Maternity Multi-Stakeholder Action Collaborative

Track 2: Setting Episode Budgets

June 15, 2017
1:00 – 2:00 pm ET

PLEASE NOTE:

- All phone lines are **unmuted** and you are no longer in "Listen Only" mode. **Please mute your own phone.**
- ReadyTalk works best with Chrome, but does work with other browsers. If you have connectivity issues, try refreshing your browser or switching to Chrome.

HCP LAN
Health Care Payment Learning & Action Network

For technical issues, please contact Kristian Motta (kmotta@rippleeffect.com) or Leah Allen (lallen@mitre.com)

Agenda

	Timeframe (ET)	Topic	Facilitators/Presenters
1	1:00 - 1:05 pm	Welcome and Meeting Overview	Tanya Alteras
2	1:05 – 1:20 pm	Content Overview	Michael Bailit
3	1:20 – 1:55 pm	Discussant Interviews and Facilitated Discussion	Andy Allison Francois de Brantes 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 amounts

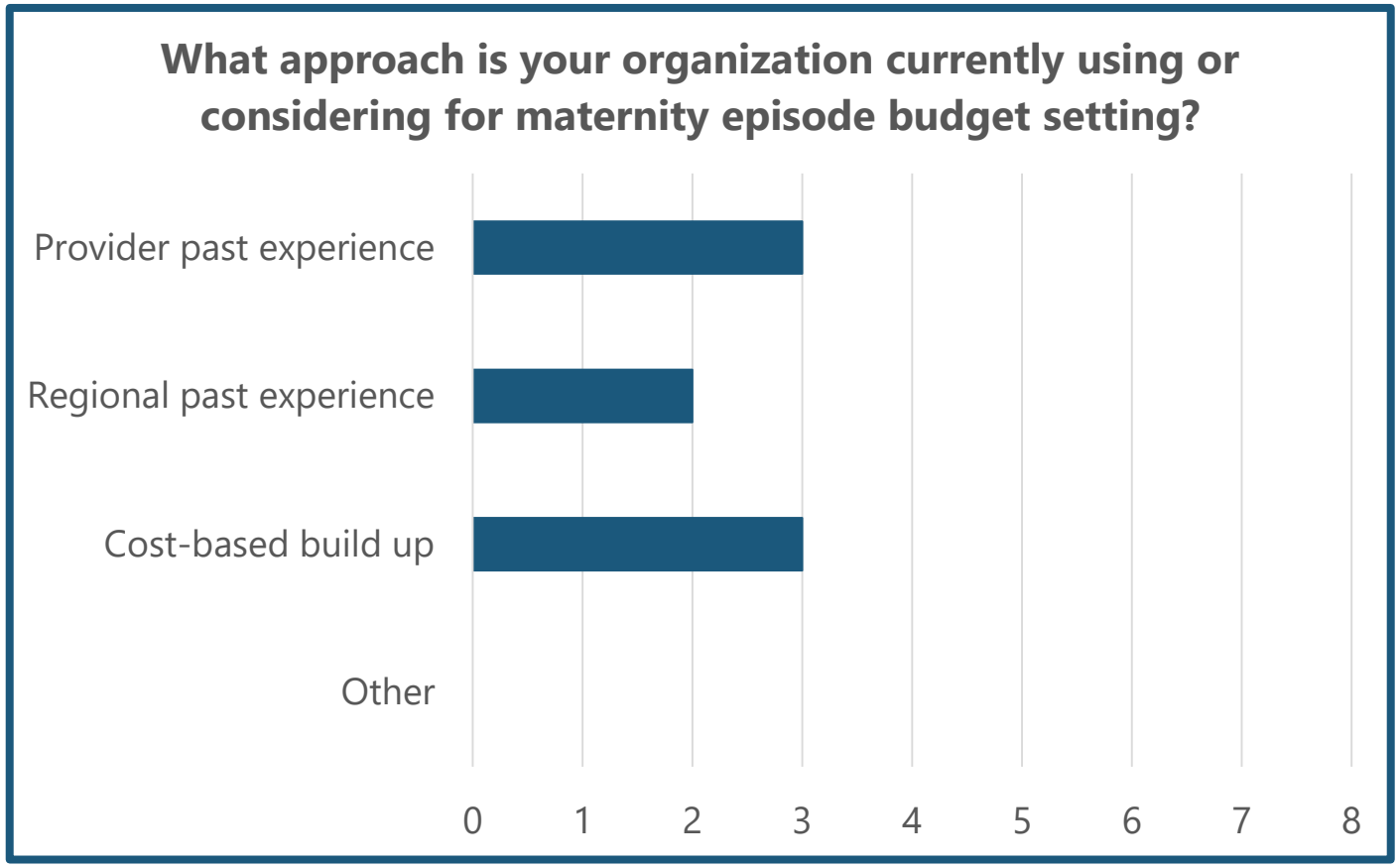
  ✓ Shared savings or incentive payments

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

Meeting Objectives

- Introduce the various methodologies for setting an episode budget, and discuss one design approach in using thresholds as a budget alternative
- Introduce the various risk models for episode-based payment
- Identify the options for incorporating quality measures into the budget/payment model
- Hear from discussants on specific approaches to episode-based budgeting

