Perinatal Payment Strategies

March 25, 2015

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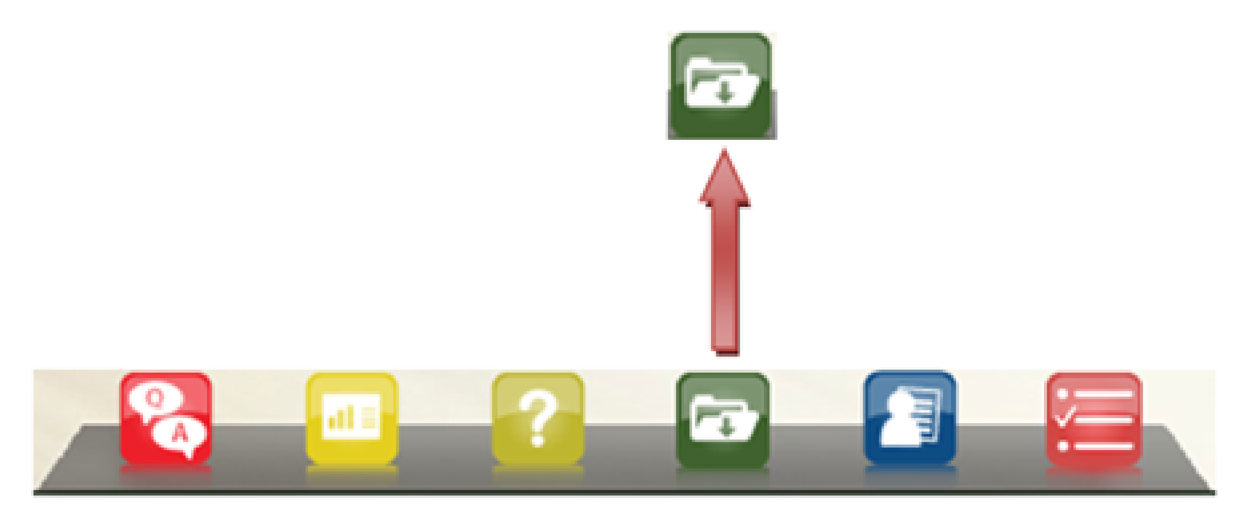

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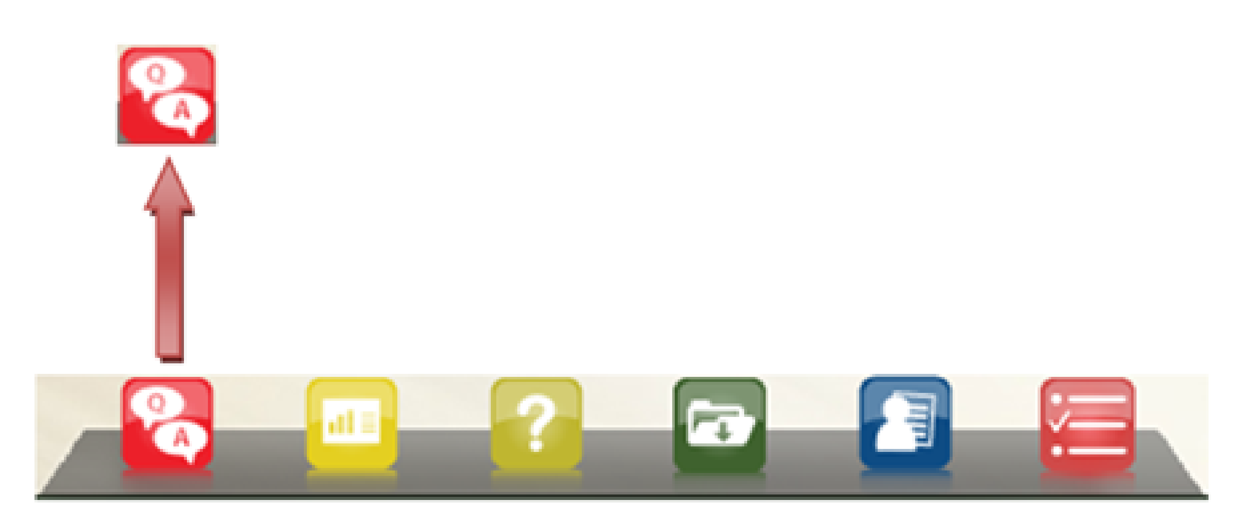

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Perinatal Payment Strategies

March 25, 2015
12:00-1:30pm ET

JudyAnn Bigby, MD, Mathematica Policy Research

Lekisha Daniel-Robinson, MSPH, CMCS

Harold D. Miller, MS, Center for Healthcare Quality and Payment Reform

Mary Applegate, MD, FAAP, FACP, Ohio Medicaid

Rebekah Gee, MD, MPH, FACOG, Louisiana Medicaid

Measuring Contraception Use in Medicaid and CHIP

- Welcome and agenda
- CMCS Maternal and Infant Health Initiative Updates
- Perinatal Payment Strategies
- State Perspectives
  - Ohio
  - Louisiana
- CMCS Maternal and Infant Health Initiative Next Steps

CMCS
Maternal and Infant Health Initiative
Updates

Lekisha Daniel-Robinson, MSPH
Coordinator, CMCS Maternal and Infant Health Initiative

CMCS Maternal and Infant Health Initiative Updates

- Postpartum Care Action Learning Series
- Resources on Strategies to Improve Postpartum Care
- Developmental contraception measure – specification update July 2015
- Funding Opportunity Announcement – release pending
- Environmental scan of state Medicaid payment strategies to address initiative goals

For more information go the Maternal and Infant Health Care Quality website

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Maternal-and-Infant-Health-Care-Quality.html

