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

<table>
<thead>
<tr>
<th>Early pregnancy (1st/ 2nd trimester)</th>
<th>Late pregnancy (3rd trimester)</th>
<th>Delivery</th>
<th>Neonatal management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care</td>
<td>Prenatal care</td>
<td>Vaginal delivery</td>
<td>NICU</td>
</tr>
<tr>
<td></td>
<td>Prenatal care</td>
<td>Well baby care</td>
<td></td>
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<tr>
<td></td>
<td>C-section</td>
<td>NICU</td>
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</tbody>
</table>

1. More effective prenatal care (low and high-risk pregnancies)
2. Decrease utilization of elective procedures
3. Ensure delivery in facilities with NICU appropriate for level of prematurity
4. Increase operational efficiency of NICUs
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- Discuss perinatal-specific episode design dimensions
- Get input on approaches to ensuring high quality outcomes through episode-based payment
Goals of Payment Initiative compared with fee-for-service

<table>
<thead>
<tr>
<th>Goal</th>
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<tbody>
<tr>
<td>✓ Reward high-quality care and outcomes</td>
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<tr>
<td>✓ Encourage clinical effectiveness</td>
</tr>
<tr>
<td>✓ Promote early intervention and coordination to reduce complications and associated costs</td>
</tr>
<tr>
<td>✓ Encourage referral to higher-value downstream providers</td>
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</table>
# Principles of payment design for Arkansas

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
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<tbody>
<tr>
<td>Patient-centered</td>
<td>Focus on improving quality, patient experience and cost efficiency</td>
</tr>
<tr>
<td>Clinically appropriate</td>
<td>Evidence-based design with close input from Arkansas patients and providers</td>
</tr>
<tr>
<td>Practical</td>
<td>Consider scope and complexity of implementation</td>
</tr>
<tr>
<td>Data-based</td>
<td>Make design decisions based on facts and data</td>
</tr>
</tbody>
</table>
## Complementary approaches to achieve these goals

<table>
<thead>
<tr>
<th>Episode-based payment</th>
<th>What is it?</th>
<th>When is it used?</th>
<th>Why use it?</th>
</tr>
</thead>
</table>
|                       | ▪ Pay for an episode based on quality and cost targets reflecting total value of clinically appropriate care | ▪ Conditions where range of services provided are clearly for a given condition (e.g., acute/post-acute care) | ▪ Rewards high-quality care and outcomes  
▪ Promotes effective care, encourages reduction in unnecessary care |

<table>
<thead>
<tr>
<th>Population-based approach</th>
<th>What is it?</th>
<th>When is it used?</th>
<th>Why use it?</th>
</tr>
</thead>
</table>
|                           | ▪ Pay for care provided to population over extended period of time  
▪ Models include medical homes and health homes | ▪ Prevention/management of chronic disease across population (healthy, at-risk and with chronic conditions) | ▪ Promote care coordination  
▪ Reward effective prevention and management of chronic diseases |

<table>
<thead>
<tr>
<th>Ongoing support to meet individual needs</th>
<th>What is it?</th>
<th>Why use it?</th>
</tr>
</thead>
</table>
|                                          | ▪ Combination of approaches above:  
  ▪ Episode-based payment matched to assessed need  
  ▪ Population-based care coordination payment | ▪ Individuals requiring ongoing support matching individualized needs (e.g., DD, LTC)  
▪ 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

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Discussion Points</th>
</tr>
</thead>
</table>
| 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? |
| 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 today’s discussion

For upcoming workgroup discussions
## Payment streams: range of options available

<table>
<thead>
<tr>
<th>Individual performance bonuses</th>
<th>Episode-based retrospective reconciliation</th>
<th>Single bundled payment for episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Fee for service payments to individual providers</td>
<td>▪ During period, providers paid separately for care delivered</td>
<td>▪ Single bundled payment (target price) paid to accountable provider or team</td>
</tr>
<tr>
<td>▪ Defined bonus payments for defined process/outcome measures</td>
<td>▪ Total episode costs retrospectively compared to target price</td>
<td>▪ Accountable provider(s) or team must pay other providers for care within the episode</td>
</tr>
<tr>
<td></td>
<td>▪ Accountable provider(s) or team shares portion of upside/downside for costs below/above target price</td>
<td>▪ Most individual providers no longer receive payments from the payor (no fee schedules or contracted rates)</td>
</tr>
</tbody>
</table>

Favored option for (most) episode payment initially, based on feasibility and stakeholder feedback.
1 Explaining the retrospective reconciliation model: three steps

