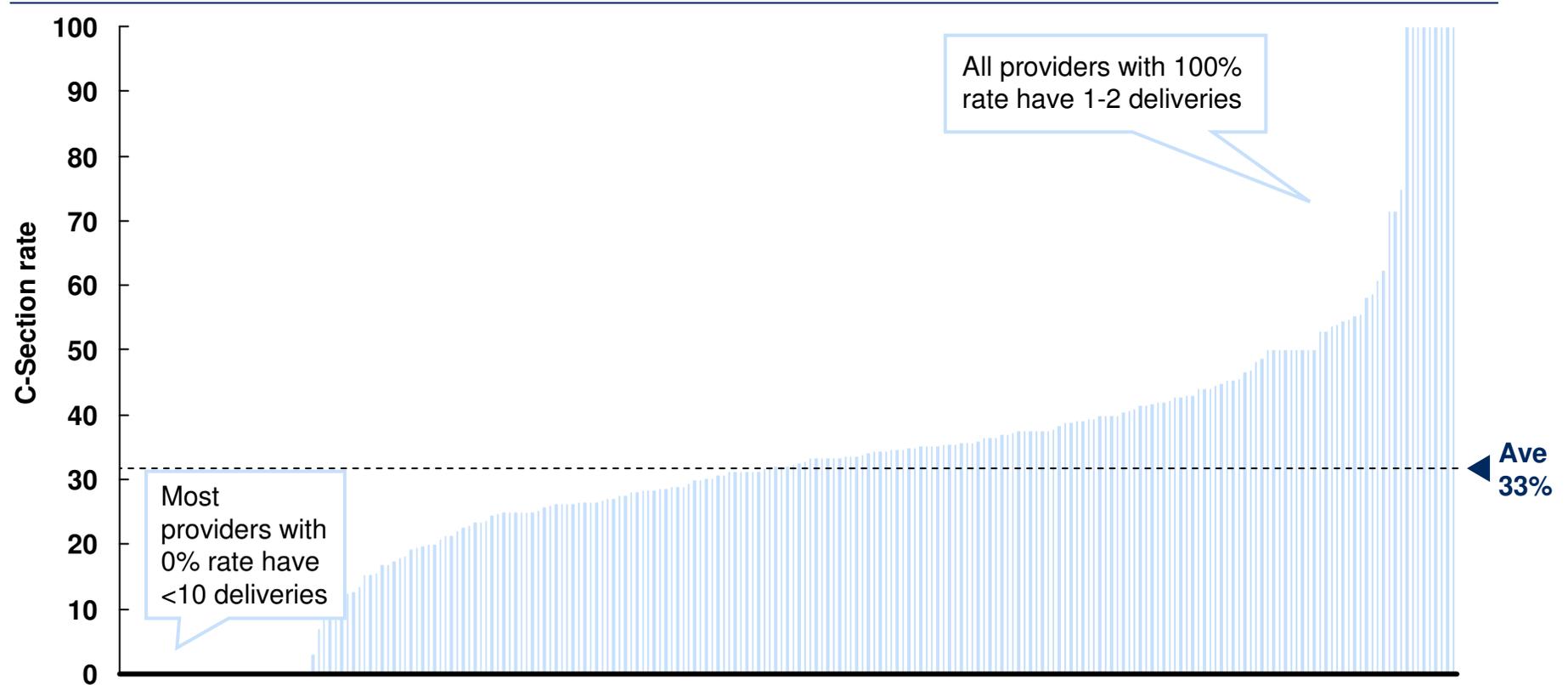
SOURCE: Arkansas Medicaid claims for mothers with deliveries between April 1, 2009-March 30, 2010 (cost based on claims paid; does not include any year-end cost settlements and adjustments)