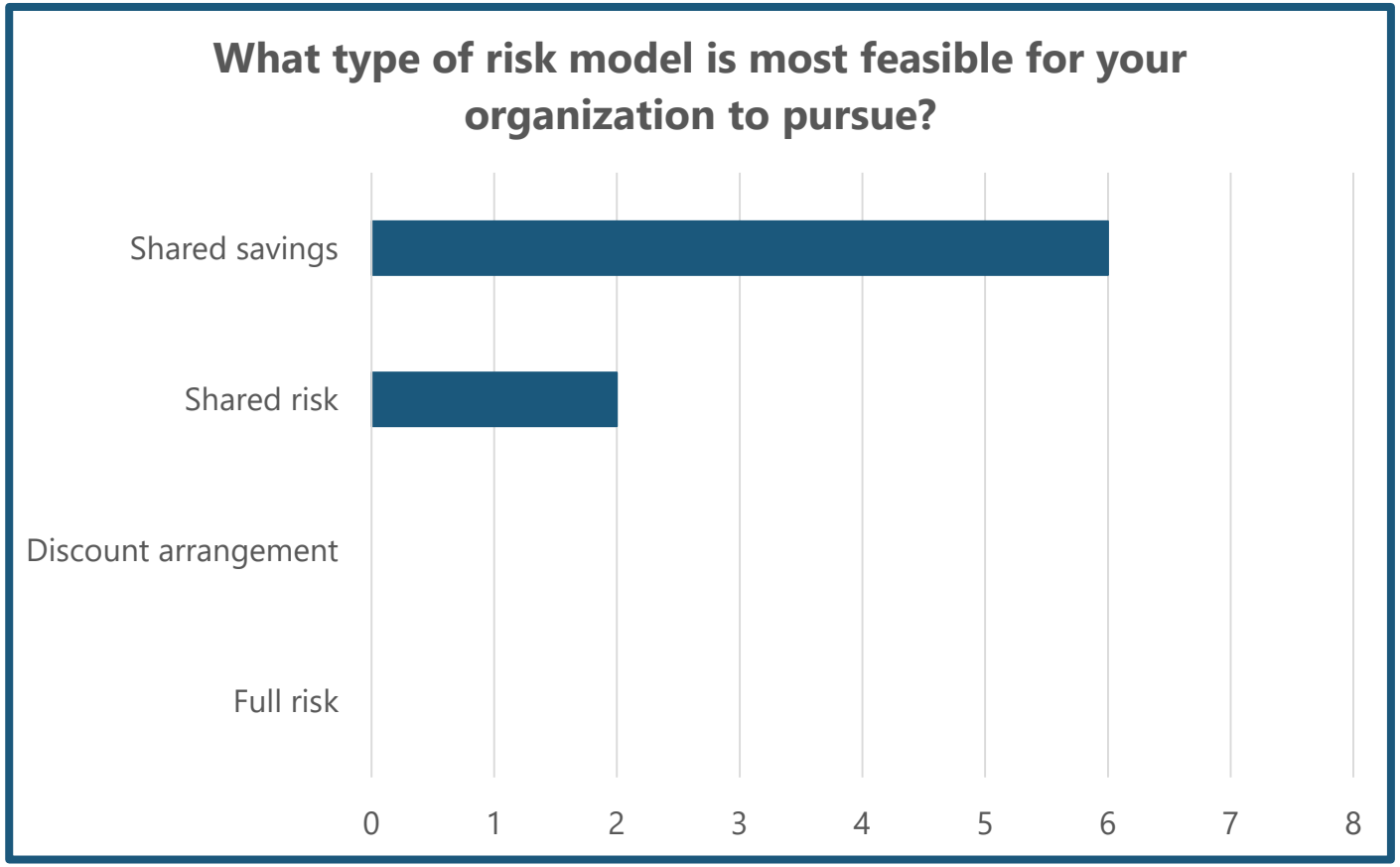
Poll Results



Answer	Total #	Total %
Provider past experience	3	38%
Regional past experience	2	25%
Cost-based build up	3	38%
Other	0	0%

Multiple Choice, Single Response Poll
8 Individual Attendees Responded

Poll Results



Answer	Total #	Total %
Shared savings	6	75%
Shared risk	2	25%
Discount arrangement	0	0%
Full risk	0	0%

Multiple Choice, Single Response Poll
8 Individual Attendees Responded

Setting Episode Budgets: Overview

Most episode-based payments models set a budget, within which a provider aims to manage costs. But not every model uses a traditional budget. The following slides cover:

- Basic episode budgeting approaches and one “real-world” example.
- An overview and example of the threshold approach.
- Risk models and ways in which to incorporate quality into the financial model of the maternity episode.

Budget Setting Approaches

There are three simplified options for setting episode budgets for maternity care:

1. Base the budget on the historical average of the provider group using a set "look back" period of time (e.g. two years)
2. Base the budget on the historical average of a geographic area or marketplace using a set "look back" period of time (e.g. two years)
3. Identify the expected services within an episode and use payer rates to build an episode budget "from the ground up"

Budget Setting Approach	Pros	Cons
Historical average of the provider group	• Relatively easy • Incentivizes providers to be more efficient	• Will not eliminate historical price variation, and rewards high-cost, less efficient providers
Historical average of a geographic area or marketplace	• Relatively easy • Reduces price variation across providers over time	• Depending on the variation in the area, the average could reward some providers and penalize other providers
Building from the "ground up"	• Sets "ideal" budgets that could eliminate price variation	• Labor and data- intensive

