Maternity Multi-Stakeholder Action Collaborative

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

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

<table>
<thead>
<tr>
<th>Timeframe (ET)</th>
<th>Topic</th>
<th>Facilitators/Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome and Meeting Overview</td>
<td>Elliott Main</td>
</tr>
<tr>
<td>2</td>
<td>Brief Overview of Setting the Patient Population</td>
<td>Michael Bailit</td>
</tr>
<tr>
<td>3</td>
<td>Discussant Interview and Facilitated Discussion</td>
<td>Karen Love, Michael Bailit</td>
</tr>
<tr>
<td>4</td>
<td>Wrap-Up and Next Steps</td>
<td>Michael Bailit</td>
</tr>
</tbody>
</table>
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

Is Your Organization Considering a Maternity APM That Includes the Following:

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

Multiple Choice, Multiple Answer Poll
14 Individual Attendees Responded
## Poll Results

What Do You Perceive to be the Greatest Challenges to Including a Broad (i.e. high-risk) Patient Population?

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Total #</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting an episode budget</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Changes in patient risk profile</td>
<td>5</td>
<td>33%</td>
</tr>
<tr>
<td>Including conditions/complications</td>
<td>5</td>
<td>33%</td>
</tr>
<tr>
<td>Excluding conditions/complications</td>
<td>5</td>
<td>33%</td>
</tr>
<tr>
<td>Risk adjustment</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Creating risk mitigation strategies</td>
<td>7</td>
<td>47%</td>
</tr>
<tr>
<td>Provider engagement/buy-in</td>
<td>7</td>
<td>47%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Multiple Choice, Multiple Answer Poll
15 Individual Attendees Responded
Poll Results

What Do You Perceive to be the Greatest Challenges to Including the Newborn?

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Total #</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linking data for two patients</td>
<td>8</td>
<td>57%</td>
</tr>
<tr>
<td>Selecting the accountable entity</td>
<td>5</td>
<td>36%</td>
</tr>
<tr>
<td>Choosing newborn service inclusions</td>
<td>3</td>
<td>21%</td>
</tr>
<tr>
<td>Risk adjustment</td>
<td>5</td>
<td>36%</td>
</tr>
<tr>
<td>Creating risk mitigation strategies</td>
<td>2</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>7%</td>
</tr>
</tbody>
</table>

Other
- No “other” responses were typed into the chat box.

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.

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

**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

**Community Health Choice:**
- Year 1 only, newborns with NICU level 4.
- Going forward, no exclusions

**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.

A written methodology will be made available on the MAC webpage, https://hcp-lan.org/groups-display/collaboratives
## Degree of Confidence in Match

<table>
<thead>
<tr>
<th>Degree of Confidence</th>
<th>Matching Mechanism</th>
</tr>
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</table>
| 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.

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

Please let us know how you would rate the value of this meeting?

<table>
<thead>
<tr>
<th>Answer</th>
<th>Total #</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Valuable</td>
<td>7</td>
<td>54%</td>
</tr>
<tr>
<td>Valuable</td>
<td>4</td>
<td>31%</td>
</tr>
<tr>
<td>Somewhat Valuable</td>
<td>2</td>
<td>15%</td>
</tr>
<tr>
<td>Not Valuable</td>
<td>0</td>
<td>0%</td>
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Multiple Choice, Single Answer Poll
13 Individual Attendees Responded
Poll Results

How can the next meeting be more valuable?

<table>
<thead>
<tr>
<th>Answer</th>
<th>Total #</th>
<th>Total %</th>
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</thead>
<tbody>
<tr>
<td>Allow for more Q&amp;A time</td>
<td>3</td>
<td>60%</td>
</tr>
<tr>
<td>Restructure guest presentation</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>More aligned reporting focus</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Provide meeting agenda sooner</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other Responses from Chat Box</td>
<td>2</td>
<td>40%</td>
</tr>
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Multiple Choice, Multiple Answer Poll
5 Individual Attendees Responded

- No “other” responses were typed into the chat box.
## Looking Ahead

<table>
<thead>
<tr>
<th>Session</th>
<th>Track</th>
<th>Session Name</th>
<th>Date</th>
<th>Time (ET)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Making the Business Case (Completed)</td>
<td>2/8</td>
<td>2-3 PM</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Quality Measurement, Part 1 (Completed)</td>
<td>3/3</td>
<td>1-2:30 PM</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>Quality Measurement, Part 2 (Completed)</td>
<td>3/20</td>
<td>2:30-4 PM</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>Setting the Patient Population</td>
<td>5/4</td>
<td>1-2 PM</td>
</tr>
<tr>
<td>5</td>
<td>1 &amp; 2</td>
<td>Innovative Models of Maternity Care Delivery &amp; Determining Services</td>
<td>5/22</td>
<td>2-3 PM</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>Setting the Episode Price &amp; Budget</td>
<td>6/15</td>
<td>1-2 PM</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>Data Infrastructure</td>
<td>7/7</td>
<td>1-2:30 PM</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>Contracting with Providers</td>
<td>7/28</td>
<td>1-2 PM</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>State Payers and MCOs</td>
<td>8/16</td>
<td>2-3 PM</td>
</tr>
</tbody>
</table>
MAC Team

Primary Points of Contact

Tanya Alteras
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mbailit@bailit-health.com