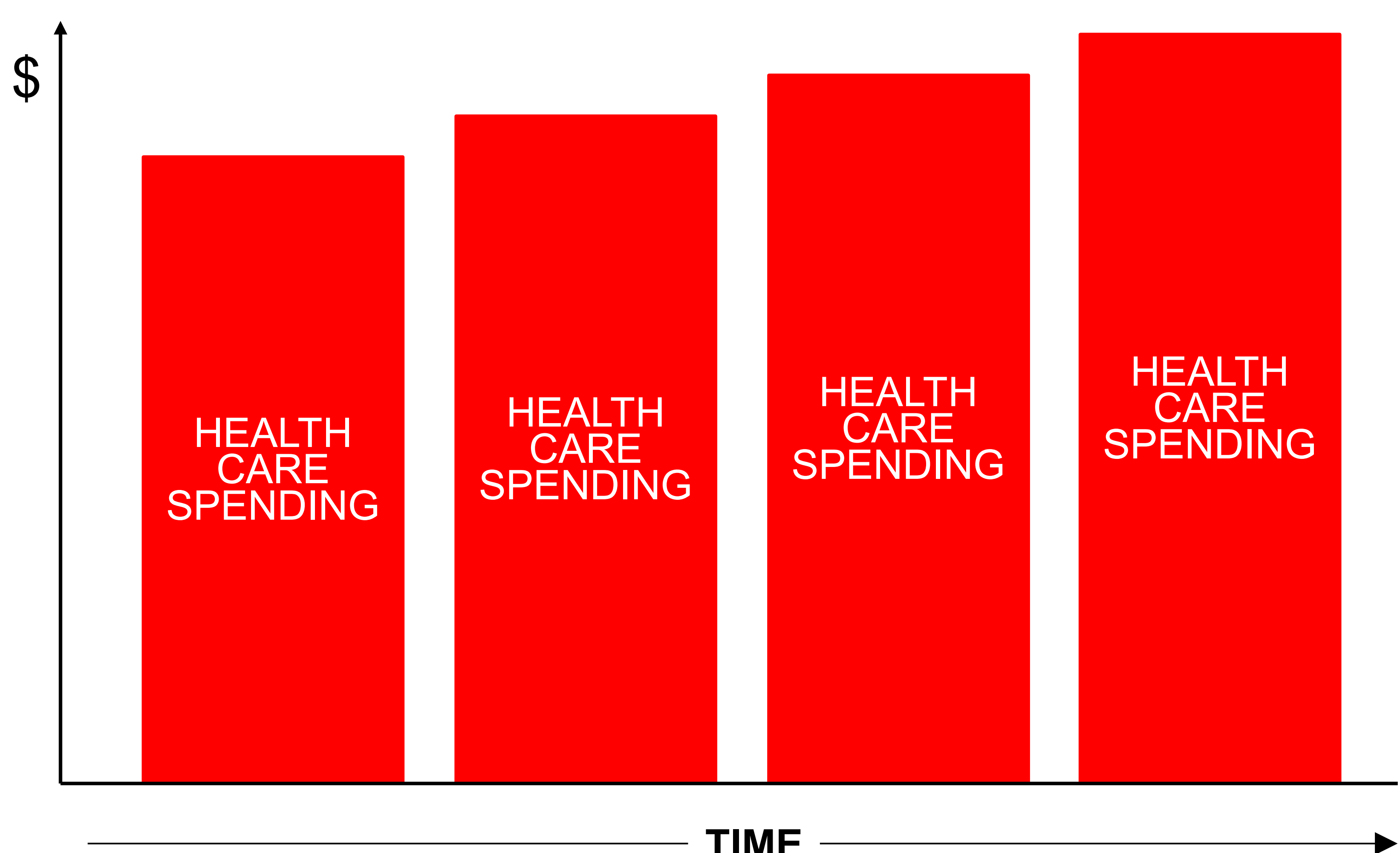
Win-Win-Win Approaches to Maternity Care:

How Payment Reform Can Enable Better Care for Mothers and Babies and Lower Medicaid Spending

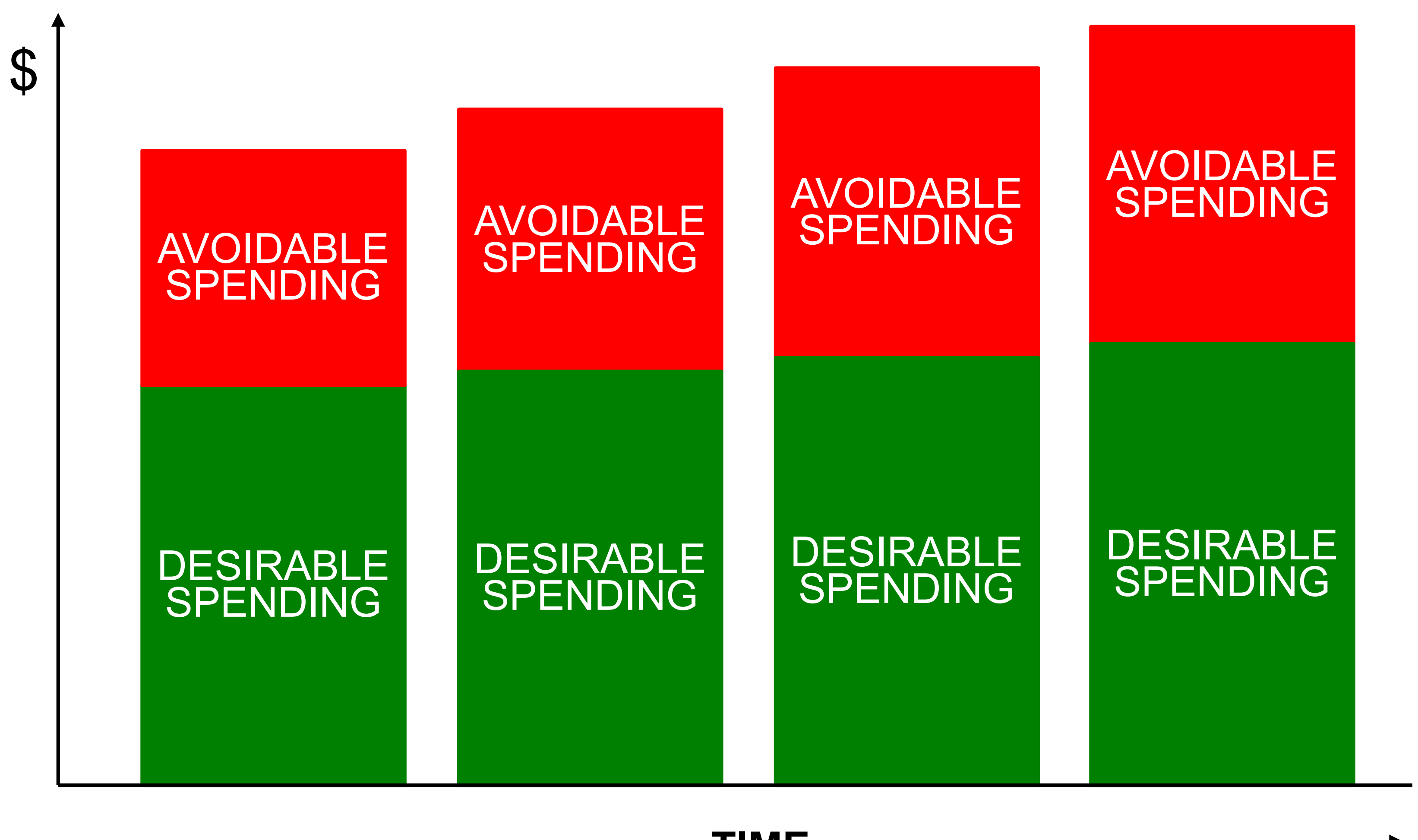
Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