# Variation in C-Section rates across providers (Medicaid example)

PRELIMINARY  
ESTIMATES

## Provider average C-Section rate

N = 21,199 births, 231 providers<sup>1</sup>



<sup>1</sup> Providers that performed delivery

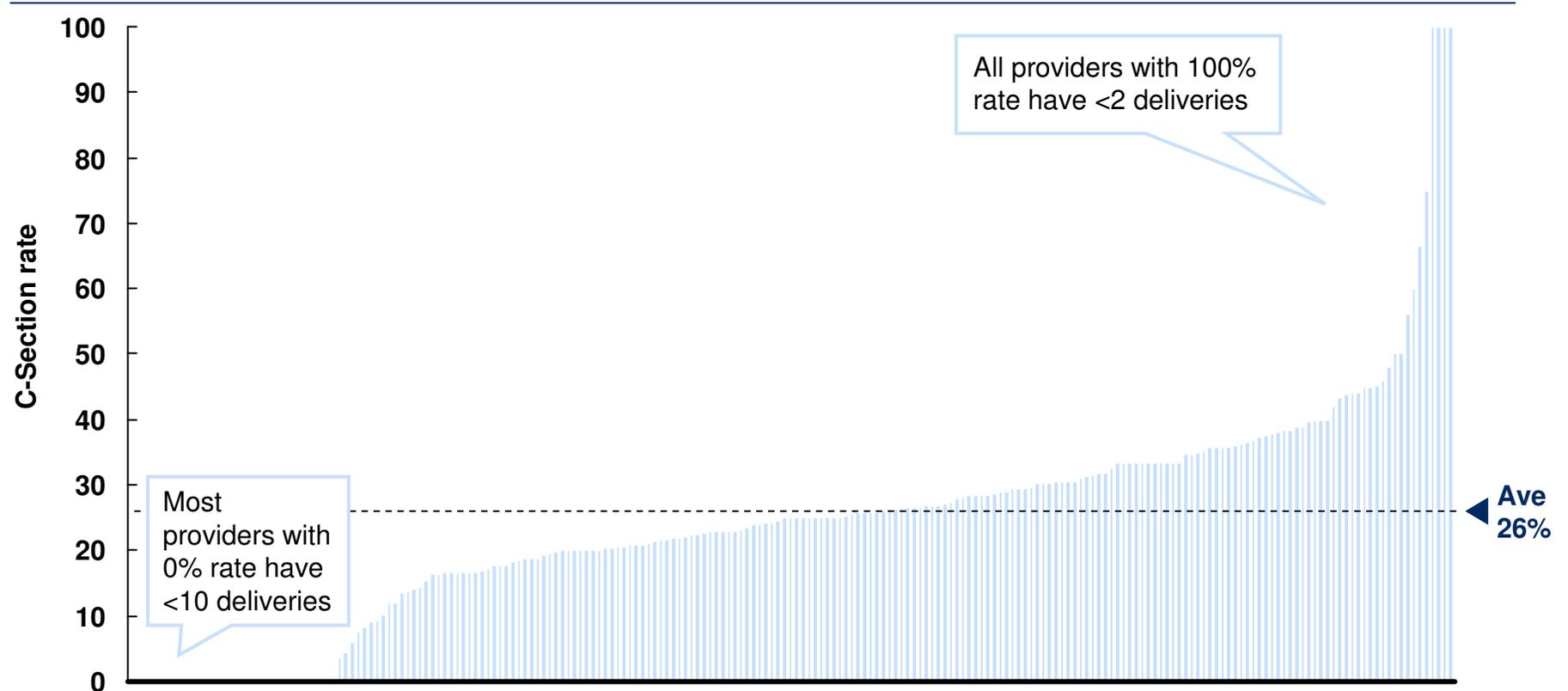
SOURCE: Arkansas Medicaid claims for mothers with deliveries between April 1, 2009-March 30, 2010 (cost based on claims paid; does not include any year-end cost settlements and adjustments)

# Variation in C-Section rates for normal pregnancies across providers (Medicaid example)

PRELIMINARY  
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## Provider average C-Section rate (normal pregnancies)

N = 12,951 births, 215 providers<sup>1</sup>



<sup>1</sup> Providers that performed delivery

<sup>2</sup> If have at least one risk factor: severe preeclampsia/eclampsia, DM-I or DM-II, placenta previa, shortened cervix, history of PTB, etc.; ~1/3 of pregnancies classified as complex for this analysis

SOURCE: Arkansas Medicaid claims for mothers with deliveries between April 1, 2009-March 30, 2010 (cost based on claims paid; does not include any year-end cost settlements and adjustments)

# Contents

- Review key opportunities to improve perinatal care

## **Review version 1.0 design elements specific to Pregnancy episode**

- Review historical data for the Pregnancy episode based on version 1.0 design
- Briefly review episode design elements common across episodes (for further discussion in late March)

## **Patient focus: how episode-based care delivery will improve the quality of pregnancy care for patients**

- A physician or physician team will be accountable for the whole episode from prenatal care through delivery and will coordinate care among all providers involved
- Evidence-based prenatal care will be provided to maximize the likelihood of a successful delivery and healthy baby
- Patients will undergo delivery by C-Section only when medically appropriate

# Preliminary proposal: Version 1.0 design elements specific to the Pregnancy episode

## Principles

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### 1 Episode definition/ scope of services

- Trigger: live birth
- Start: initial assessment of pregnancy (look-back 40 weeks from delivery)
- Duration: episode ends 60 days post delivery
- Episode includes
  - All inpatient and outpatient claims for the mother associated with a pregnancy ICD-9 diagnosis code for the duration of the episode
  - All pharmacy claims for duration of episode
  - Select maternal readmissions within 30 days post delivery
- Episode excludes neonatal care

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### 2 Principal accountable provider(s)

- The Provider (or the provider in his/her group) that performs the delivery is the Principal Accountable Provider (PAP)
- If separate providers perform prenatal care and delivery, delivering provider and prenatal provider are both PAPs (shared accountability)
  - Delivering PAP is the provider associated with the surgical delivery code
  - Prenatal PAP is the provider with either the procedure code for antepartum care OR if no antepartum procedure code, the provider with the most office visits during the prenatal period
- Prenatal care must be provided for a minimum of 2 months prior for a PAP to be attributed to the episode

