Maternity Multi-Stakeholder Action Collaborative

Setting the Patient Population
May 4, 2017
1:00 – 2:00 pm ET

HCP LAN
Health Care Payment Learning & Action Network

For technical issues, please contact Leah Allen at: lallen@mitre.org

Agenda

	Timeframe (ET)	Topic	Facilitators/Presenters
1	1:00 - 1:05 pm	Welcome and Meeting Overview	Elliott Main
2	1:05 – 1:20 pm	Brief Overview of Setting the Patient Population	Michael Bailit
3	1:20 - 1:55 pm	Discussant Interview and Facilitated Discussion	Karen Love Michael Bailit
4	1:55 – 2:00 pm	Wrap-Up and Next Steps	Michael Bailit

Antitrust Statement

- MAC participants agree that all activities are in compliance with federal and state antitrust laws. In the course of discussion, **no financial information from participants will be shared with others or with the general public.**
- During meetings and other activities, including all formal and informal discussions, each participant will refrain from discussing or exchanging information regarding any competitively sensitive topics. Such information includes, but is not limited to:

  ✓ PMPM payments

  ✓ Shared savings or incentive payments

  ✓ Information about market share, profits, margins, costs, reimbursement levels or methodologies for reimbursing providers, or terms of coverage

MAC Status Update

- Three sessions have been completed to date:
  - Making the Business Case for Maternity APMs (*Track 1*)
  - Quality Measurement, Part I (*Track 2*)
  - Quality Measurement Part II (Track 2)

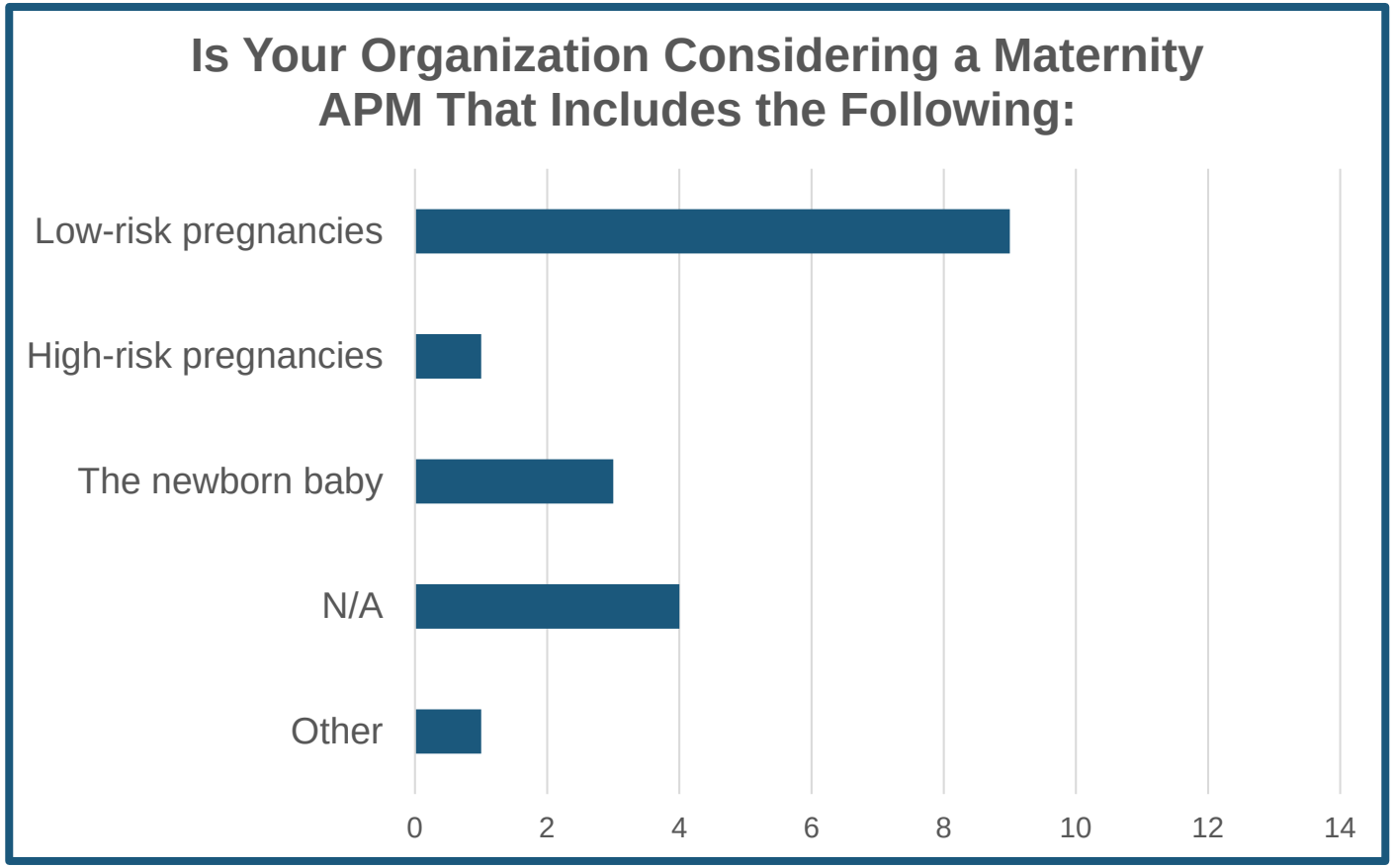
- With today's meeting on "Setting the Patient Population," we kick off a series of 5 "Track 2" virtual meetings on the design and operation of an episode payment model for maternity.
  1. Setting the Patient Population (today!)
  2. Determining Services in the Episode and Exploring Innovative Models of Maternity Care Delivery
  3. Episode Price & Budget
  4. Data Infrastructure
  5. Contracting with Providers

- While the topics are interconnected, we will address each of them discretely to help focus and address nuanced issues necessary for you to effectively design and implement a maternity episode payment model.