www.CHQPR.org

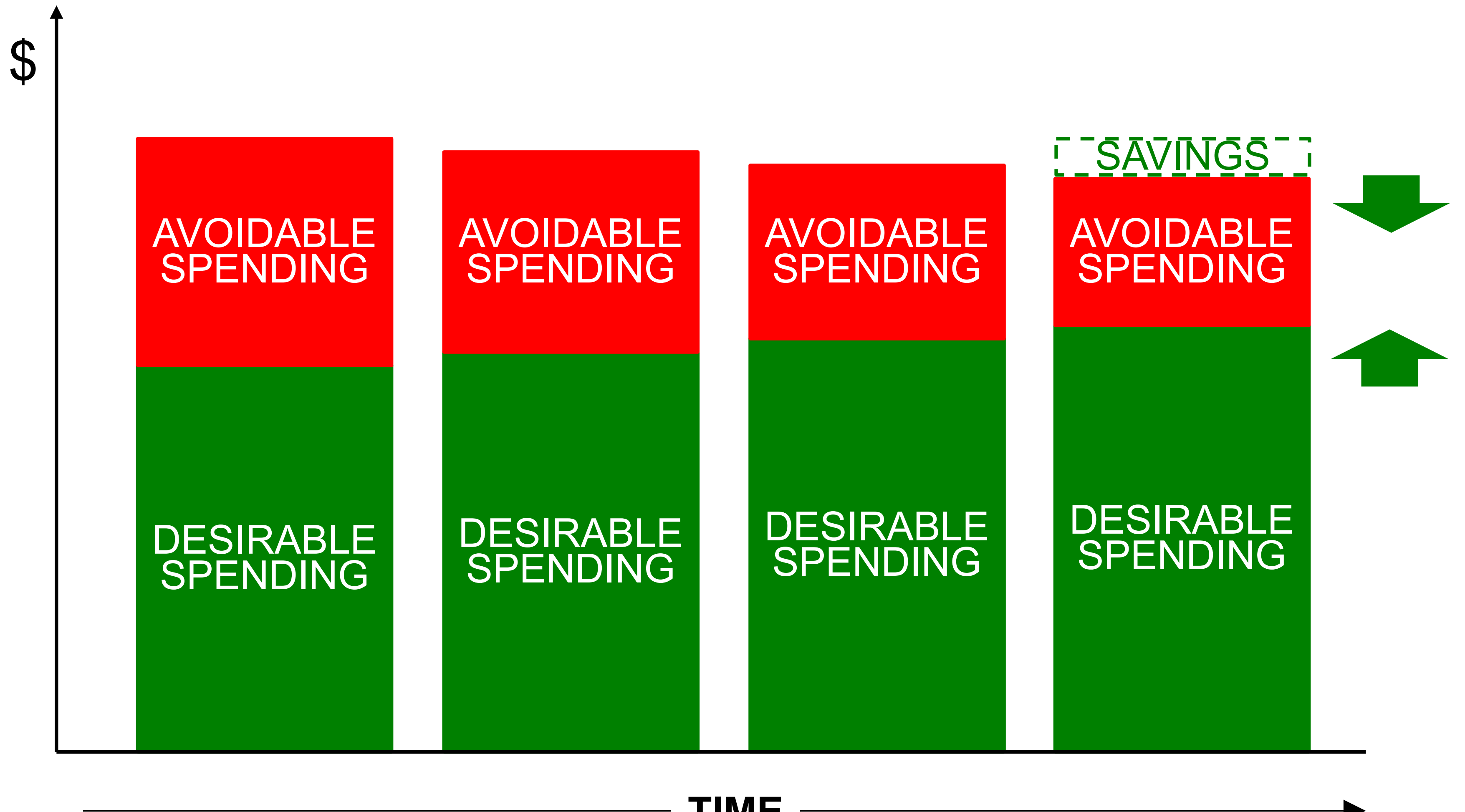
The Problem of High and Growing Healthcare Spending