Example: Community Health Choice

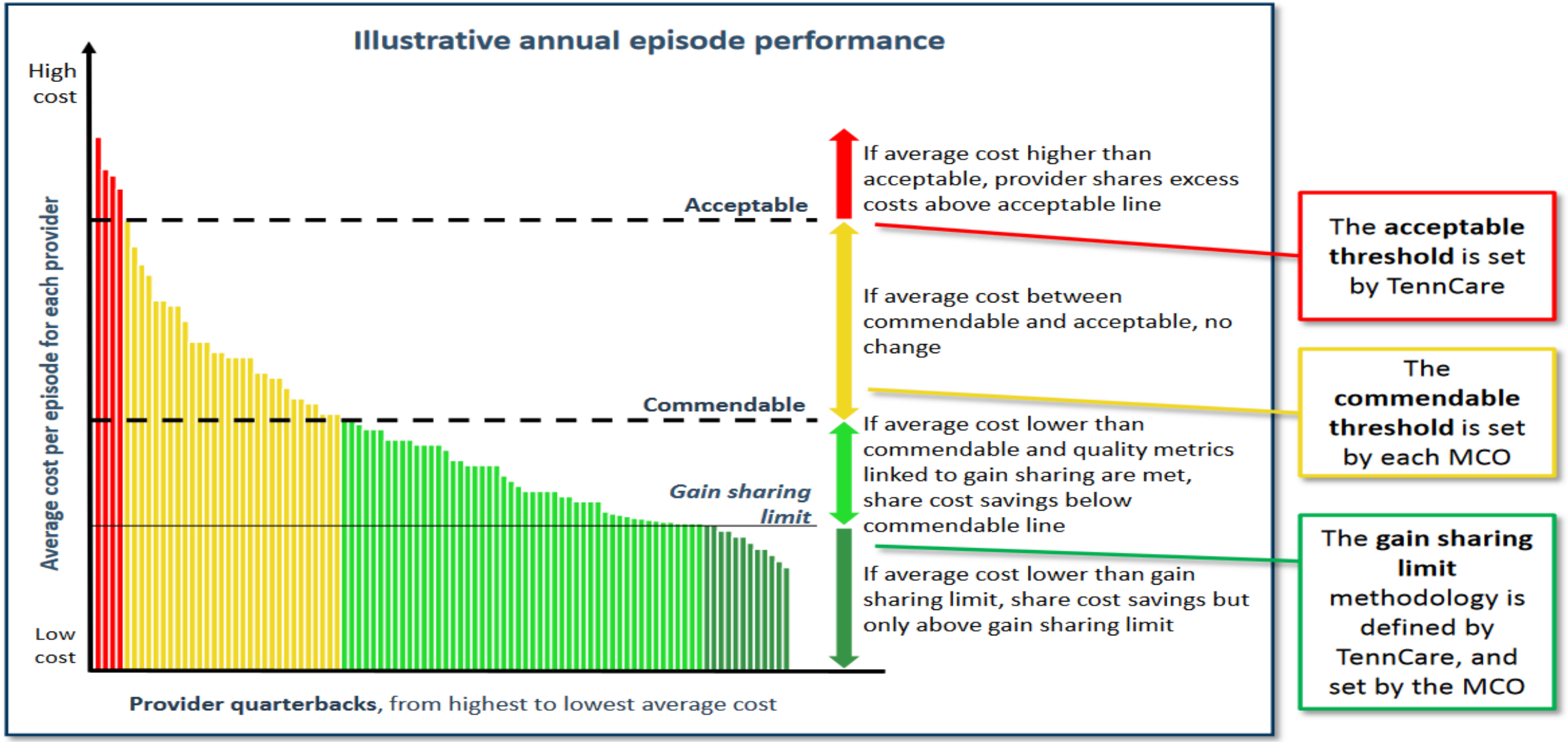
- CHC breaks the budget into three components and adds them together for one episode budget.
- This approach allows for more accurate budgets, gives providers case and provider-specific targets and allows for more completed episodes.

CHC Budget Components	How Budget Was Derived	Adjustments to Budget
Pregnancy Budget	• Averages based on historic prenatal costs	• Budget is prorated by the number of months the provider has been caring for the patient prenatally.
Delivery Budget	• Blended vaginal and C-section rate based on historical C-section rates	• Rate is adjusted based on patient demographics, historical comorbidities, and concurrent risk factors
Newborn Budget	• Averages based on historic costs for newborns by nursery level.	• In CHC's pilot, Nursery Level 4 was excluded because of the low volume and high costs that greatly skewed averages. However, it was found that Nursery Level designation is somewhat arbitrary. CHC now includes a stop loss cap to protect providers from catastrophic risk.

Using Thresholds as a Budget Alternative

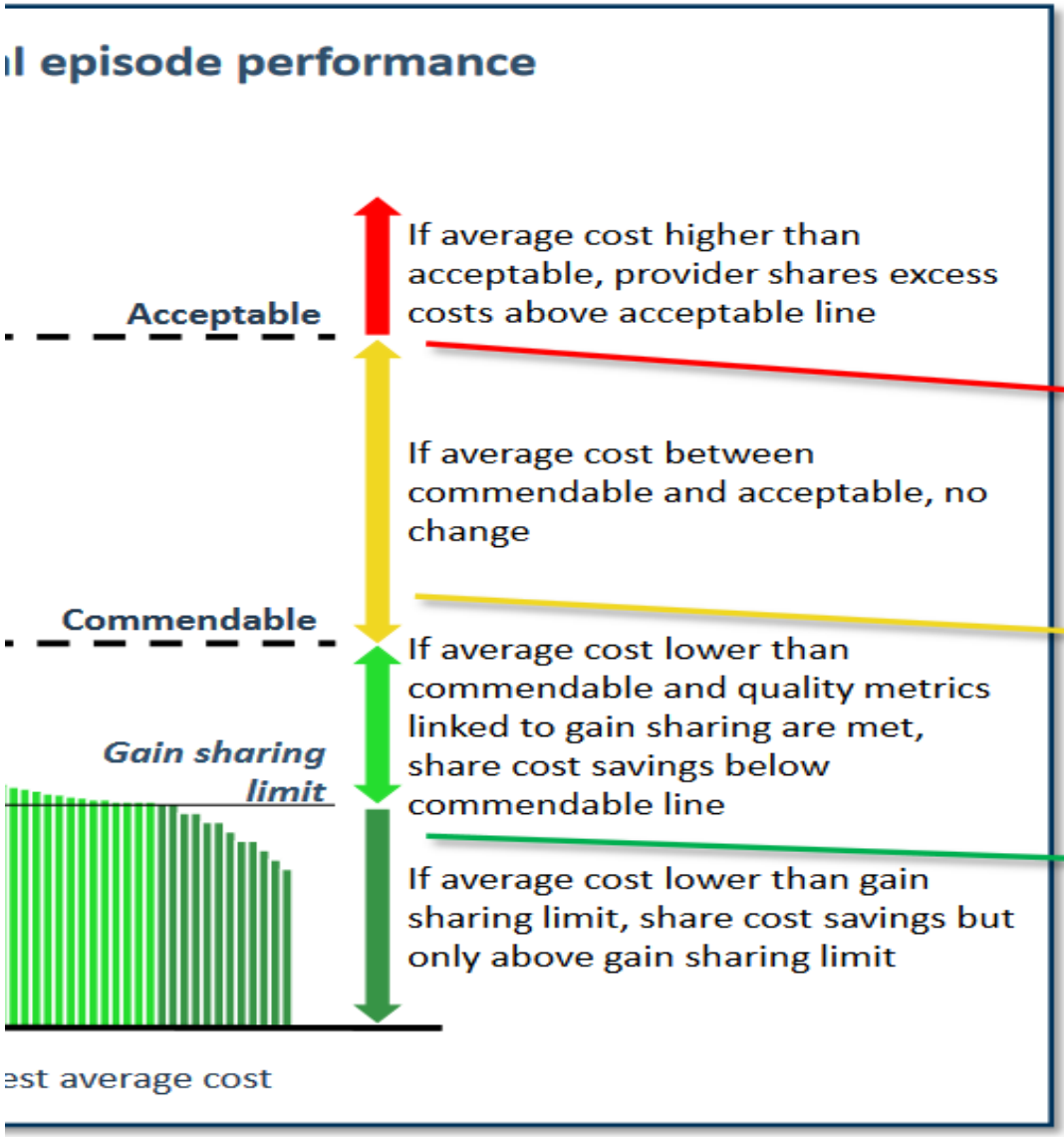
- Arkansas, Ohio and Tennessee set average payment **thresholds**, instead of episode-specific budgets.
  - There are slight variations in how each state has applied the thresholds, but the theory is the same.
- These thresholds are based on average historical costs.
- Depending on where a provider falls within the threshold – based on both resource utilization and clinical performance quality - determines whether there is shared savings, a financial penalty, or no change in payment from the negotiated reimbursement rate.
- By setting thresholds based on performance of all providers, each state can make their episode-based payment "budget neutral" (i.e., equal number of providers are penalized as are rewarded).