Meeting Objectives

- ✓ Introduce considerations regarding
  - Determining which pregnant women to include in the episode
  - Determining whether to include newborns in the episode
- ✓ Learn about key challenges related to including newborns as part of the overall patient population
- ✓ Discuss action steps MAC participants can take to further their efforts in this area
- ✓ Solicit participant questions and comments and any specific requests related to content of future meeting topics

Poll Results



Answer	Total #	Total %
Low-risk pregnancies	***9***	***64%***
High-risk pregnancies	***1***	***7%***
The newborn baby	***3***	***21%***
N/A	***4***	***29%***
Other • *MBGH is working on a maternity improvement project that will explore a pilot with 2 employers and 2 health plans using maternity payment bundles.*	***1***	***7%***

Multiple Choice, Multiple Answer Poll
14 Individual Attendees Responded

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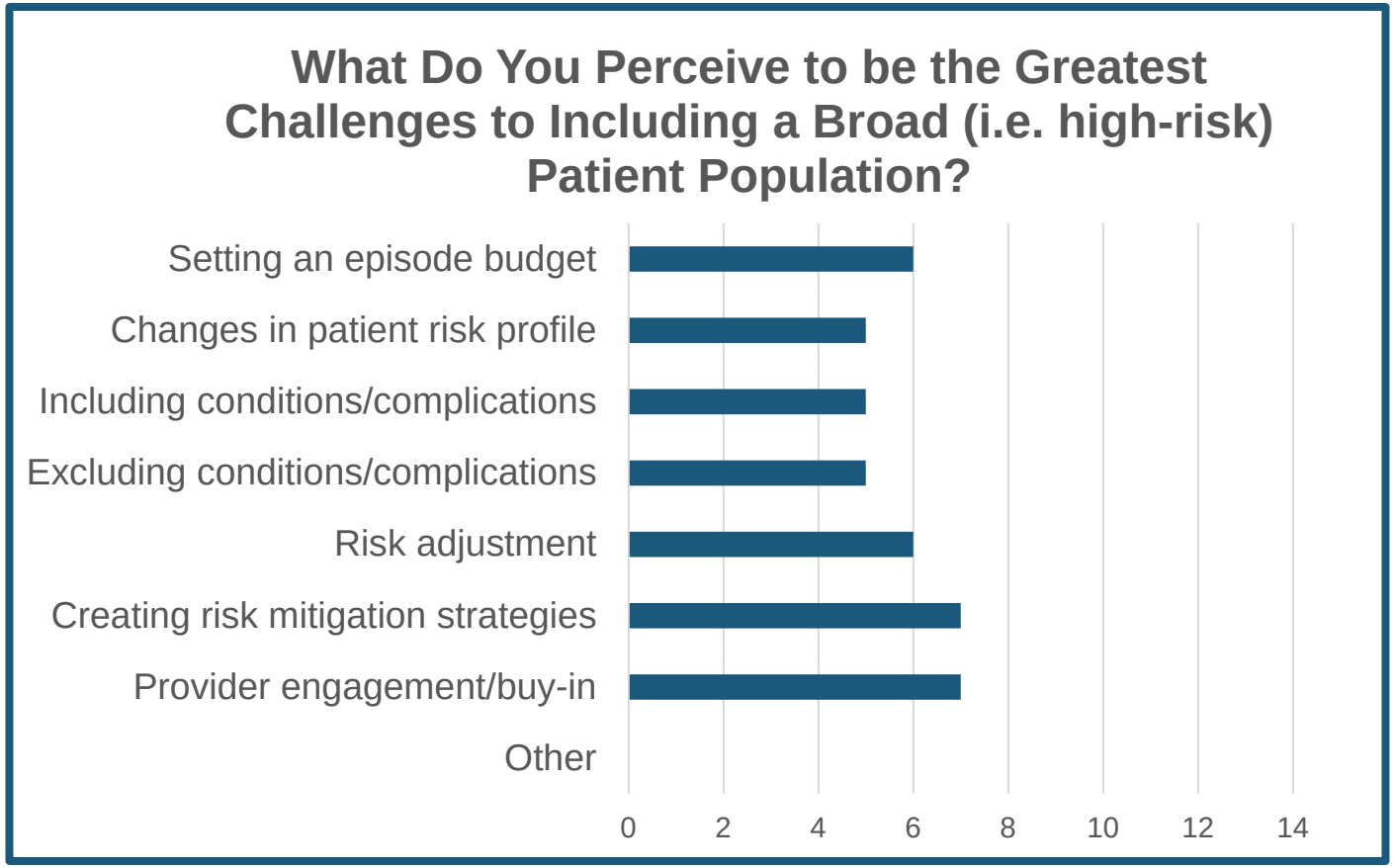
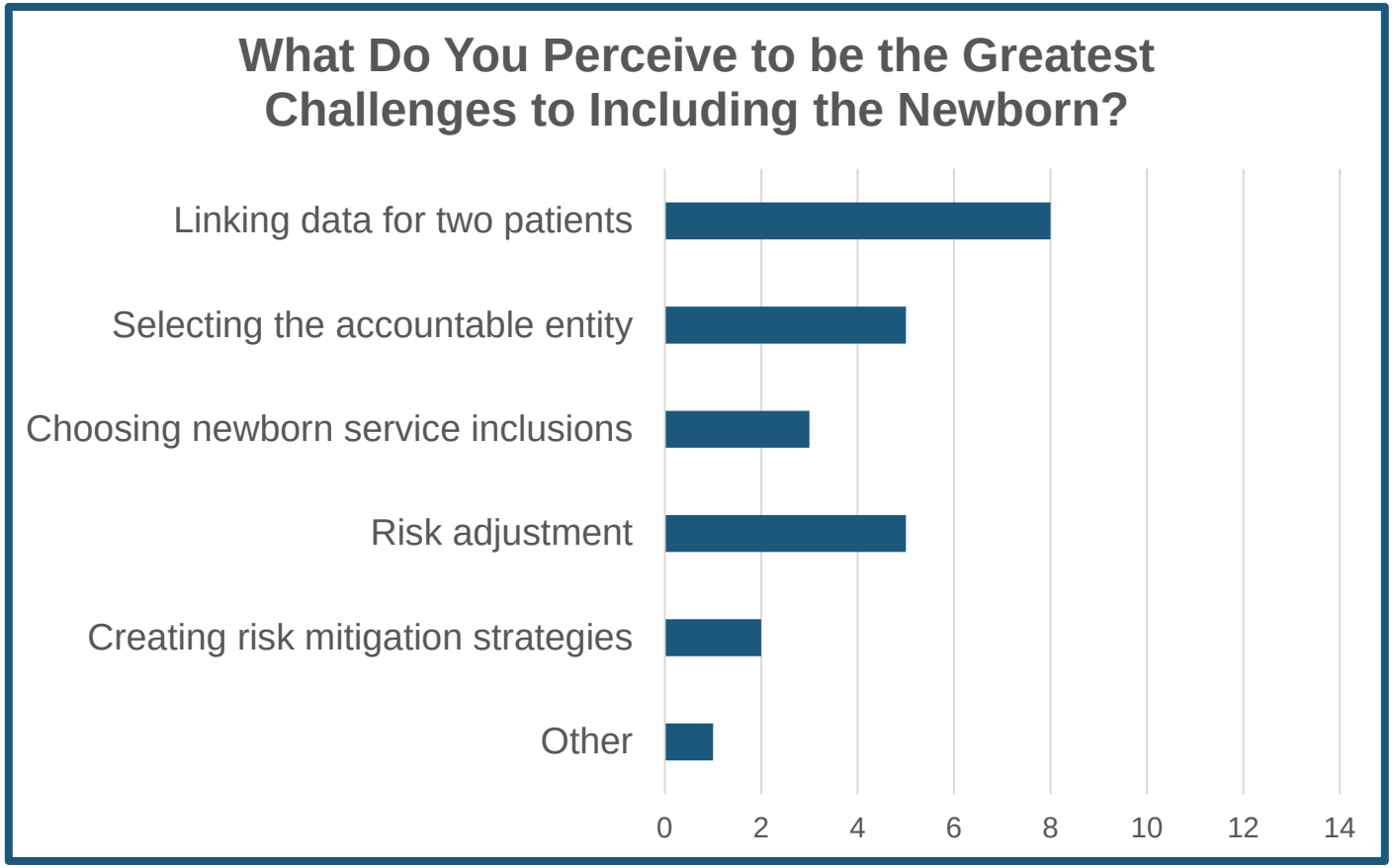
Poll Results