The Opportunity: Spending That is Unnecessary or Avoidable



The Goal: Less Avoidable $, More Desirable $, Less Total $



Significant Opportunities to Reduce Maternity Care Spending

$

AVOIDABLE SPENDING

DESIRABLE SPENDING

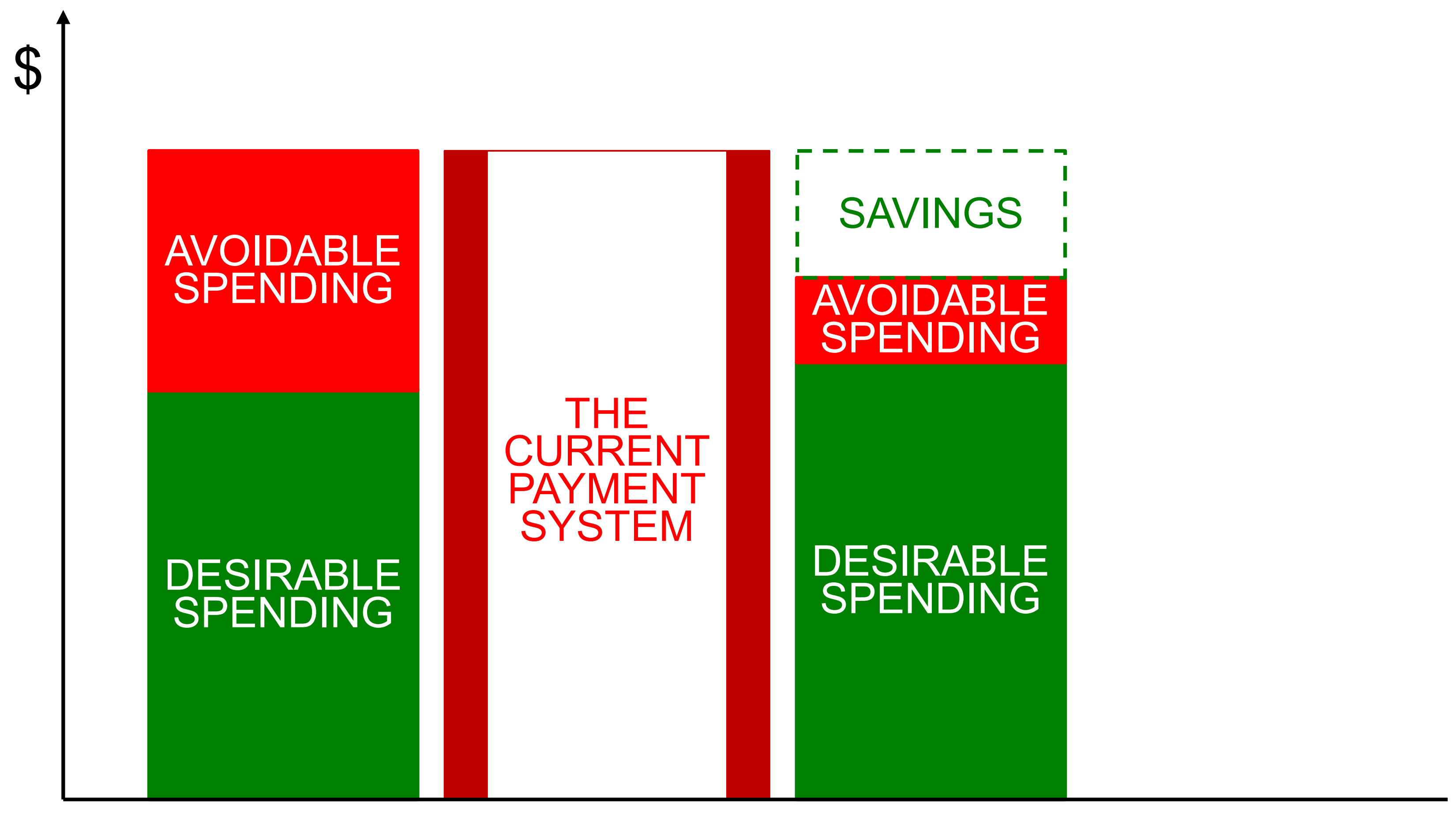
- Reducing unplanned pregnancies
- Reducing C-sections
- Reducing early elective deliveries
- More deliveries in birth centers
- Reducing birth complications
- Reducing preterm and low birthweight babies