## Preliminary proposal: Version 1.0 design elements specific to the Pregnancy episode (cont'd)

### Principles

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#### 3 Patient exclusions on a clinical basis

- Patients will be excluded from 1<sup>st</sup> version of the episode if they follow a meaningfully different care pathway or have a low incidence risk factor with high cost distribution (e.g., severe preeclampsia). These may be included in future versions of the episode
- Some patients will be included in the episode, with appropriate cost threshold adjustments based on severity (e.g., twins, moderate preeclampsia)
- Remaining patients will be treated as normal pregnancies with no adjustments

#### 4 Quality

- Linked to payment
    - Early elective inductions < 39 weeks
    - Deliveries at less than <28 weeks at hospitals without level 3 NICU
  - Reporting only
    - Patients who had gestational age of the fetus estimated by ultrasound at or prior to 20 weeks
    - Screening for Gestational Diabetes
    - Screening for Asymptomatic Bacteriuria
    - Hepatitis B specific antigen screening
    - HIV screening
    - Group B streptococcus screening (GBS)
- } prenatal screening
- Specialist consult use for very high-risk episodes (those with risk factors that lead to exclusion from episode design) (reporting only)
  - Administration of full course of antenatal steroids
  - Percentage of deliveries with a postpartum care visit

# 1 Episode definition/ scope of services: overview and criteria



## The episode includes the following services

- Prenatal visits (office/clinic, Emergency Room, or specialist consultation)**
- Labs, imaging, and diagnostic tests**
- Delivery (vaginal or c-section)**
- Inpatient care**
- Medication**
- Maternal readmissions**

- All claims with a primary or secondary ICD-9 diagnosis code for pregnancy
- All medications prescribed during the entire episode
- All readmissions of the following types within 30 days post delivery: obstetric surgical complications; postpartum hemorrhage; major puerperal infection; pelvic injury/wounds; venous disorders and thromboembolism

### 3 Patient exclusions: initial summary of patients excluded from the v1.0 episode model

	Description	Example conditions/ criteria for exclusion
<b>Pregnancy-related conditions</b>	<ul style="list-style-type: none"><li>Patients with risk factors that require a meaningfully different care pathway or have a low incidence and high cost distribution risk factor</li></ul>	<ul style="list-style-type: none"><li>Severe preeclampsia</li><li>Type I Diabetes</li><li>Multiple gestation <math>\geq 3</math></li><li>Placenta previa</li><li>Early/threatened labor <math>&lt; 28</math> weeks</li></ul>
<b>Other comorbidities</b>	<ul style="list-style-type: none"><li>Patients with rare diseases/genetic disorders</li></ul>	<ul style="list-style-type: none"><li>Cystic Fibrosis, Sickle Cell</li></ul>

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## **Review historical data for the Pregnancy episode based on version 1.0 design**

- Briefly review episode design elements common across episodes (for further discussion in late March)