Answer	Total #	Total %
Setting an episode budget	*6*	*40%*
Changes in patient risk profile	*5*	*33%*
Including conditions/complications	*5*	*33%*
Excluding conditions/complications	*5*	*33%*
Risk adjustment	*6*	*40%*
Creating risk mitigation strategies	*7*	*47%*
Provider engagement/buy-in	*7*	*47%*
Other	*0*	*0%*

Multiple Choice, Multiple Answer Poll
15 Individual Attendees Responded

Poll Results



Answer	Total #	Total %
Linking data for two patients	***8***	***57%***
Selecting the accountable entity	***5***	***36%***
Choosing newborn service inclusions	***3***	***21%***
Risk adjustment	***5***	***36%***
Creating risk mitigation strategies	***2***	***14%***
Other • *No "other" responses were typed into the chat box.*	***1***	***7%***

Multiple Choice, Multiple Answer Poll
14 Individual Attendees Responded

Considerations for Establishing a Broad Patient Population

- By excluding certain categories of subpopulations, the episode gets narrowed to include the “easiest-to-treat” patients. By only including predictable and “easy-to-treat” patients, episode savings and quality improvement opportunities diminish. *This is a common episode design issue.*
- Higher risk patients can be included using one or more adjustments to mitigate provider and payer risk on the population.

Subpopulation	Risk Mitigation Strategy
Women with gaps in insurance enrollment	Limit gaps in enrollment to less than 30 days.
Women who are late in seeking prenatal care	Prorate the prenatal budget for the time period when prenatal care was delivered.
High-risk pregnant women	Use a risk adjuster to modify budgets for clinical severity.

Narrowing the Pregnant Woman Population: Factors Related to Budget

- A good place to start with building an episode is to assume that all pregnant women will be included and that episode budgets are set to adequately cover all of the expected services.
- Poorly set budgets can put providers at risk for meeting unattainable targets and can place plans at risk for overpaying providers.
- The reasons why some pregnant women might be excluded from an episode are largely centered around a payer's ability to accurately set an episode budget. Challenges with accurately setting budgets could be caused by not addressing cost variation in certain subpopulations.

On June 15 we will meet to discuss setting the episode budget and revisit these issues

Rationale for Creating Patient Exclusions (1/2)

- **A gap in insurance enrollment during the time of the episode**
  - Care might be provided to the woman and paid for by another payer during the episode time frame, or if the woman is uninsured, she may not receive any care at all during that time frame.
  - In a Medicaid population, because pregnancy is a qualifying condition typical Medicaid eligibility "churn rates" might not affect this population as much as it may for other populations / conditions – however, there is still potential for pregnant women to lose eligibility if their incomes changes during the time of their pregnancy.

Rationale for Creating Patient Exclusions (2/2)

- **Delay in seeking prenatal care**
  - Women who seek prenatal care too late in their pregnancy (e.g., third trimester) for any reason (e.g., uninsured, chose to not seek care) may not be able to benefit from prenatal interventions that could affect their pregnancy outcomes.
  - Providers will not want to be placed at risk for patients to whom they did not provide most or any prenatal care.
- **High-risk pregnancy**
  - Women at higher risk for pregnancy complications (e.g., 3+ gestation, certain serious pre-existing medical conditions, mental health or substance use conditions) may incur higher costs that might be more difficult to predict, and therefore make it more difficult to accurately set provider episode budgets.

Example Exclusions from Current Maternity Episode Models

Integrated Healthcare Association

- Hospital discharge status is AMA, or transferred during labor
- Clinical history demonstrates:
  - Active cancer
  - AIDS
  - Fetal surgery
  - Multiple gestation 3+ (or twins that share one amniotic sac)
  - Multiple sclerosis
  - Pulmonary embolism
  - Renal dialysis
  - Rupture of uterus
  - Transplant

Tennessee Episode of Care Program:

- Clinical history demonstrates active cancer
- A Maternal Fetal Medicine (MFM) specialist is the provider that triggers the episode
- Other business exclusions (e.g., lack of continuous Medicaid enrollment)

Community Health Choice:

- Year 1 only, newborns with NICU level 4.
- Going forward, no exclusions

New York DSRIP:

- Pregnancy without delivery
- Hospital discharge status is AMA
- Members who die in hospital
- Those without inpatient / outpatient stay and relevant professional claim (orphan episode)
- Comorbidities of HIV, cancer, suicide, or ESRD
- Newborns with NICU level 4

Arkansas:

- Pregnancy without delivery
- Pregnancy related conditions like: amniotic fluid embolism, placenta previa, puerperal sepsis
- Other conditions like: cancer, cystic fibrosis, DVT/PE, ESRD, type 1 diabetes
- Other exclusions

Geisinger ProvenCare:

- All deliveries in which there was not at least 12 weeks of continuous prenatal care

Considerations for Including the Baby in the Episode

- Inadequate prenatal care increases the risk for negative birth outcomes.
- Logically, it makes sense to include the costs of at least some newborn services, and certain outcomes of the baby, within a maternity episode.
- Maternity is the only episode in which one patient becomes two (or three, or four…) and it requires some careful consideration and logistics, including:
  - **Ensuring that the mom and baby can be linked within the data** – some states and plans have the ability to do this automatically – and in the case where it does not exist, the payer would have to create its own.
  - **Contracting appropriately**, which may or may not include contracting with providers who care for the baby.