SAVINGS

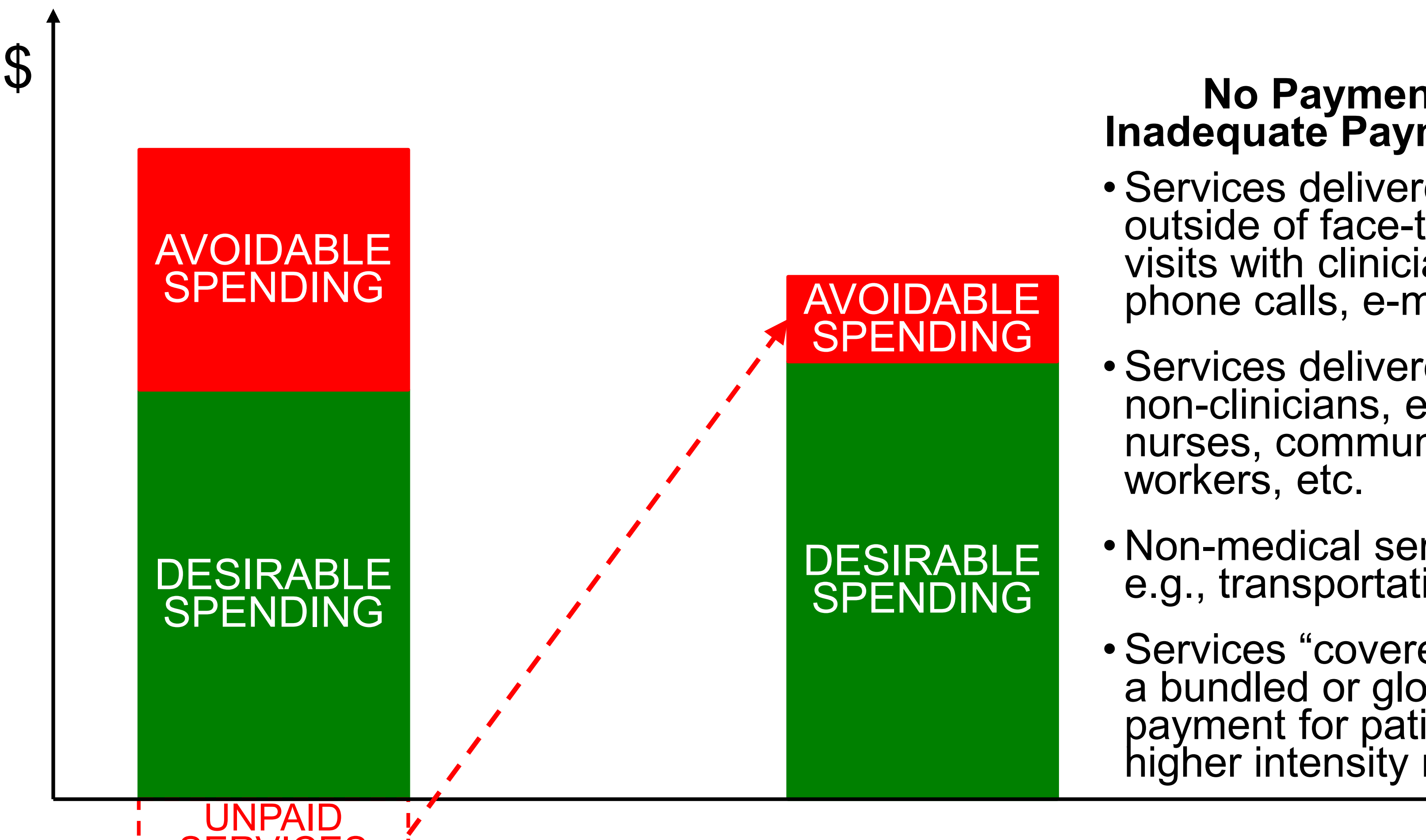
AVOIDABLE SPENDING

DESIRABLE SPENDING

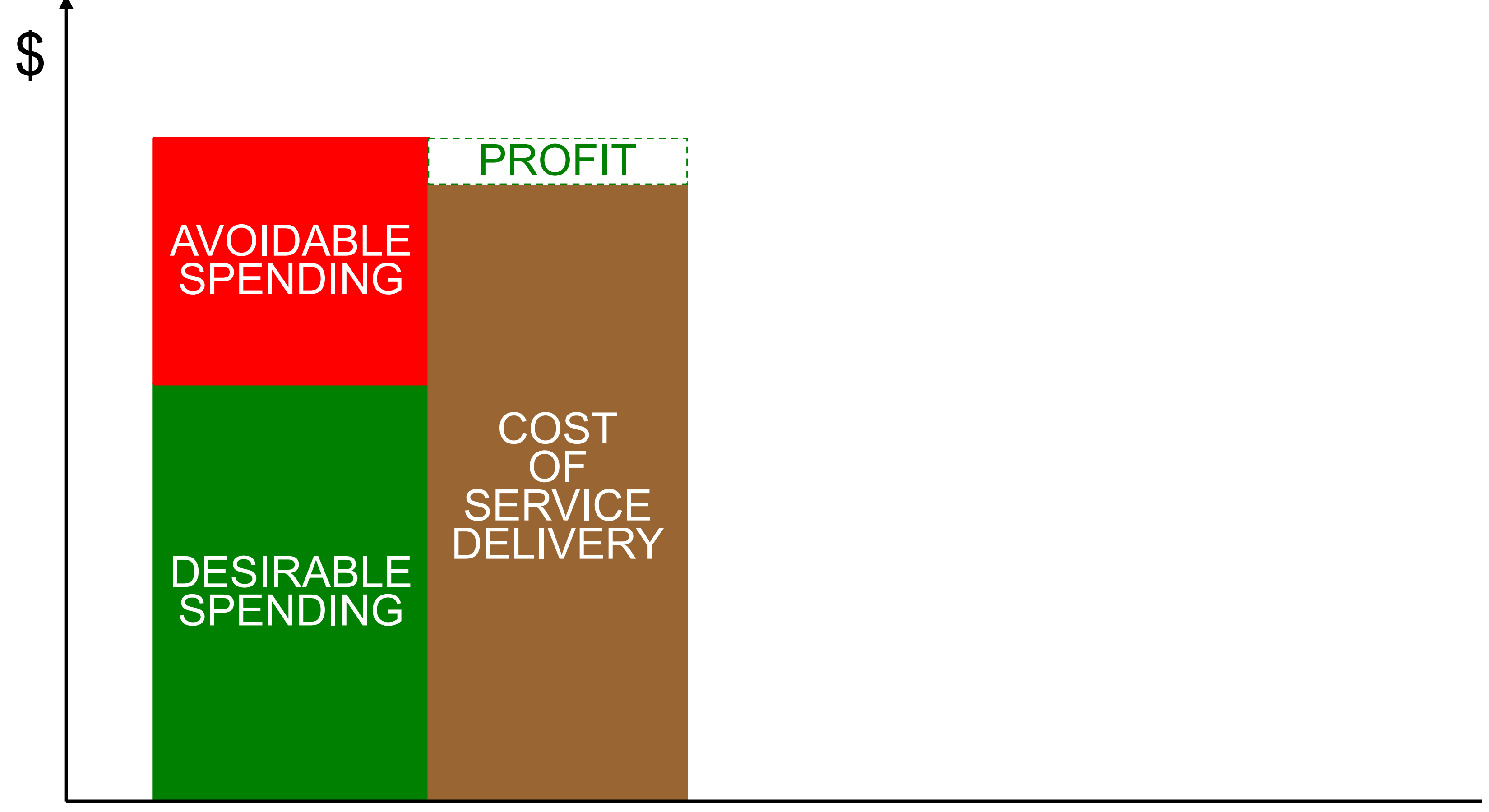
A Major Barrier: The Current Payment System