Thresholds: Tennessee's Approach



Source: www.tn.gov/assets/entities/hcfa/attachments/EpisodesThresholds2017.pdf

Tennessee's Approach: A Closer Look



The **acceptable threshold** is set by TennCare

The **commendable threshold** is set by each MCO

The **gain sharing limit** methodology is defined by TennCare, and set by the MCO

Acceptable threshold is set so that providers with the highest risk-adjusted average annual cost would experience a penalty.

The MCO sets its own **commendable threshold** level, such that an equal number of providers share in savings as those who share in penalty. (OH, AR set this level, not the MCO).

Gain sharing limit methodology set by the state is a list of essential services. Then, each MCO averages the five lowest cost episodes that include those services to come up with the gain sharing limit.

Source: www.tn.gov/assets/entities/hcfa/attachments/EpisodesThresholds2017.pdf

Determining the Risk Model

- **Shared Savings**: Allows providers to share in savings when costs are below the negotiated episode budget/threshold
- **Shared Risk:** Allows providers to share in savings when costs are below the negotiated episode budget/threshold and requires financial responsibility when costs are above the negotiated rate
- **Discount Arrangement or Guaranteed Savings:** Payer retains a percentage of the budget (e.g., 1-3%) as guaranteed savings
- **Full Risk:** Provider takes all financial risk, in exchange for being able to keep 100% of its earned savings

Integrating Quality into the Payment Model

There are two ways in which quality can be incorporated into maternity episodes; they are not mutually exclusive.

Quality performance affects the risk arrangement

- Quality thresholds must be met before a provider is able to share in savings (AR, TN, OH, Horizon and NY*)
- The percentage of provider savings or risk is tied to the level of quality performance (CHC, NY*)

**NY VBP Roadmap gives guidance to MCOs on how to contract and offers two options for incorporating quality.*

Quality performance financial implications are independent of the risk arrangement

- Each provider is eligible for a set incentive amount based on quality performance. Some years the plan may spend more than others based on provider performance.
- Bonus pool dollars are distributed among providers based on quality performance. Providers don't get a guaranteed payment level, but payers are able to budget incentive level.
- *These models have not been observed in maternity episode-based payment, but have been observed in other VBP models.*

Approaches from the Field

Live interview with colleagues from McKinsey and the Altarum Institute

Andy Allison
Senior Expert in the Health Care Systems and Services (HSS)
McKinsey

Francois de Brantes
Vice President and Director, Center for Payment Innovation
Altarum Institute

Wave 1 performance period launch: Medicaid spend threshold methodology

Determining…

Threshold levels

- Ohio Medicaid will set cost and quality thresholds for all MCPs
- Ohio Medicaid will set one acceptable threshold for all of Medicaid so that ~10 percent of providers are above the acceptable threshold, assuming no behavior change[1]
- Ohio Medicaid will set one commendable threshold for all of Medicaid such that it would be budget neutral after positive and negative incentive payments, assuming no change in the PAP curve[2]
- Ohio Medicaid is using the same methodology to set thresholds across all Wave I episodes

Payments

- For Ohio Medicaid, including the managed care plans, the incentive payment allocation for PAPs will be 50 percent
- Payments will be proportional to the non-risk adjusted payment for each PAP

1 The threshold will be set midway between the avg. cost for the last provider above acceptable and the first one not. Including 10% of providers means including the minimum number of providers such that at least 10% of providers are included

2 Assumes all providers pass the quality measures

Wave 1 performance period launch: Proposed Medicaid spend thresholds[1]

		Acceptable	Commendable	Positive incentive limit
Asthma	Value, $	$372	$292	$24
	'All Medicaid' percentile	90th percentile	55th percentile	N/A
COPD	Value, $	$1,087	$683	$58
	'All Medicaid' percentile	91th percentile	21th percentile	N/A
Perinatal	Value, $	$4,405	$3,169	$1,235
	'All Medicaid' percentile	90th percentile	12th percentile	N/A

1 Subject to inflationary adjustment based on actuarial review; final adjusted thresholds will be posted in 2016 and included on all reports in 2016

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NOTE: Thresholds are based on risk-adjusted episode reimbursement and should be used in tandem with average risk-adjusted episode reimbursement delivered on quarterly provider reports.