Data Considerations

- It is important to perform analysis using your own data to determine whether excluding or including certain subpopulations works for you.
- A payer could analyze the variation in costs for the subpopulations in question – e.g., pregnant women with a behavioral health diagnosis – to identify patterns of spending and build appropriate risk mitigation strategies into the episode.

- Ask yourself, to what extent do episode costs differ for the subpopulation(s)?
  - If there is little variation within the subpopulation, are costs higher than the total population in a statistically significant way? If so, episode budgets for subpopulations could be increased to account for expected additional costs.
  - If there is great variation within the subpopulation, it will be important to understand the cause. Could it be due to inadequate care where certain women receive additional services, while some are left untreated? Could it be due to provider type, where certain women are being cared for by higher-priced providers?

Linking Mom and Baby in Data

- One barrier to including the baby in the episode is a reported challenge of not being able to link the mom and baby through Medicaid data.
  - Medicaid programs do not typically include family identifiers, like commercial plans often do, making it difficult to link one individual's (the baby) outcomes with another (the mom).
  - Simply matching moms and babies on last names or address alone causes too many false matches.
- The Center for Outcomes Research and Education (CORE), an independent research team affiliated with Providence Health and Services in Oregon and Southwest Washington, has identified a methodology to help Medicaid programs overcome this barrier.
- Out of a desire to assist a program focused on providing comprehensive health care and care management services for pregnant women with substance use disorders, CORE developed an approach that matched moms and babies 88.5% (out of 17,094 moms) of the time with a high degree of confidence in 87% of the matches.

Linking Mom and Baby in Data: Overview of Methodology

1. Use maternal pregnancy outcome diagnoses codes to identify women who have given birth and all the dates of service surrounding their child's birth.
2. Identify birth claims for the all the children in the data.
3. Link mother and child on dates of service associated with date of service for giving birth and date of birth for the child.
4. Use the remaining demographic information to complete matching with various levels of confidence

CORE | Center for Outcomes Research and Education

A written methodology will be made available on the MAC webpage, https://hcp-lan.org/groups-display/collaboratives

Degree of Confidence in Match

CORE Center for Outcomes Research and Education

Degree of Confidence	Matching Mechanism
High Confidence Matches	• **Phone number matches between mother and child, regardless of other matching information** • **Family identifier matches (although this was rare).** These two were considered high confidence matches as the likelihood of a mother and unrelated child having the same phone number associated with them is negligible to nothing, and the family identifier has been assigned by OHA (the Medicaid agency) as an administrative ID to connect household members.
Confident Matches	• **A match between last name as well as address** • **A match between address alone** These two were considered slightly more skeptical matches with the major concern being mobility and large apartment buildings. There is a small chance a child could be born in between an address change or that multiple children could be born on the same day in one of the larger buildings.
Low Confidence Matches	• **Last name match alone** This type of match was often visibly wrong when simply eyeballing the data, but could not be excluded on the odd chance that it was an accurate match.

Approaches from the Field

Live interview with colleague in Texas

Karen Love
Executive Vice President and
Chief Operating Officer
Community Health Choice