## **Preliminary note about data presented in the following pages**

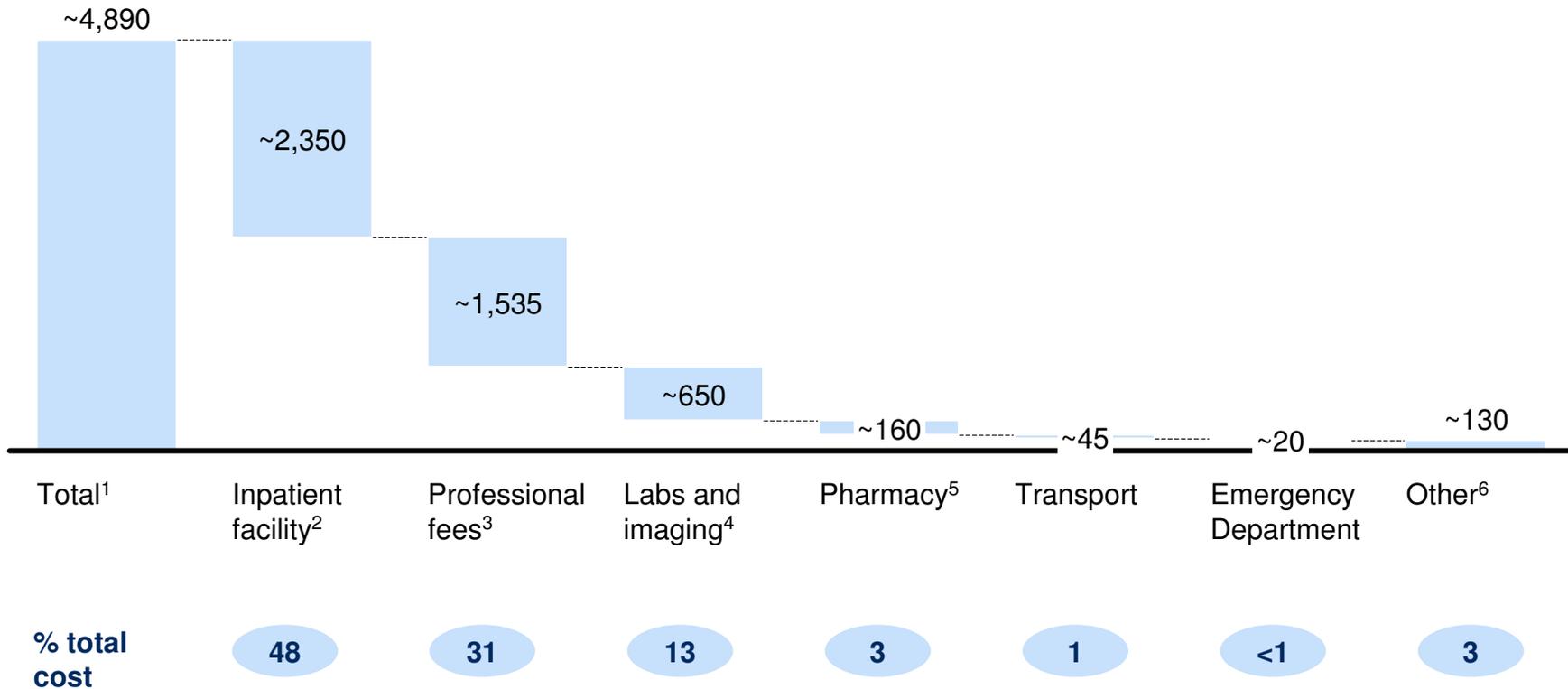
- For simplicity, data presented in this document is based on Arkansas Medicaid claims for mothers with live deliveries between April 1, 2009-March 30, 2010 (data for other participating payors to follow)
- Episodes are defined as described earlier in this document
- Data presented in this document includes the following adjustments:
  - excludes pregnancies with total costs under \$1,000 and over \$50,000
  - no other patient or provider exclusions have been made unless specifically indicated
- Provider data is based on Billing ID; therefore it presents all providers in one group as a single provider
- All data presented are preliminary and intended to facilitate today's discussion

# Basic cost structure of a pregnancy episode (Medicaid example)

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Average cost per episode  
Dollars

N = 21,199 births



1 Does not currently include maternal readmissions

2 Includes all inpatient stays during the pregnancy

3 Includes professional fees for all services during the prenatal period and for delivery, except for those related to Emergency Department care and those associated with labs and imaging

4 Including ultrasounds and Fetal Non-Stress testing

5 All medications prescribed or provided during the pregnancy episode

6 Includes facility costs for other procedures (e.g., home visits, cerclage, examination of fetal fluid)

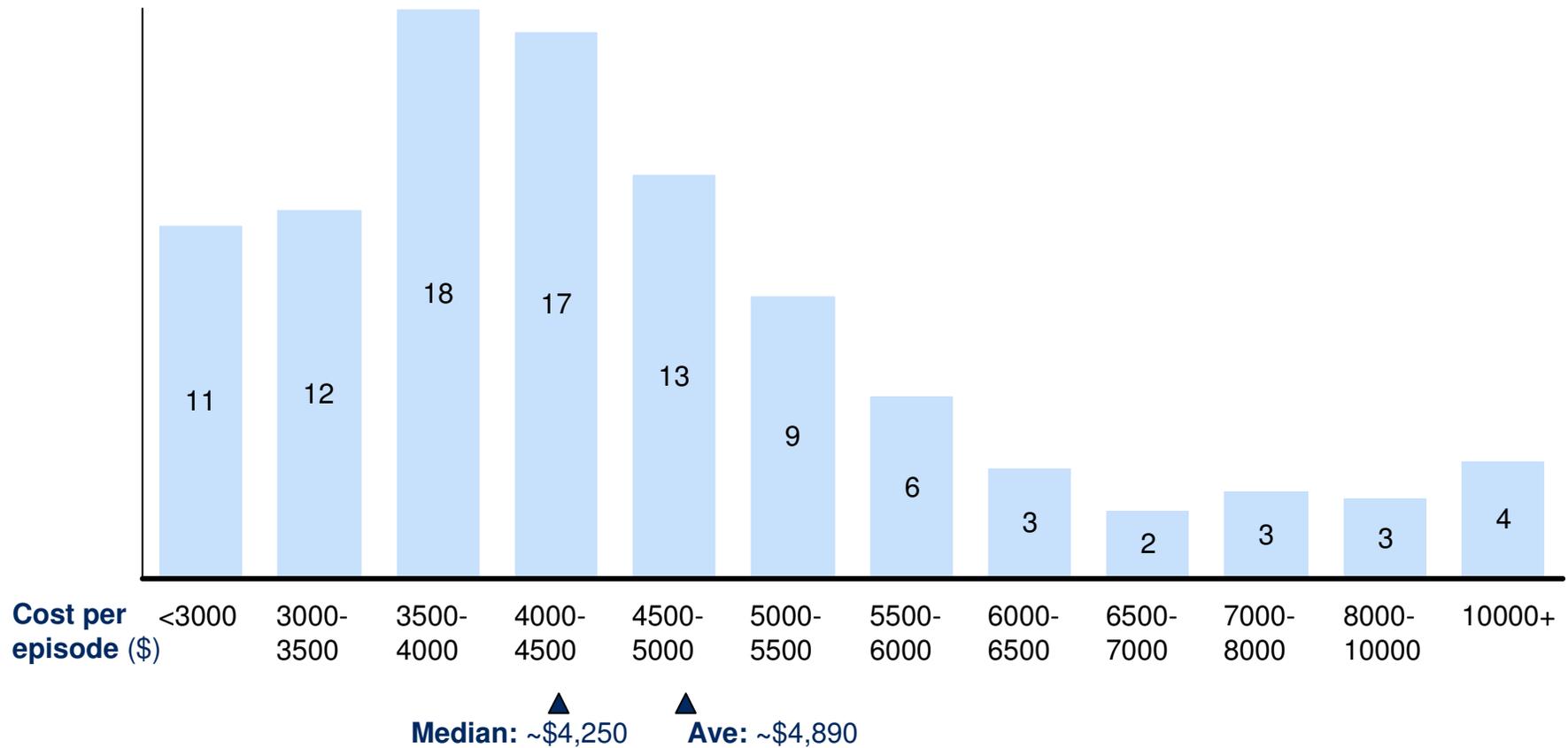
SOURCE: Arkansas Medicaid claims for mothers with deliveries between April 1, 2009-March 30, 2010 (cost based on claims paid; does not include any year-end cost settlements and adjustments)