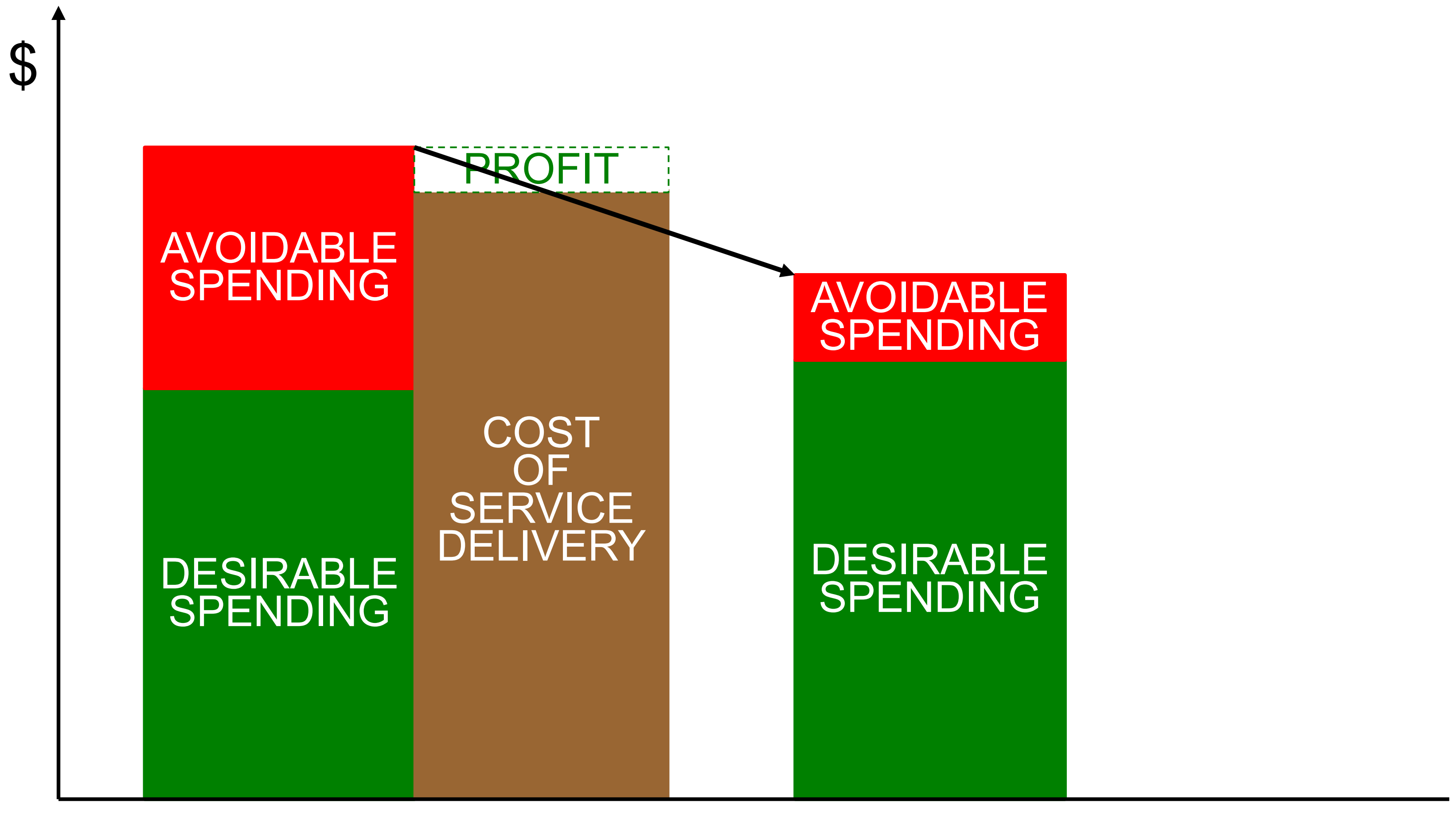
Barrier #1: No $ or Inadequate $ for High-Value Services



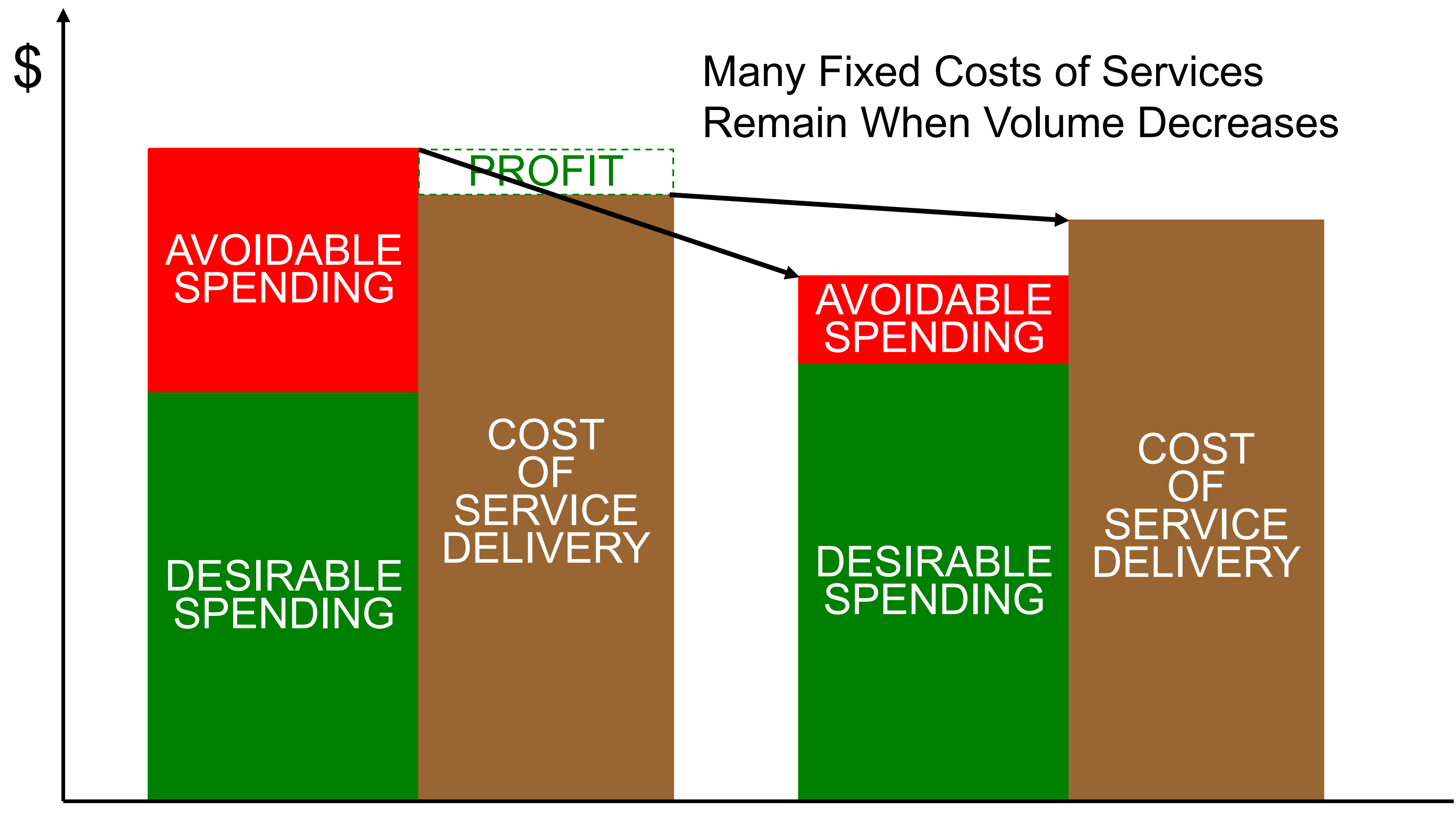
Barrier #2: Avoidable Spending is Revenue for the Providers…