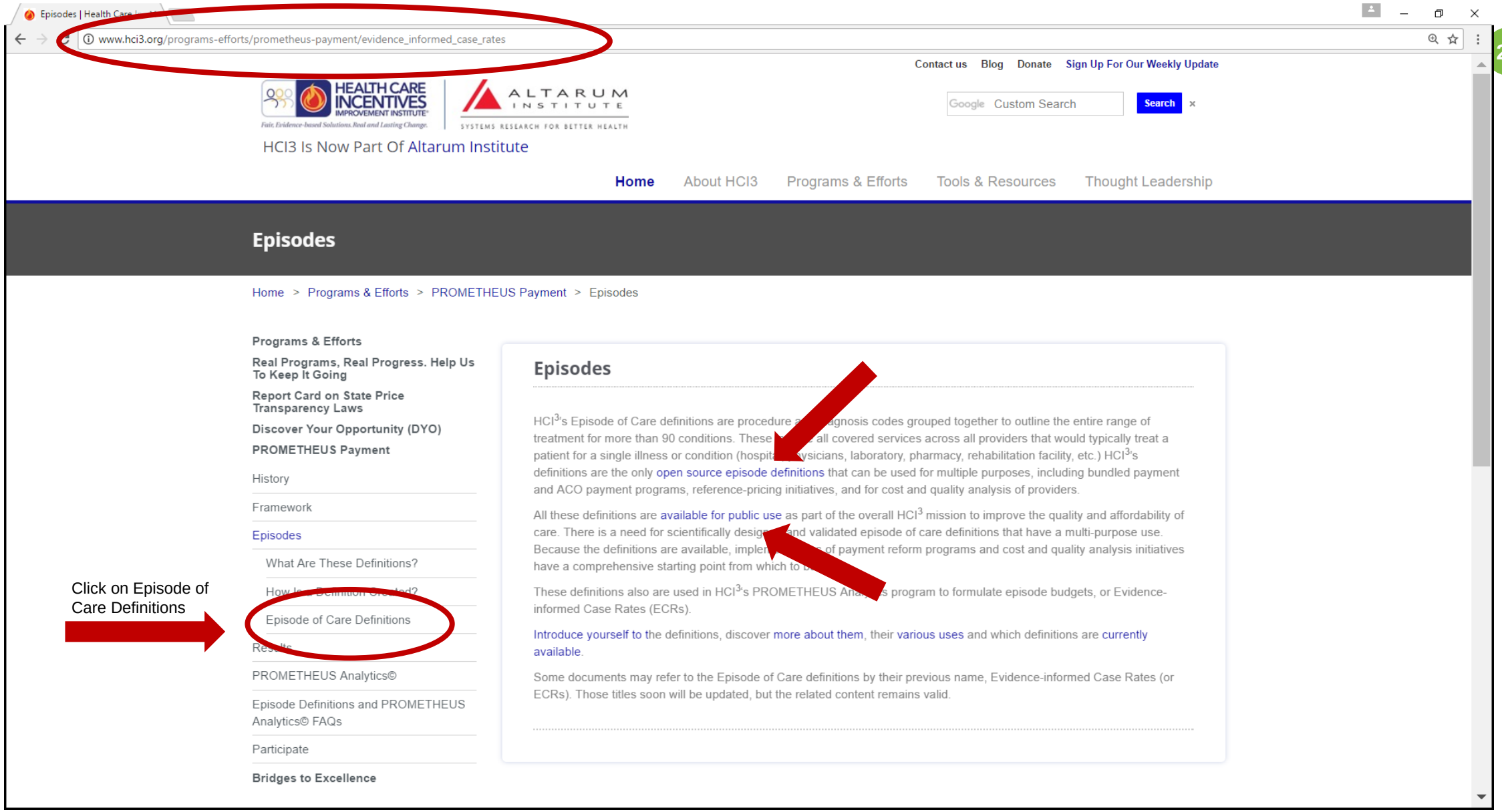
Meeting Follow-Up Activities & Feedback

1. The LAN will:

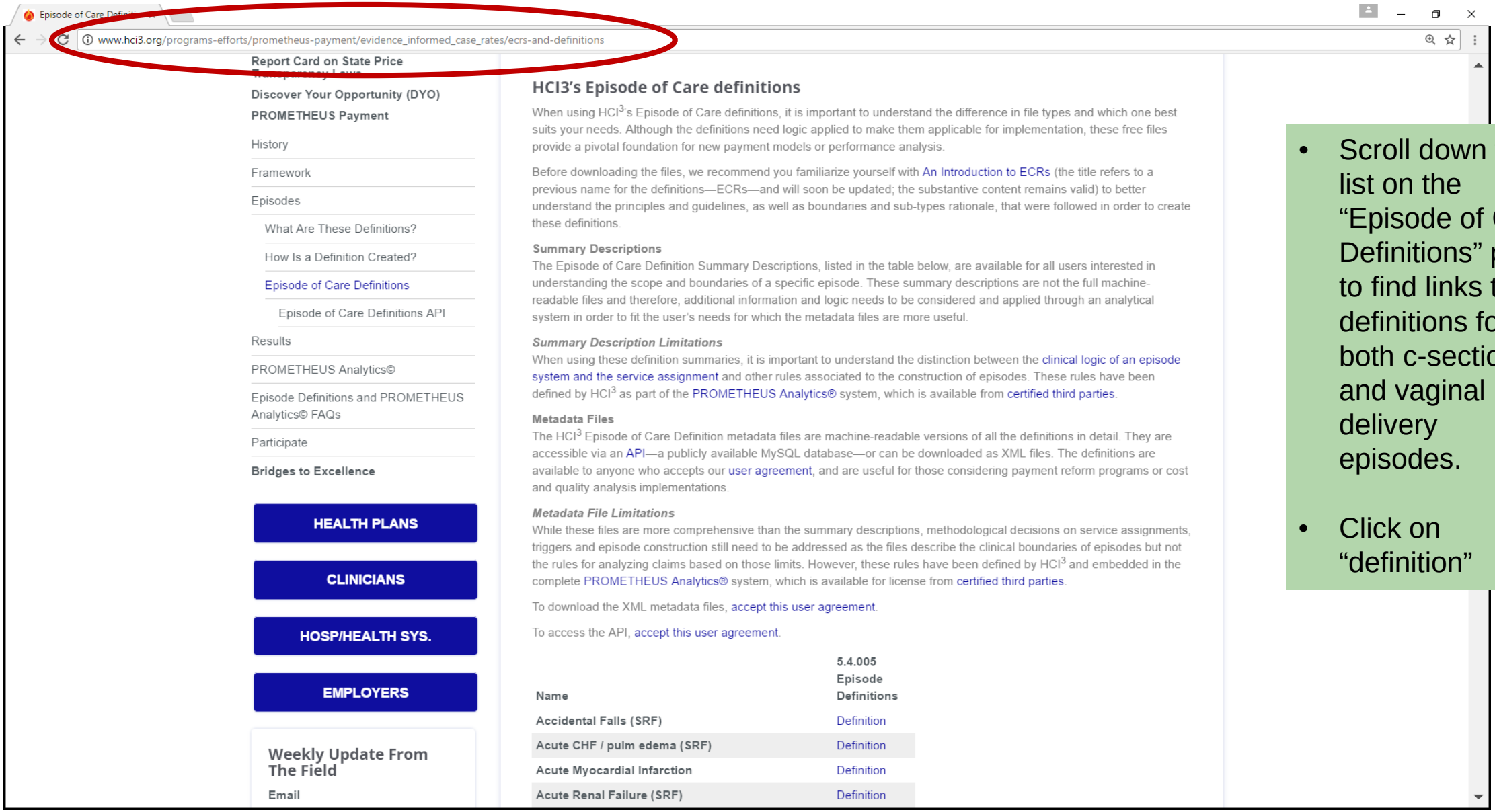
- Distribute a summary of this meeting.
- Reach out to MAC participants to seek input on 1) the extent to which this session and associated materials were helpful; and 2) what can be improved for future sessions.

2. We encourage participants to:

- Provide the LAN with feedback on their activity related to the issues discussed today, either by email, phone, or via the communication portal.
- Explore whether your organization (or your state's MCOs) have the capacity and infrastructure to link claims data on mothers and babies
- Examine your claims data and potentially run analytics on what an episode budget would look like depending on the population included.