# Cost variation in the pregnancy episode (Medicaid example)

PRELIMINARY  
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**Cost per episode**  
Percent of episodes

N = 21,179 births<sup>1</sup>



1 Fewer births than in other data because some mothers had multiple births over this time period; their average cost across both their pregnancies is presented here

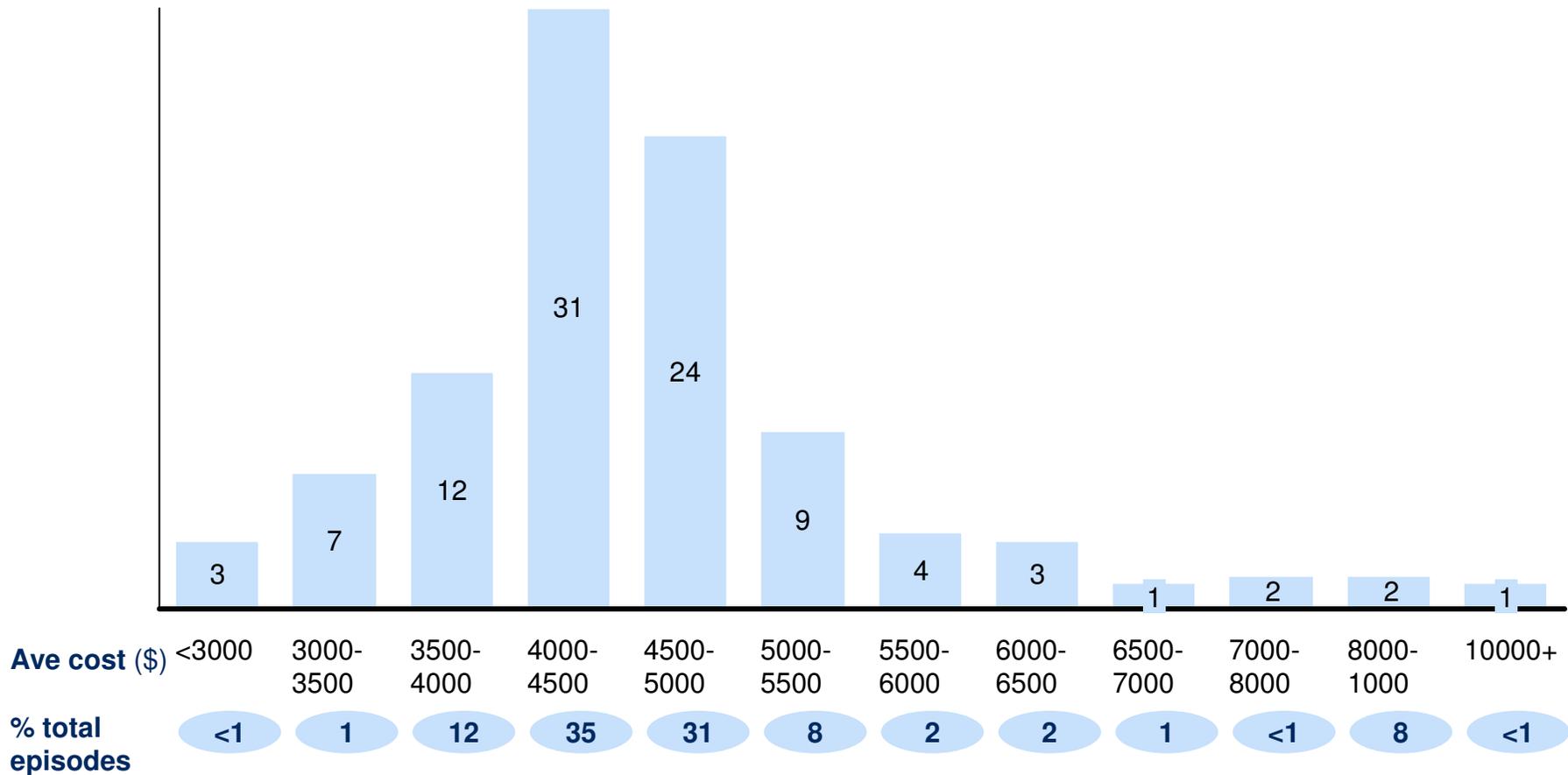
SOURCE: Arkansas Medicaid claims for mothers with deliveries between April 1, 2009-March 30, 2010 (cost based on claims paid; does not include any year-end cost settlements and adjustments)