SOURCE: Ohio Medicaid claims data, CY 2014

All Medicaid PAP curve (used to set thresholds) - Perinatal

Provider risk-adjusted cost distribution

PAP average episode cost

Low volume High volume[1]

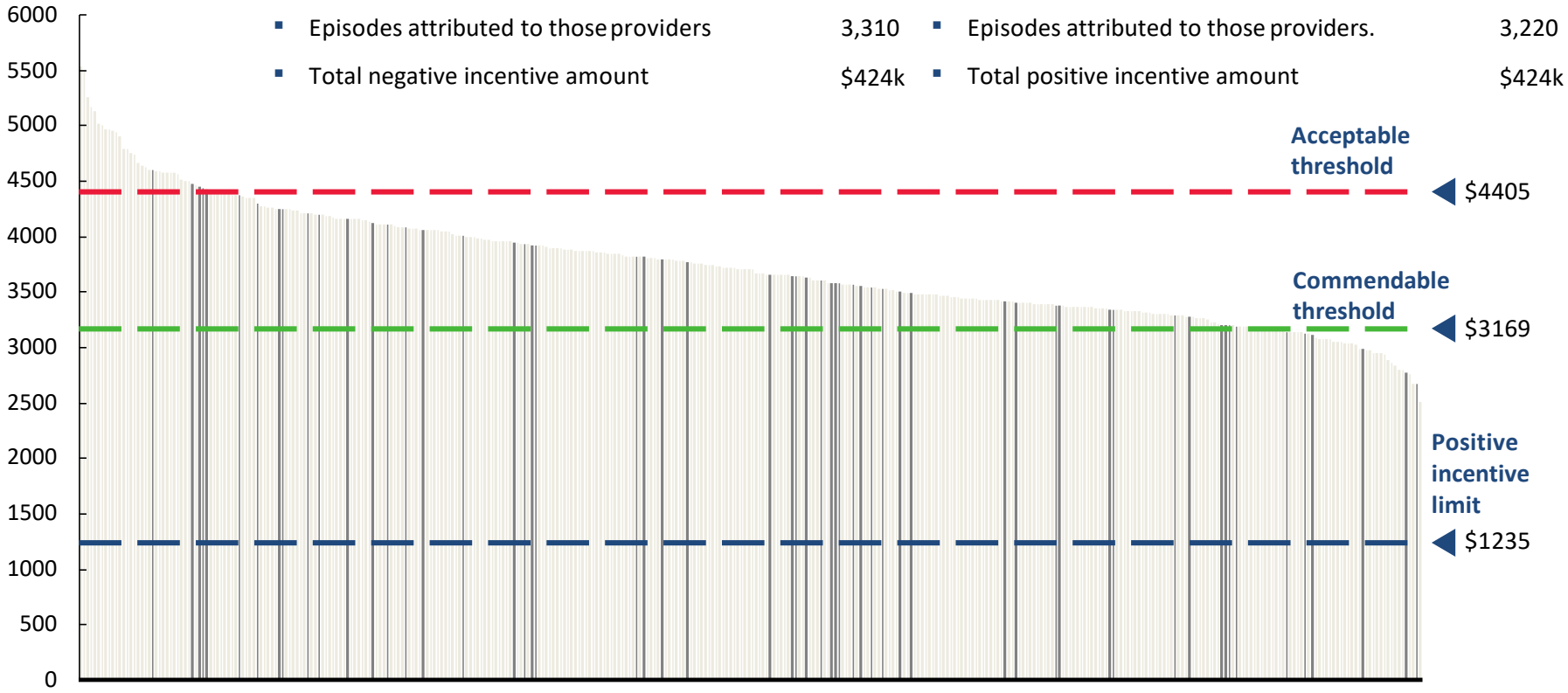
'All Medicaid' summary statistics

Negative incentive payments

Providers above acceptable threshold	38
Episodes attributed to those providers	3,310
Total negative incentive amount	$424k

Positive incentive payments[2]

Providers below commendable threshold	45
Episodes attributed to those providers.	3,220
Total positive incentive amount	$424k



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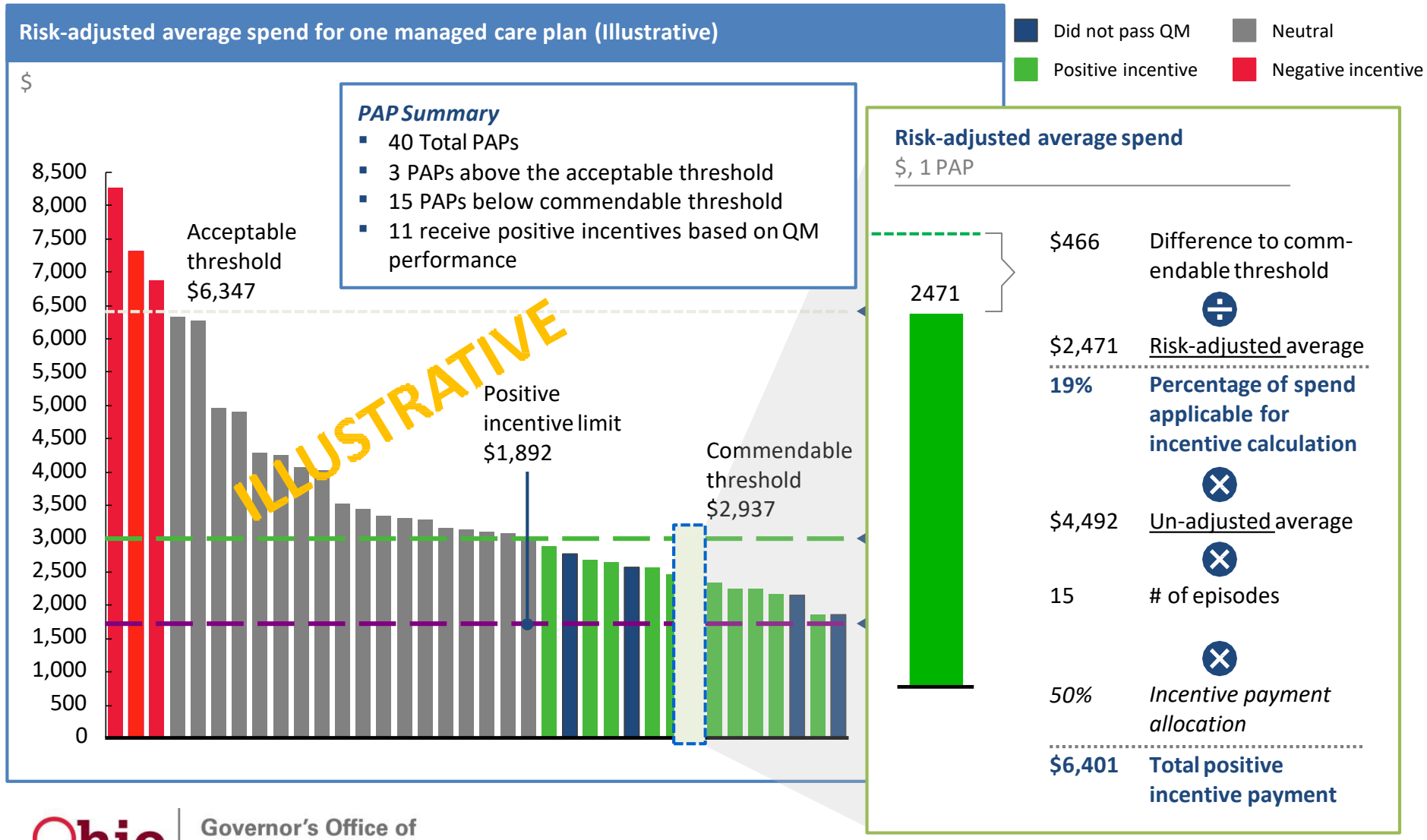
1. Top 10 percent of providers by volume
2. Assumes all providers pass quality metrics tied to incentive payments