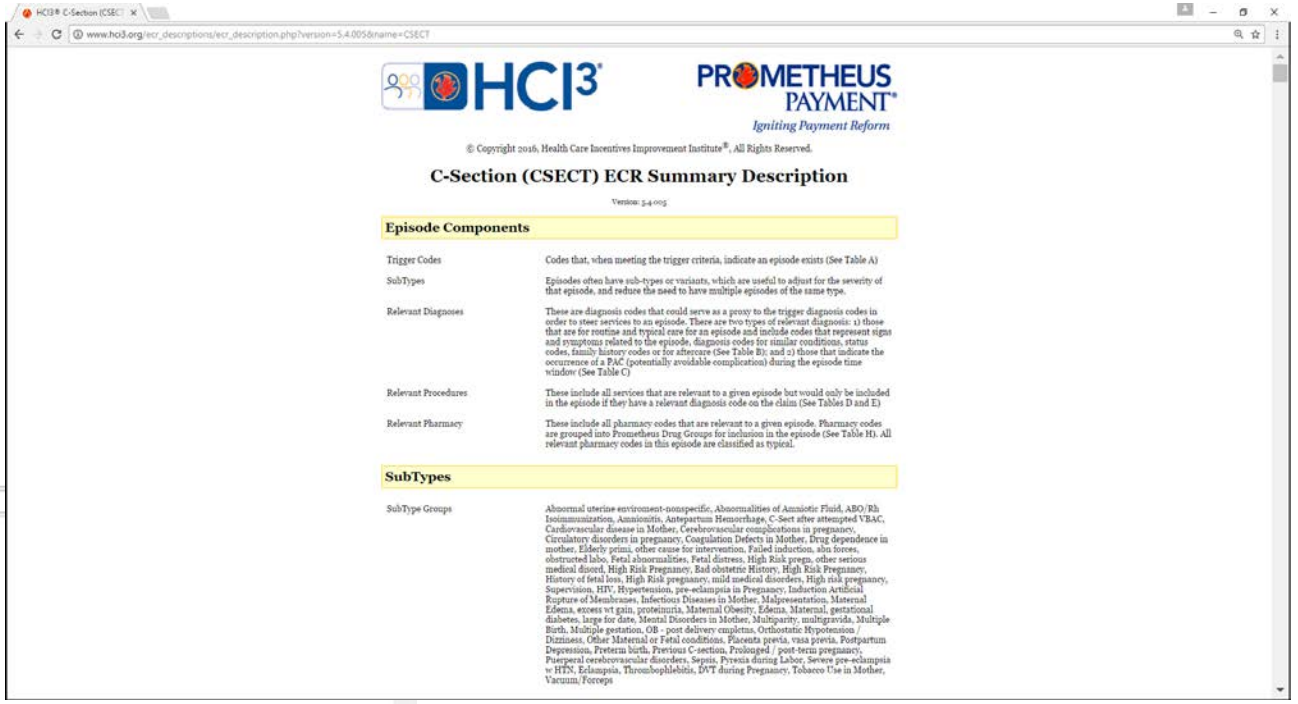


Click on Episode of Care Definitions



- Scroll down the list on the "Episode of Care Definitions" page to find links to definitions for both c-section and vaginal delivery episodes.
- Click on "definition"

The definitions link takes you to codes for episode triggers, diagnoses, potentially avoidable complications, and procedures



HCI3 PROMETHEUS PAYMENT
Igniting Payment Reform

C-Section (CSECT) ECR Summary Description

Version: 5.4.005

Episode Components

Trigger Codes	Codes that, when meeting the trigger criteria, indicate an episode exists (See Table A)
SubTypes	Episodes often have sub-types or variants, which are useful to adjust for the severity of that episode, and reduce the need to have multiple episodes of the same type.
Relevant Diagnoses	These are diagnosis codes that could serve as a proxy to the trigger diagnosis codes in order to steer services to an episode. There are two types of relevant diagnosis: 1) those that are for routine and typical care for an episode and include codes that represent signs and symptoms related to the episode, diagnosis codes for similar conditions, status codes, family history codes or for aftercare (See Table B); and 2) those that indicate the occurrence of a PAC (potentially avoidable complication) during the episode time window (See Table C)
Relevant Procedures	These include all services that are relevant to a given episode but would only be included in the episode if they have a relevant diagnosis code on the claim (See Tables D and E)
Relevant Pharmacy	These include all pharmacy codes that are relevant to a given episode. Pharmacy codes are grouped into Prometheus Drug Groups for inclusion in the episode (See Table H). All relevant pharmacy codes in this episode are classified as typical.

SubTypes

SubType Groups	Abnormal uterine environment-nonspecific, Abnormalities of Amniotic Fluid, ABO/Rh Isoimmunization, Amnionitis, Antepartum Hemorrhage, C-Sect after attempted VBAC, Cardiovascular disease in Mother, Cerebrovascular complications in pregnancy, Circulatory disorders in pregnancy, Coagulation Defects in Mother, Drug dependence in mother, Elderly primi, other cause for intervention, Failed induction, abn forces, obstructed labo, Fetal abnormalities, Fetal distress, High Risk pregn, other serious medical disord, High Risk Pregnancy, Bad obstetric History, High Risk Pregnancy, History of fetal loss, High Risk pregnancy, mild medical disorders, High risk pregnancy, Supervision, HIV, Hypertension, pre-eclampsia in Pregnancy, Induction Artificial Rupture of Membranes, Infectious Diseases in Mother, Malpresentation, Maternal Edema, excess wt gain, proteinuria, Maternal Obesity, Edema, Maternal, gestational diabetes, large for date, Mental Disorders in Mother, Multiparity, multigravida, Multiple Birth, Multiple gestation, OB - post delivery cmpletns, Orthostatic Hypotension / Dizziness, Other Maternal or Fetal conditions, Placenta previa, vasa previa, Postpartum Depression, Preterm birth, Previous C-section, Prolonged / post-term pregnancy, Puerperal cerebrovascular disorders, Sepsis, Pyrexia during Labor, Severe pre-eclampsia w HTN, Eclampsia, Thrombophlebitis, DVT during Pregnancy, Tobacco Use in Mother, Vacuum/Forceps