# Cost variation among providers (Medicaid example)

PRELIMINARY  
ESTIMATES

**Provider average cost per episode**  
Percent of providers<sup>1</sup>

N = 21,199 births, 231 providers



<sup>1</sup> Providers that performed delivery

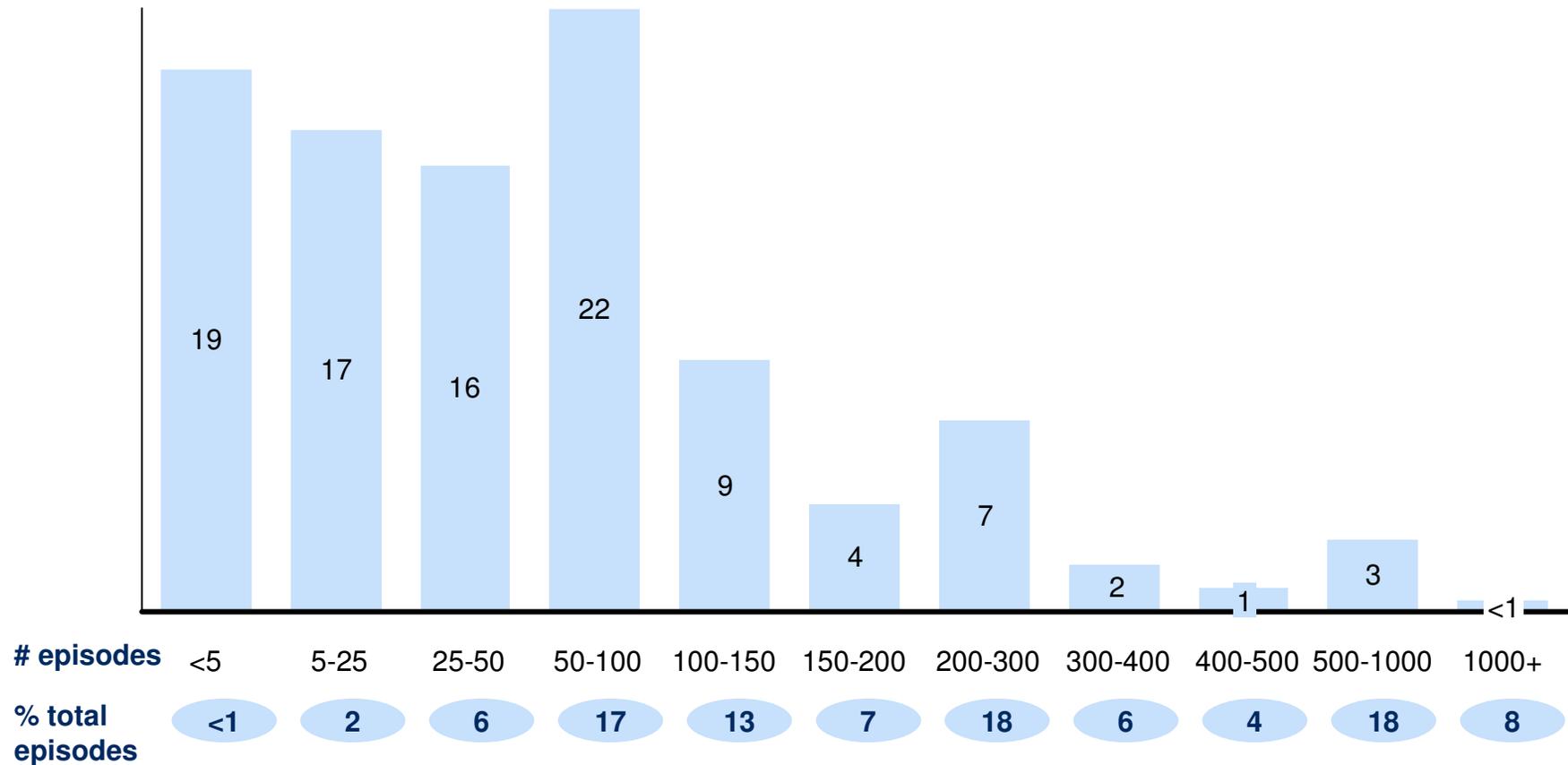
SOURCE: Arkansas Medicaid claims for mothers with deliveries between April 1, 2009-March 30, 2010 (cost based on claims paid; does not include any year-end cost settlements and adjustments)