SOURCE: Ohio Medicaid FFS and encounter data, CY 2014

Positive incentive payments are based on average risk-adjusted episode reimbursement for providers that pass quality metrics



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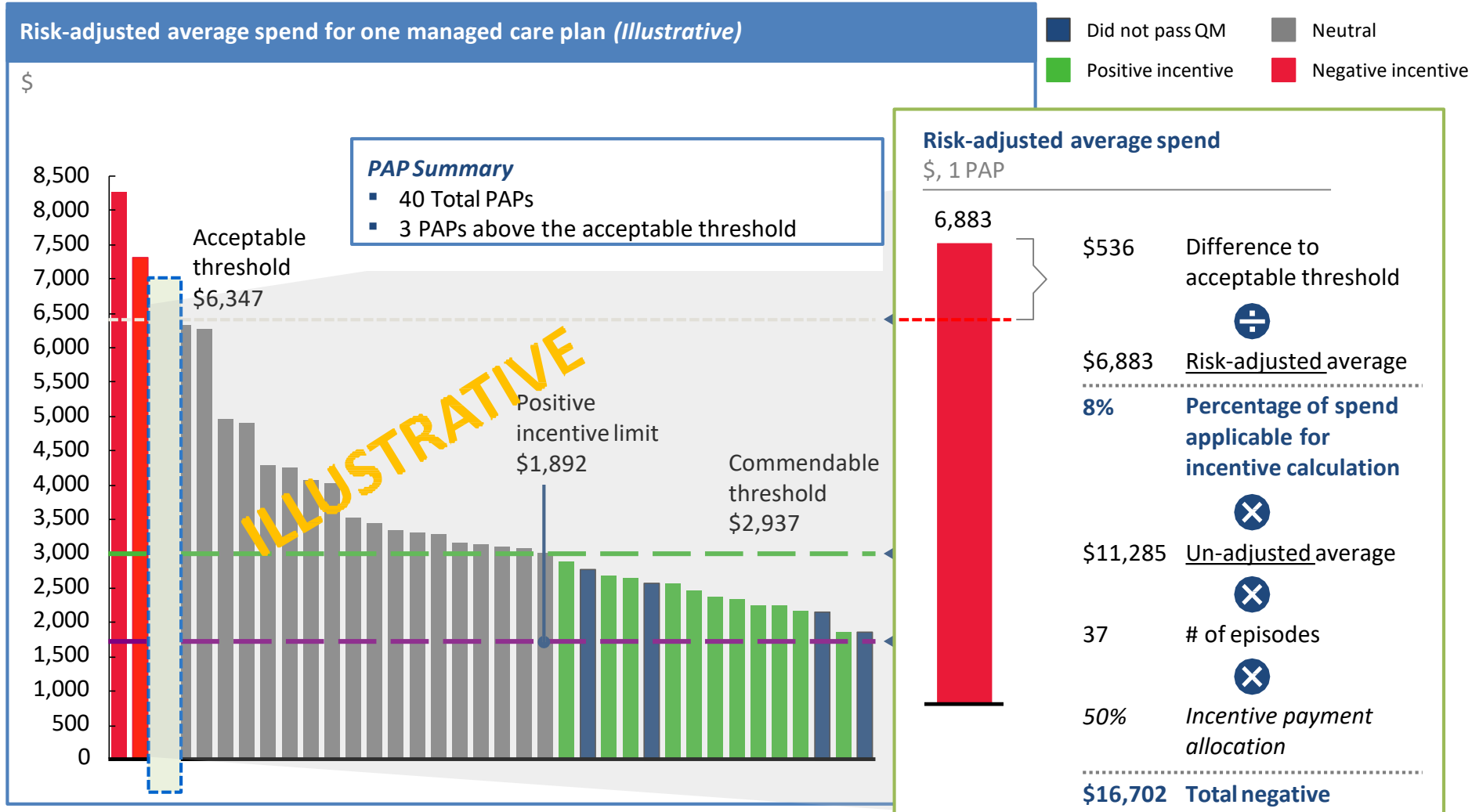
Negative incentive payment is calculated based on average episode spend within each payer



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Patient journey: Perinatal episode

Potential episode trigger event

Patient suspects pregnancy, may take a home test, and makes appointment to confirm pregnancy