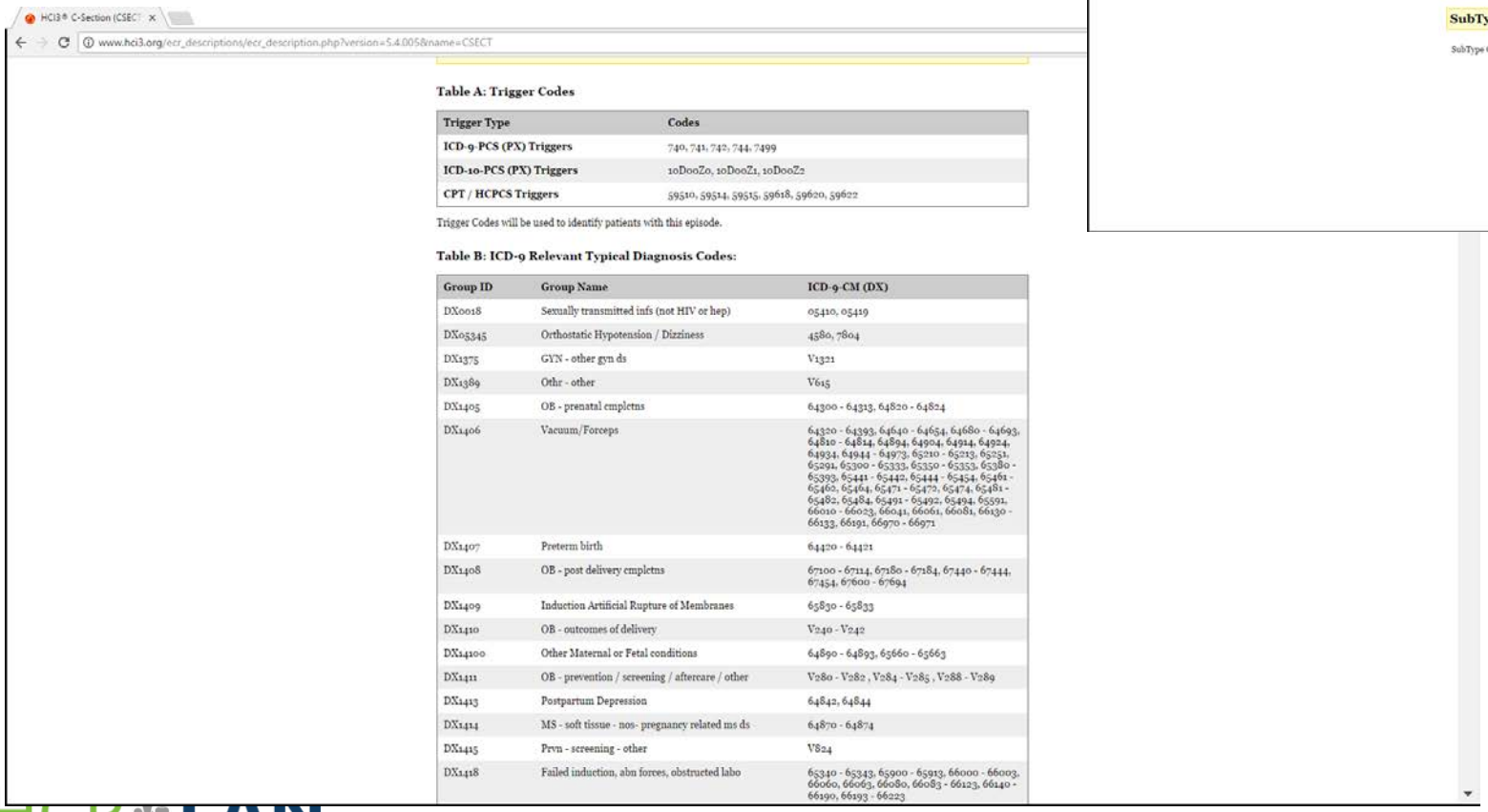


Table A: Trigger Codes

Trigger Type	Codes
ICD-9-PCS (PX) Triggers	740, 741, 742, 744, 7499
ICD-10-PCS (PX) Triggers	10D00Z0, 10D00Z1, 10D00Z2
CPT / HCPCS Triggers	59510, 59514, 59515, 59618, 59620, 59622

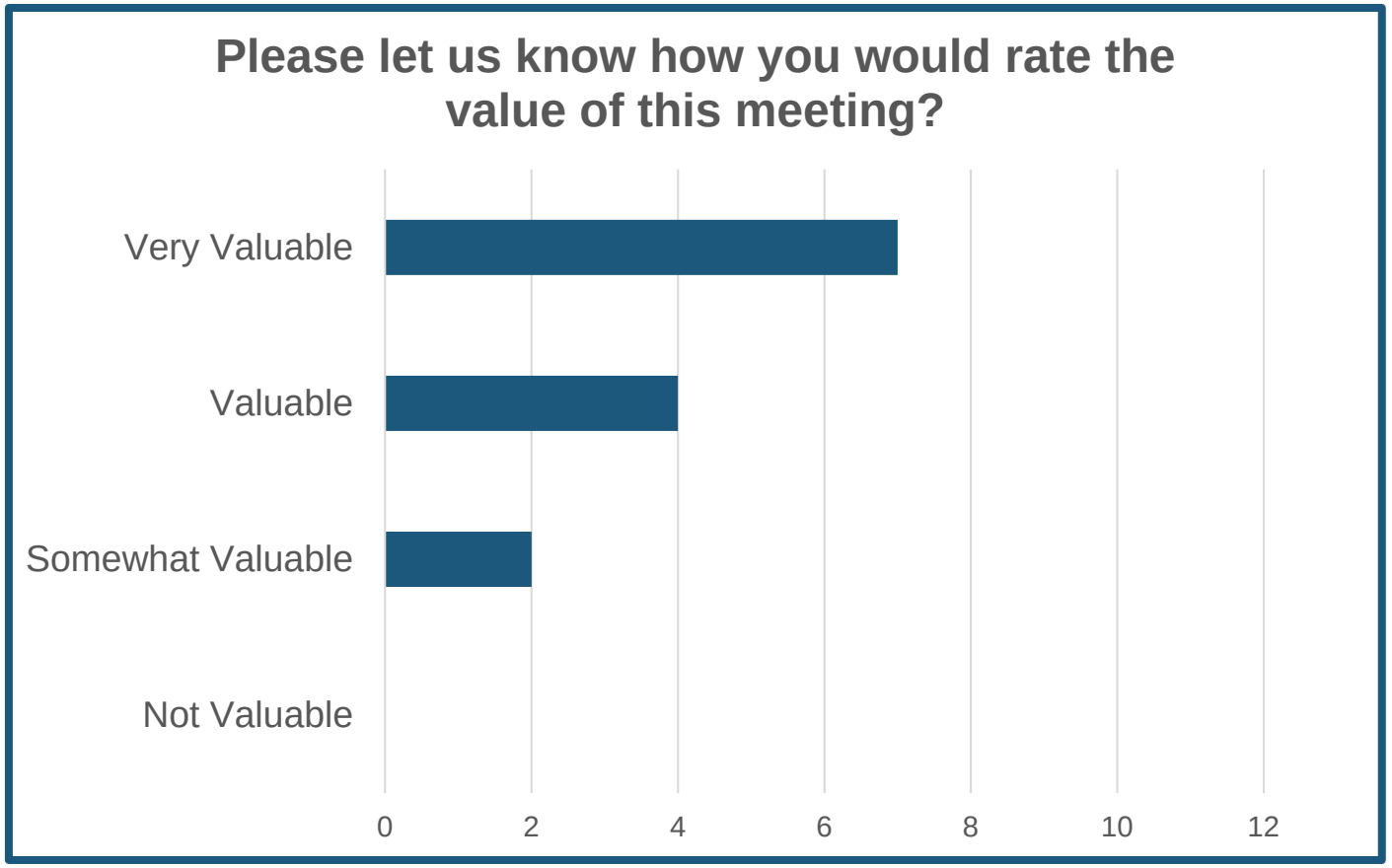
Trigger Codes will be used to identify patients with this episode.