# Distribution of volume across providers (Medicaid example)

PRELIMINARY  
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**Variation in provider delivery volume**  
Percent of providers<sup>1</sup>

N = 21,199 births, 231 providers



<sup>1</sup> Providers that performed delivery

SOURCE: Arkansas Medicaid claims for mothers with deliveries between April 1, 2009-March 30, 2010 (cost based on claims paid; does not include any year-end cost settlements and adjustments)

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**Briefly review episode design elements common across episodes (for further discussion in late March)**

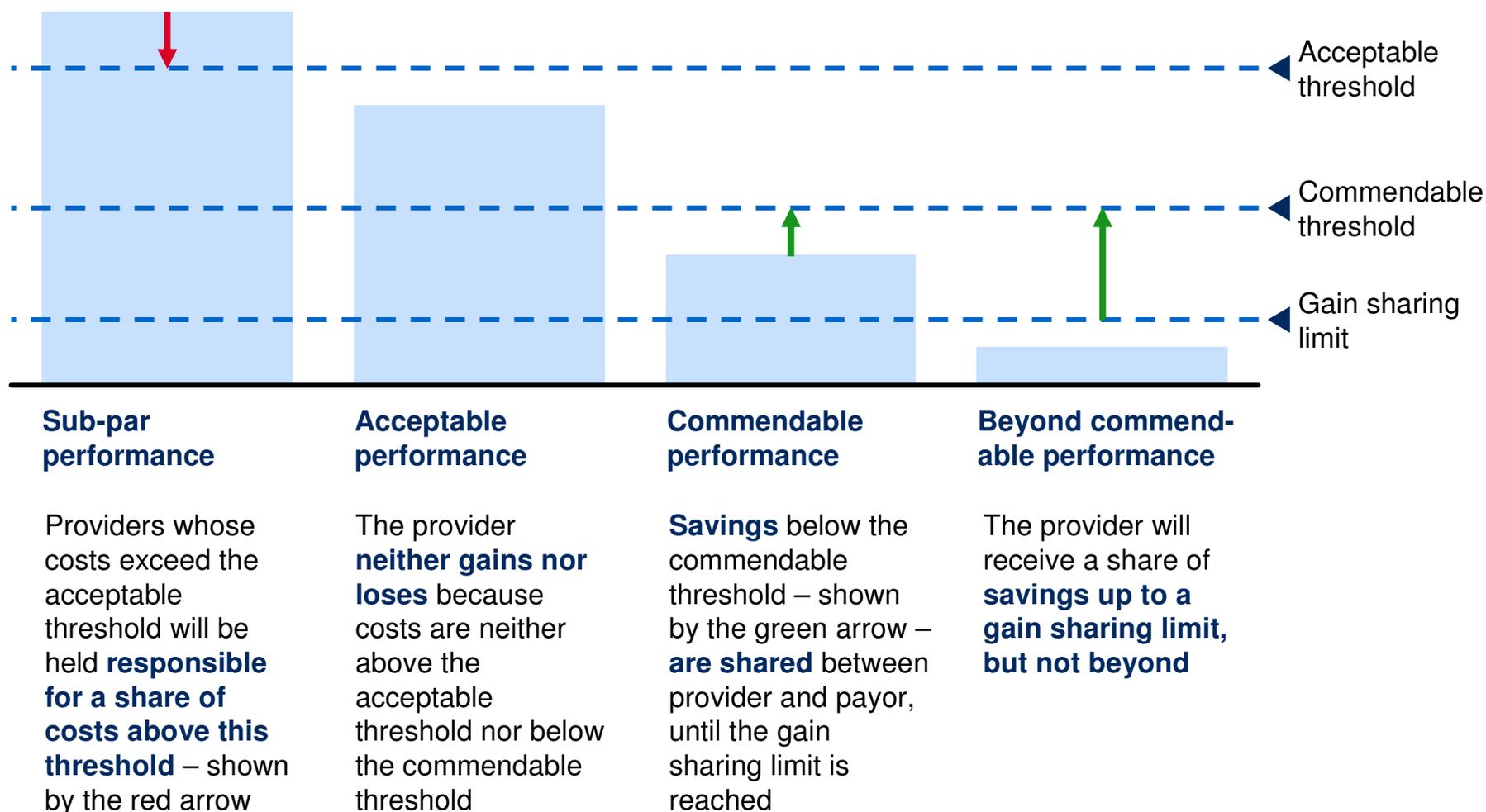
## In addition, version 1.0 episode design will incorporate several design elements common across clinical areas