Prenatal care

- The expecting mother receives prenatal care such as office visits, screening and testing (e.g., genetic screening, drug tests)
- Factors influencing prenatal care quality include level of patient-centered care (e.g., PCMH, birth centering), timeliness and frequency of visits and risk-assessment (to make appropriate referrals and minimize ED visits)
- Supportive services may include psychosocial evaluation, counseling and education on topics including nutrition and breast feeding

Delivery

- The delivery, either vaginal or C-section, typically occurs in an IP setting and may involve varying levels of care
- Procedures performed may include induction, anesthesia/epidural, episiotomy, additional testing / screening
- Supportive services may include discussion of ancillary support, formal consultations, neonatal support, transportation

Postpartum care[1]

- The mother receives postpartum care such as follow-up visits, mental health evaluations, referrals, and education and counseling on topics including breast feeding and reproductive health planning including contraception

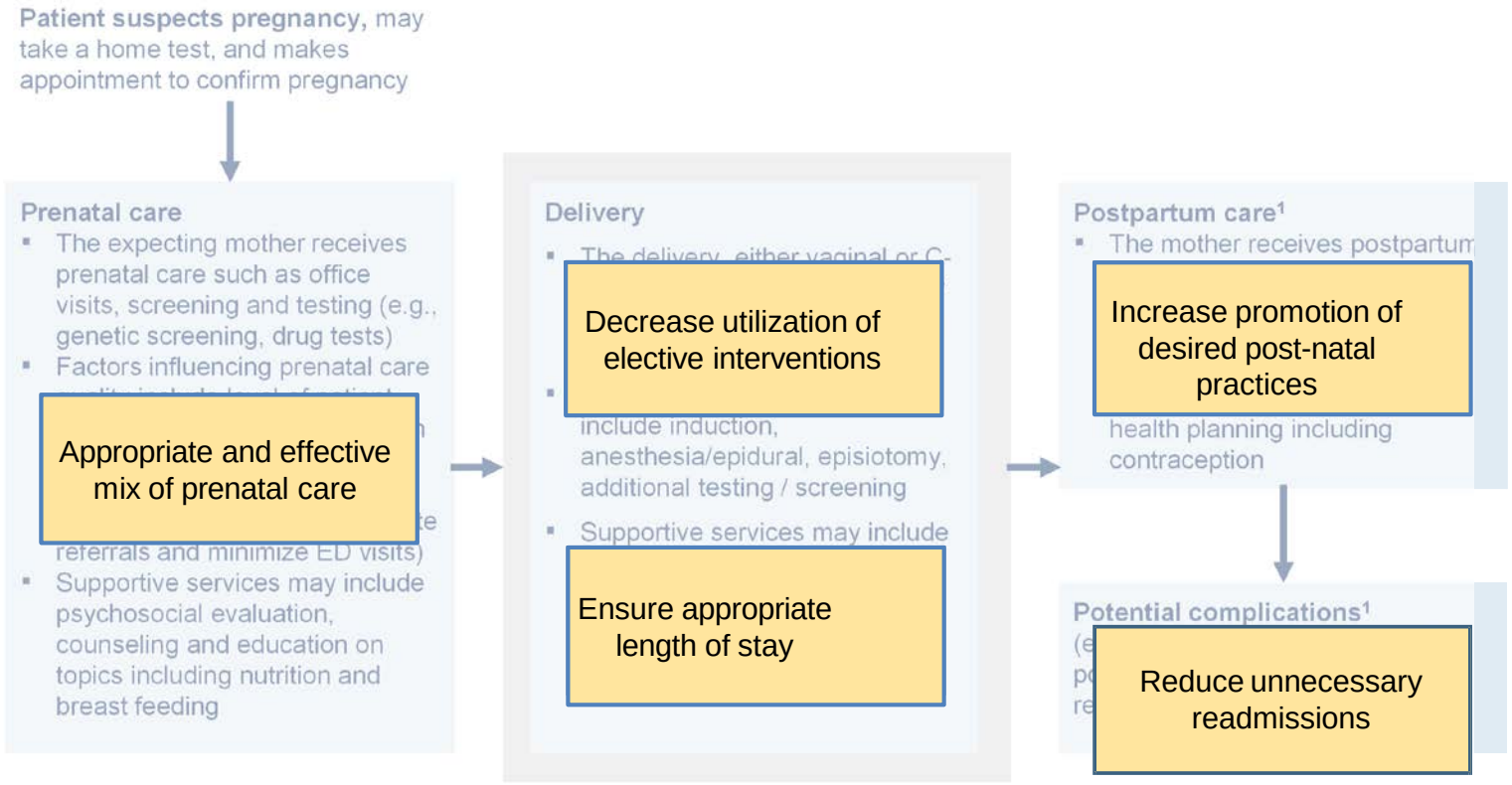
Potential complications[1]
(e.g., bleeding, urination issues, postpartum depression, readmissions)

1 Episode only includes care for the mother after delivery

Sources of value: Perinatal episode

PERINATAL

Potential episode trigger event



1 Episode only includes care for the mother after delivery

Perinatal episode definition (1/2)

Area	Episode base definition
1 **Episode trigger**	▪ A delivery Px code and a confirmatory live birth Dx on any claim type[1]
2 **Episode window**	▪ Episodes begin **280 days** before the date of delivery ▪ Episodes end **60 days** after discharge from the delivery facility
3 **Claims included[2]**	▪ **During the pre-trigger window:** All inpatient, outpatient, professional, and pharmacy claims tied to relevant prenatal care (e.g. screening, examinations) and complications (e.g. placenta previa, pre-eclampsia, vomiting, etc.) less excluded medications ▪ **During the trigger window:** All inpatient, outpatient, professional, and pharmacy claims less excluded medications ▪ **During post-trigger window:** Same claims and medications as pre-trigger window, all inpatient admissions during the first 30 days less specific exclusions
4 **Principal accountable provider**	▪ The PAP is the **physician** or **physician group** responsible for billing the delivery procedure ▪ The billing provider ID on the claim with the procedure will be used to identify the PAP ▪ Payers may alternatively choose to identify the PAP based on the contracting entity responsible for the triggering claim