<table>
<thead>
<tr>
<th>Before start of reporting period</th>
<th>During period</th>
<th>At end of period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish target price for episode</td>
<td>Determine actual total cost of episode</td>
<td>Distribute gains or costs to accountable providers</td>
</tr>
<tr>
<td>▪ Set a clinically fair target price for the episode</td>
<td>▪ Reimburse each provider based on a fee schedule for services rendered</td>
<td>▪ Compare actual episode cost against the target price</td>
</tr>
<tr>
<td>▪ Share targets with providers</td>
<td>▪ Calculate total cost of episode, inclusive of all relevant services and providers</td>
<td>▪ Distribute additional payment or reduction to accountable providers</td>
</tr>
</tbody>
</table>

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
Explaining the retrospective reconciliation model: illustrative example

<table>
<thead>
<tr>
<th></th>
<th>Accountable Provider Team A</th>
<th>Accountable Provider Team B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average cost per patient</td>
<td>$14,500</td>
<td>$16,500</td>
</tr>
<tr>
<td>Relevant measures of quality</td>
<td>Satisfactory</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Clinically fair target price for the episode(^1)</td>
<td>$15,500</td>
<td>$15,500</td>
</tr>
<tr>
<td>Amount above or below target price</td>
<td><strong>$1,000</strong> in savings shared between payor and accountable provider team</td>
<td><strong>($1,000)</strong> in excess costs paid by payor and accountable provider team</td>
</tr>
</tbody>
</table>

- 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.
Most applicable model for Arkansas today: retrospective reconciliation

<table>
<thead>
<tr>
<th>Individual performance bonuses</th>
<th>Episode-based retrospective reconciliation</th>
<th>Single bundled payment for episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Does not achieve quality and coordination aims of episode-based payment</td>
<td>▪ Rewards development of clinical relationships that have impact on total cost of care without requiring providers to develop financial relationships with one another</td>
<td>▪ Effectively encourages providers to form stronger business relationships that integrate clinical and financial aspects of care</td>
</tr>
<tr>
<td>▪ (May be a valuable component of population-based model for chronic episodes)</td>
<td>▪ Well suited for Arkansas today where providers:</td>
<td>▪ Well suited for delivery systems with high levels of integration and established financial relationships</td>
</tr>
<tr>
<td></td>
<td>─ May not have financial relationships with each other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>─ May not have capabilities to sub-contract with other providers</td>
<td></td>
</tr>
</tbody>
</table>
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?
Contents

- 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
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)
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
## Perinatal episode definition

<table>
<thead>
<tr>
<th>Prenatal care</th>
<th>Delivery</th>
<th>Postpartum care</th>
<th>Neonatal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary physician (OB/GYN, Family Practice)</td>
<td>Inpatient facility for labor, delivery, post-partum care</td>
<td>IP facility for NICU</td>
<td>Neonatology</td>
</tr>
<tr>
<td>Inpatient admissions</td>
<td>Anesthesiology</td>
<td>Maternal/ neonate transport</td>
<td></td>
</tr>
<tr>
<td>Outpatient radiology</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Outpatient lab</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pharmacy</td>
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Principal accountable provider to be rewarded or responsible for subset of neonatal outcomes and costs
## 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

### Questions

- 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?
## 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.

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
## 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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- Briefly recap input received from Workgroup Meeting #1 on perinatal care
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- Discuss perinatal-specific episode design dimensions

Get input on approaches to ensuring high quality outcomes through episode-based payment
### 3 In some cases, the model may be further augmented with additional quality objectives

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Options available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure model will not result in underuse of care</td>
<td>▪ Payment contingent on delivery of care universally agreed as critical/ necessary (e.g., at least 1 ultrasound for pregnancy)</td>
</tr>
<tr>
<td></td>
<td>▪ Select “audits” to understand abnormally low utilization (e.g., for very low number of visits/year for CHF patients)</td>
</tr>
<tr>
<td>Encourage evidence-based medicine and practices¹</td>
<td>▪ Require reporting of select quality + process metrics, (e.g., % of CHF patients on an ACE or ARB)</td>
</tr>
<tr>
<td></td>
<td>▪ Increase transparency of quality metrics (e.g., to other providers)</td>
</tr>
<tr>
<td>Encourage outcomes not directly related to costs within episode</td>
<td>▪ Identify select quality metrics to track (e.g., degree of knee flexion 60 days after knee replacement)</td>
</tr>
<tr>
<td></td>
<td>▪ Increase transparency of performance (e.g., to providers, public)</td>
</tr>
<tr>
<td></td>
<td>▪ Consider linking to incremental payments or “bonuses”</td>
</tr>
</tbody>
</table>

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