	Description
<b>a</b> Payment mechanics	<ul style="list-style-type: none"><li>▪ Structure of risk and gain sharing arrangements</li><li>▪ Transition vs. end-state model</li></ul> <hr/>
<b>b</b> Other patient-level adjustments	<ul style="list-style-type: none"><li>▪ Patient risk/severity adjustments</li><li>▪ Outlier exclusions on a cost basis</li></ul> <hr/>
<b>c</b> Provider-level adjustments	<ul style="list-style-type: none"><li>▪ Stop-loss provisions</li><li>▪ Adjustments for providers in areas with poor physician access</li><li>▪ Adjustments for critical access hospitals</li><li>▪ Adjustments for differences in regional pricing</li><li>▪ Adjustments or exclusions for providers with low case-volume</li></ul>

More in-depth discussion of these dimensions scheduled for late March (participants from all clinical workgroups invited to attend)

## Gain and risk sharing: a Principal Accountable Provider will fall into one of four categories, depending on the provider's average cost per episode

Average cost per episode, for each Principal Accountable Provider

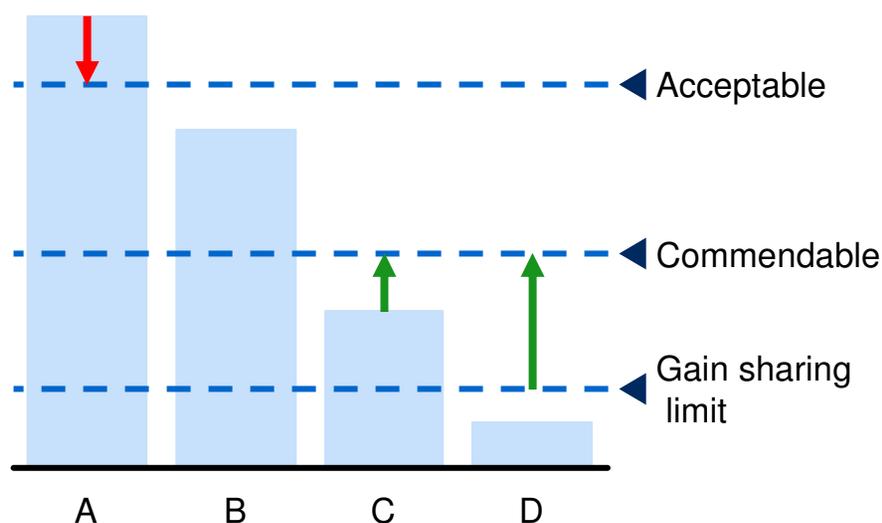


Note: in the coming months, each participating payor will determine the level of upside and downside sharing for each episode

# Gain and risk sharing: a transition period will expose fewer providers to downside risk

## Transition period

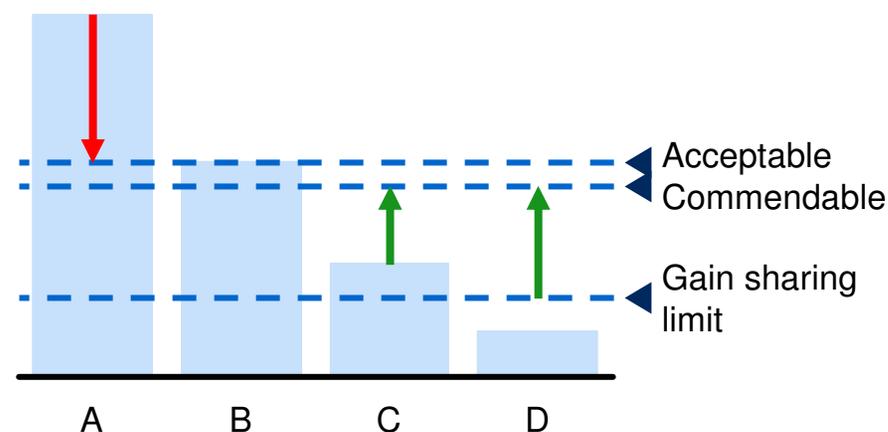
Average cost per episode, for each Principal Accountable Provider



- Higher acceptable threshold (fewer providers exposed to downside risk)
- Providers begin implementing practice changes to meet outlined post-transition thresholds

## Post-transition period

Average cost per episode, for each Principal Accountable Provider



- Acceptable threshold will be brought closer to the commendable threshold
- Commendable threshold will be brought to post-transition level

**Guiding principle:** give providers the time and resources to change practice patterns and improve performance before full risk and gain sharing is in effect