Table B: ICD-9 Relevant Typical Diagnosis Codes:

Group ID	Group Name	ICD-9-CM (DX)
DX0018	Sexually transmitted infs (not HIV or hep)	05410, 05419
DX05345	Orthostatic Hypotension / Dizziness	4580, 7804
DX1375	GYN - other gyn ds	V1321
DX1389	Othr - other	V615
DX1405	OB - prenatal cmpletns	64300 - 64313, 64820 - 64824
DX1406	Vacuum/Forceps	64320 - 64393, 64640 - 64654, 64680 - 64693, 64810 - 64814, 64894, 64904, 64914, 64924, 64934, 64944 - 64973, 65210 - 65213, 65253, 65291, 65300 - 65333, 65350 - 65353, 65380 - 65393, 65441 - 65442, 65444 - 65454, 65461 - 65462, 65464, 65471 - 65472, 65474, 65481 - 65482, 65484, 65491 - 65492, 65494, 65591, 66010 - 66023, 66041, 66061, 66081, 66130 - 66133, 66191, 66970 - 66971
DX1407	Preterm birth	64420 - 64421
DX1408	OB - post delivery cmpletns	67100 - 67114, 67180 - 67184, 67440 - 67444, 67454, 67600 - 67694
DX1409	Induction Artificial Rupture of Membranes	65830 - 65833
DX1410	OB - outcomes of delivery	V240 - V242
DX14200	Other Maternal or Fetal conditions	64890 - 64893, 65660 - 65663
DX1411	OB - prevention / screening / aftercare / other	V280 - V282 , V284 - V285 , V288 - V289
DX1413	Postpartum Depression	64842, 64844
DX1414	MS - soft tissue - nos- pregnancy related ms ds	64870 - 64874
DX1415	Prvn - screening - other	V824
DX1418	Failed induction, abn forces, obstructed labo	65340 - 65343, 65900 - 65913, 66000 - 66003, 66060, 66063, 66080, 66083 - 66123, 66140 - 66190, 66193 - 66223

This is a preview to the episode budget building discussion scheduled for June 15.

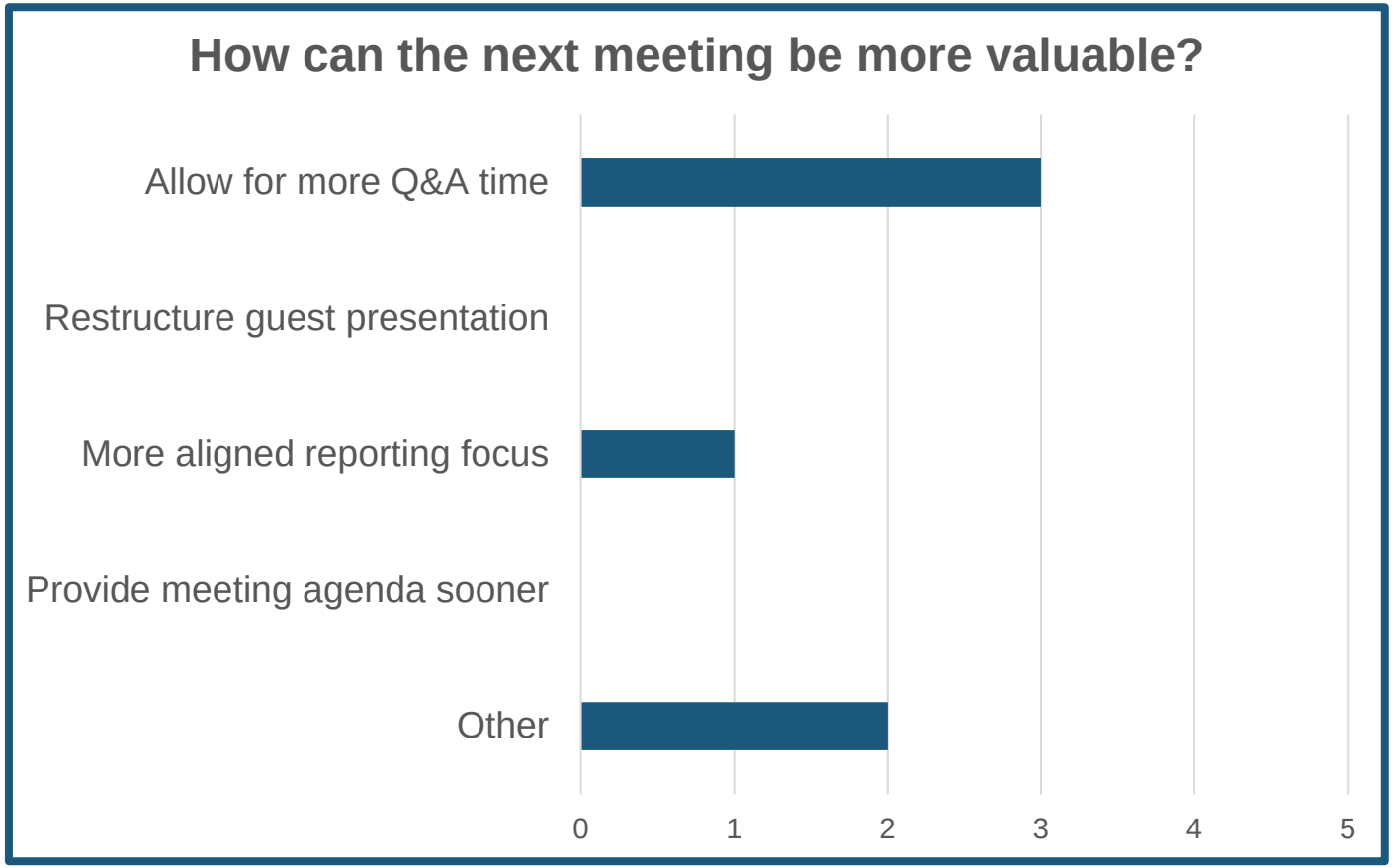
Poll Results



Answer	Total #	Total %
Very Valuable	*7*	*54%*
Valuable	*4*	*31%*
Somewhat Valuable	*2*	*15%*
Not Valuable	*0*	*0%*

Multiple Choice, Single Answer Poll
13 Individual Attendees Responded

Poll Results



Answer	Total #	Total %
Allow for more Q&A time	***3***	***60%***
Restructure guest presentation	***0***	***0%***
More aligned reporting focus	***1***	***20%***
Provide meeting agenda sooner	***0***	***0%***
Other Responses from Chat Box • *No "other" responses were typed into the chat box.*	***2***	***40%***

Multiple Choice, Multiple Answer Poll
5 Individual Attendees Responded

Looking Ahead

Session	Track	Session Name	Date	Time (ET)
1	1	Making the Business Case **(Completed)**	2/8	2-3 PM
2	2	Quality Measurement, Part 1 **(Completed)**	3/3	1-2:30 PM
3	2	Quality Measurement, Part 2 **(Completed)**	3/20	2:30-4 PM
		SESSION POSTPONED	**4/14**	**1-2 PM**
4	2	Setting the Patient Population	5/4	1-2 PM
5	1 & 2	Innovative Models of Maternity Care Delivery & Determining Services	5/22	2-3 PM
6	2	Setting the Episode Price & Budget	6/15	1-2 PM
7	2	Data Infrastructure	7/7	1-2:30 PM
8	2	Contracting with Providers	7/28	1-2 PM
9	1	State Payers and MCOs	8/16	2-3 PM

MAC Team

Primary Points of Contact

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