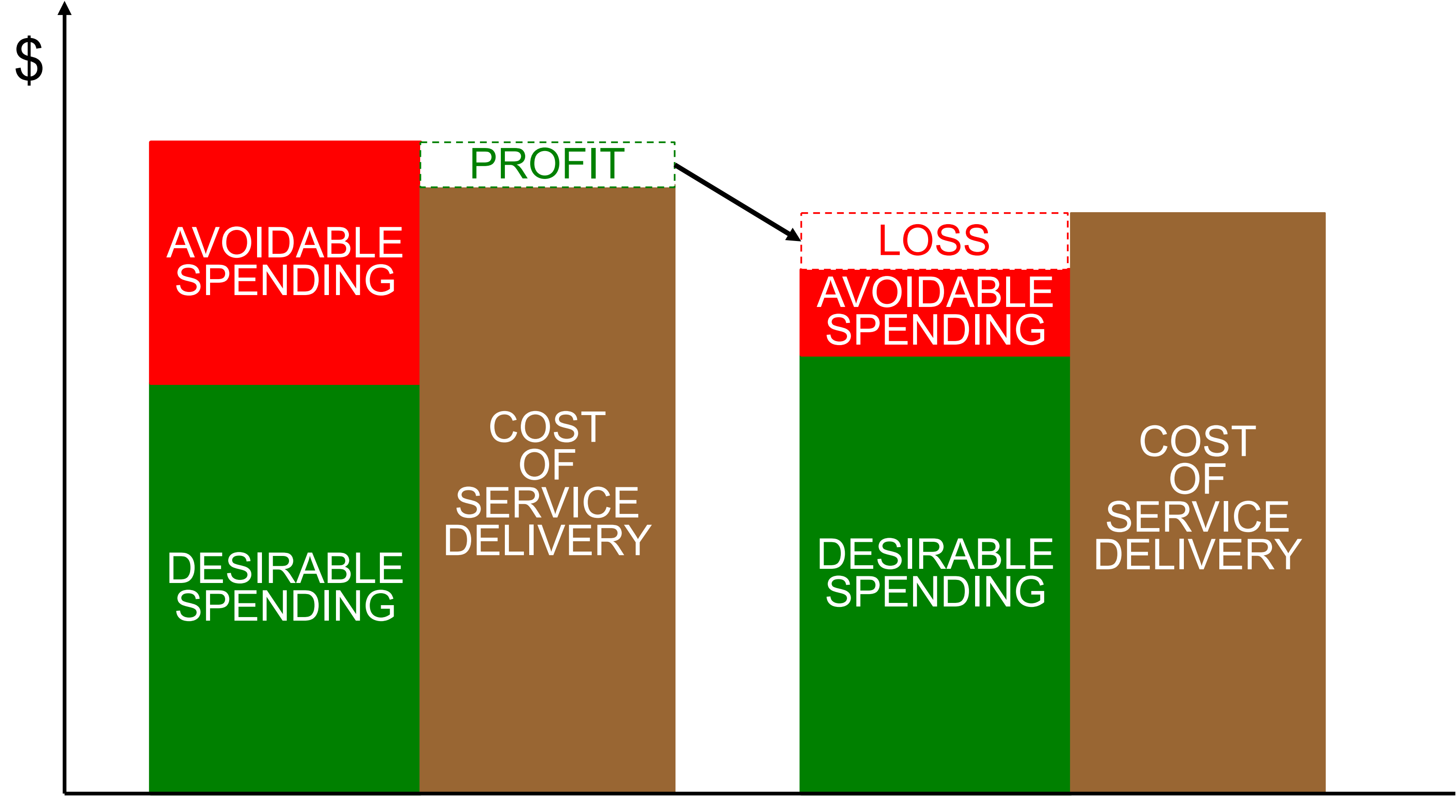
…And When Avoidable Services Aren't Delivered…



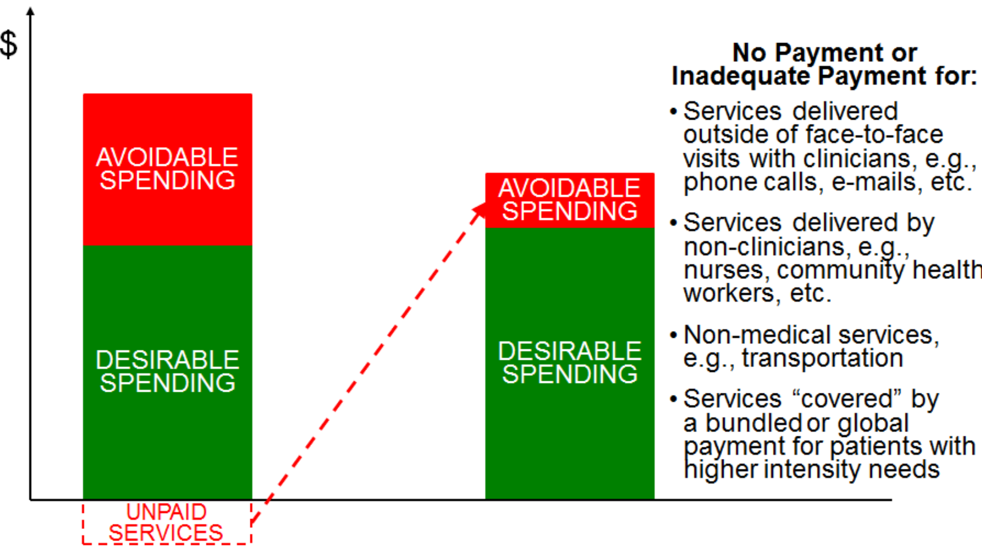
…Providers' Fixed Costs Don't Disappear…