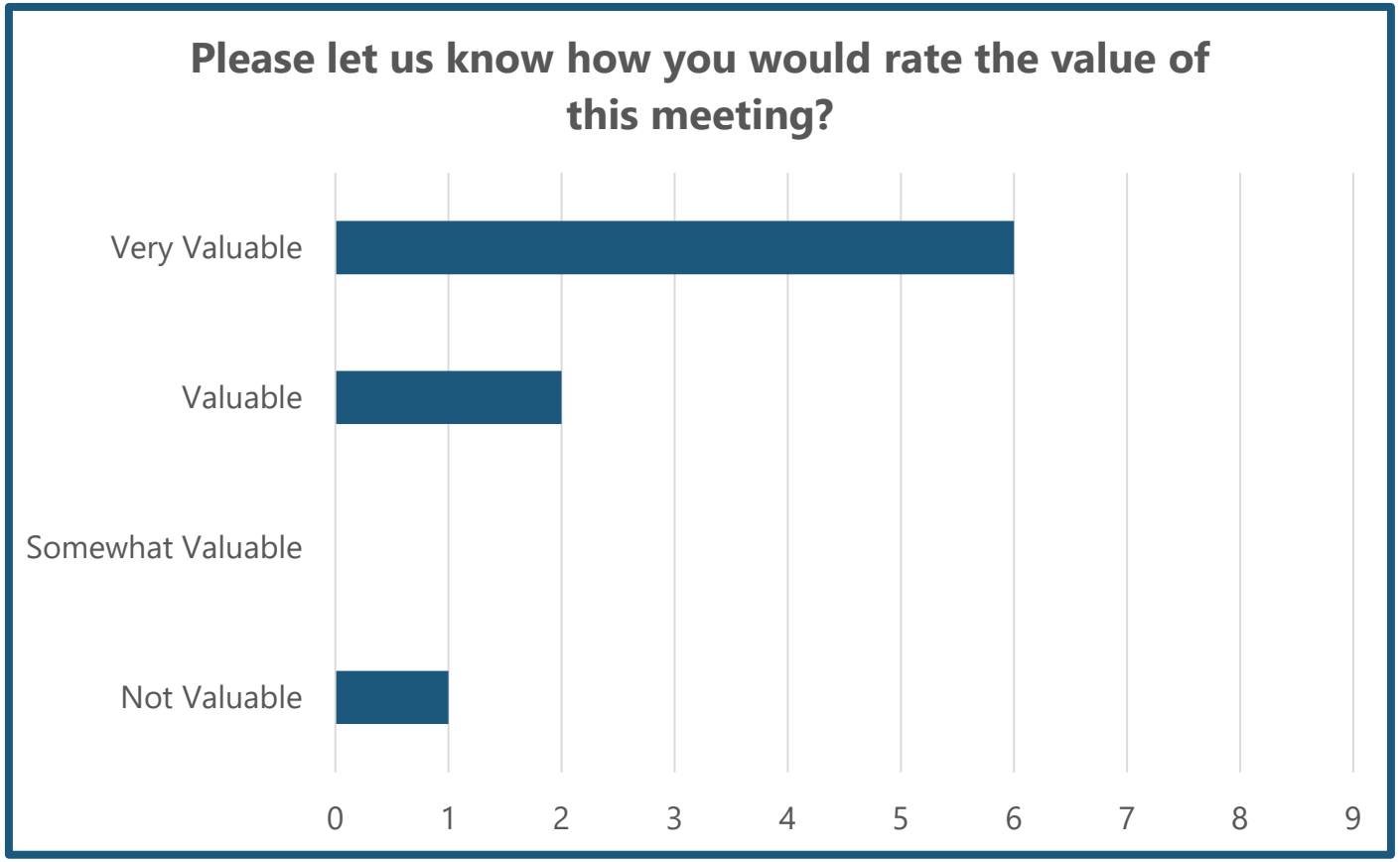
1 The live birth code and delivery procedure code can occur on different claims but must occur within 7 days of each other
2 A full list is available in the detailed business requirements

Perinatal episode definition (2/2)

Area	Episode base definition
5 **Risk adjustment and episode exclusion**	▪ **Risk adjustment:** 77 factors for use in risk adjustment including obesity, previous C-section, STI, and anemia[1] ▪ **Episode exclusion:** There are three types of exclusions: – Business exclusions: ▫ Members under 12 years old and over 49 years old ▫ Others: Multiple payers, third party liability, inconsistent enrollment, PAP out of State, no PAP, dual eligibility, long-term care, long hospitalization, missing APR-DRG, missing indicated facility, and incomplete episodes – Clinical exclusions: ▫ Members with any of 8 clinical factors[1] ▫ Members with an unusually large number of comorbidities[1] ▫ Members who left treatment against medical advice or died – High cost outlier exclusions: Episode's risk adjusted spend is 3 standard deviations above the mean (after business and clinical exclusions)
6 **Quality metrics**	▪ **Quality metrics linked to gain-sharing:** – Prenatal HIV screening rate – Prenatal GBS screening rate – C-section rate – Percent of episodes with follow-up visit within 60 days ▪ **Quality metrics for reporting only:** – Percent of episodes with prenatal gestational diabetes screening – Percent of episodes with prenatal hepatitis B screening – Number of ultrasounds – Percent of episodes with chlamydia screening

1 A full list is available in the detailed business requirements

Poll Results



Answer	Total #	Total %
Very Valuable	6	67%
Valuable	2	22%
Somewhat Valuable	0	0%
Not Valuable	1	11%

Multiple Choice, Single Response Poll
9 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 **(Completed)**	5/4	1-2 PM
5	1 & 2	Alternative Models of Maternity Care Delivery & Determining Services **(Completed)**	5/22	2-3 PM
6	2	Setting the Episode Price & Budget	6/15	1-2 PM
7	2	****Next Session: Data Infrastructure****	**7/7**	**1-2 PM**
8	2	Contracting with Providers	7/28	1-2 PM
9	1	State Payers and MCOs	8/16	2-3 PM

MAC Team

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