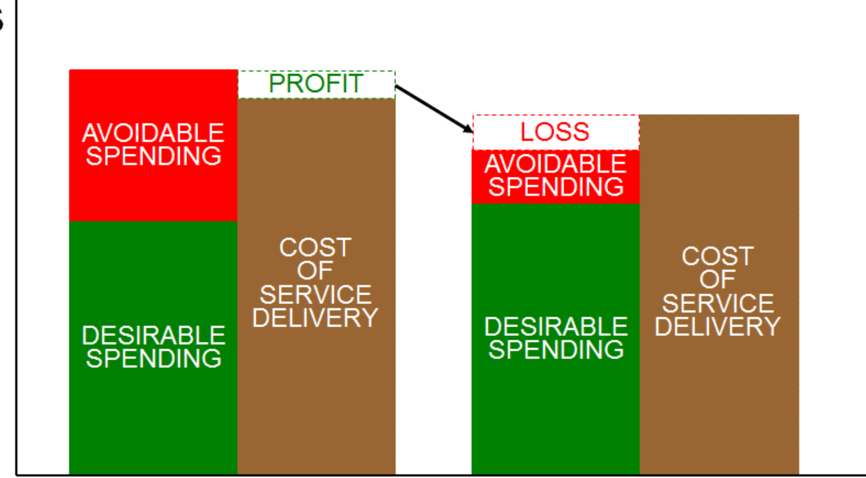


…Leaving Providers With Losses (or Bigger Losses Than Today)

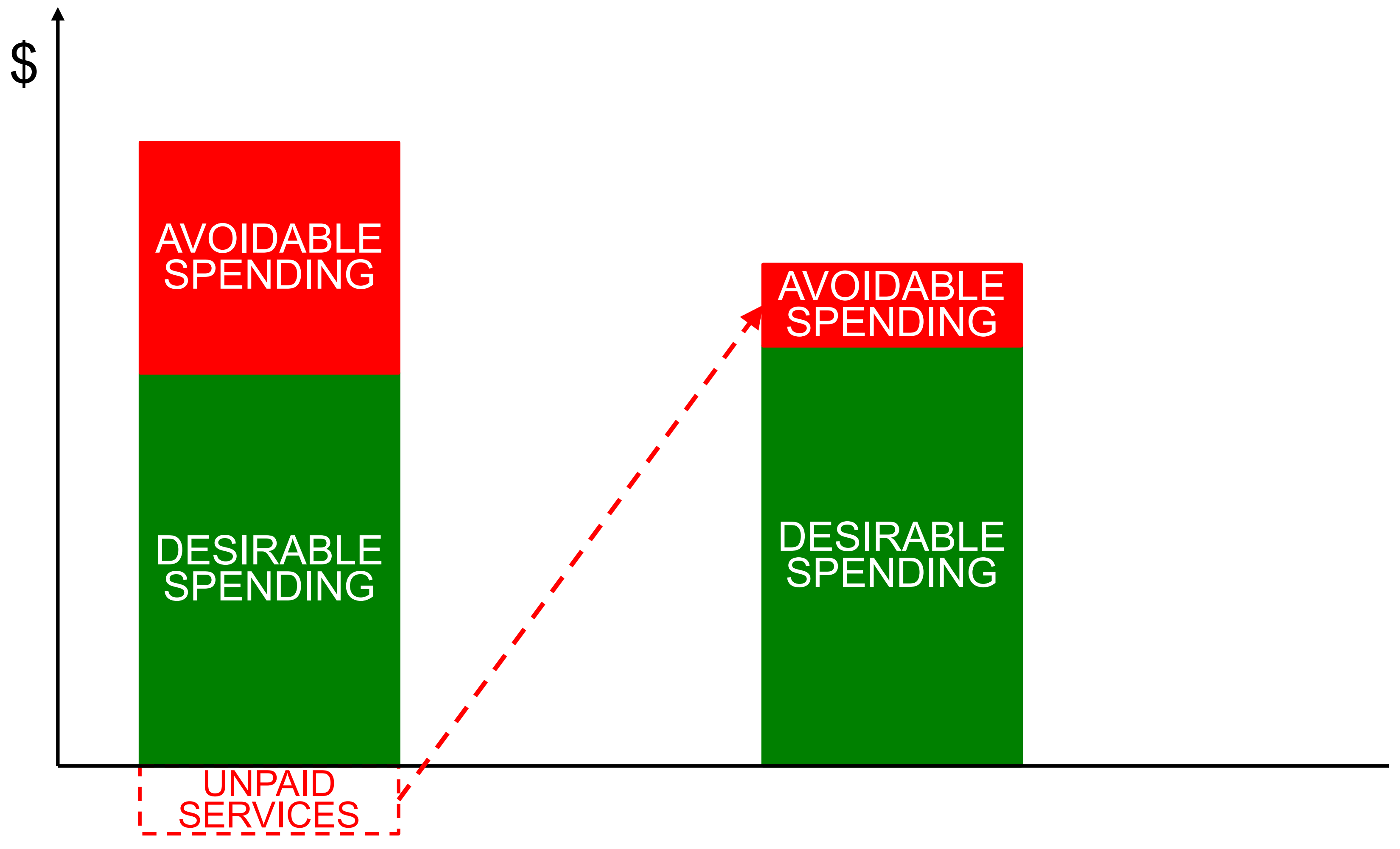


A Payment *Change* isn't *Reform* Unless It *Removes the Barriers*





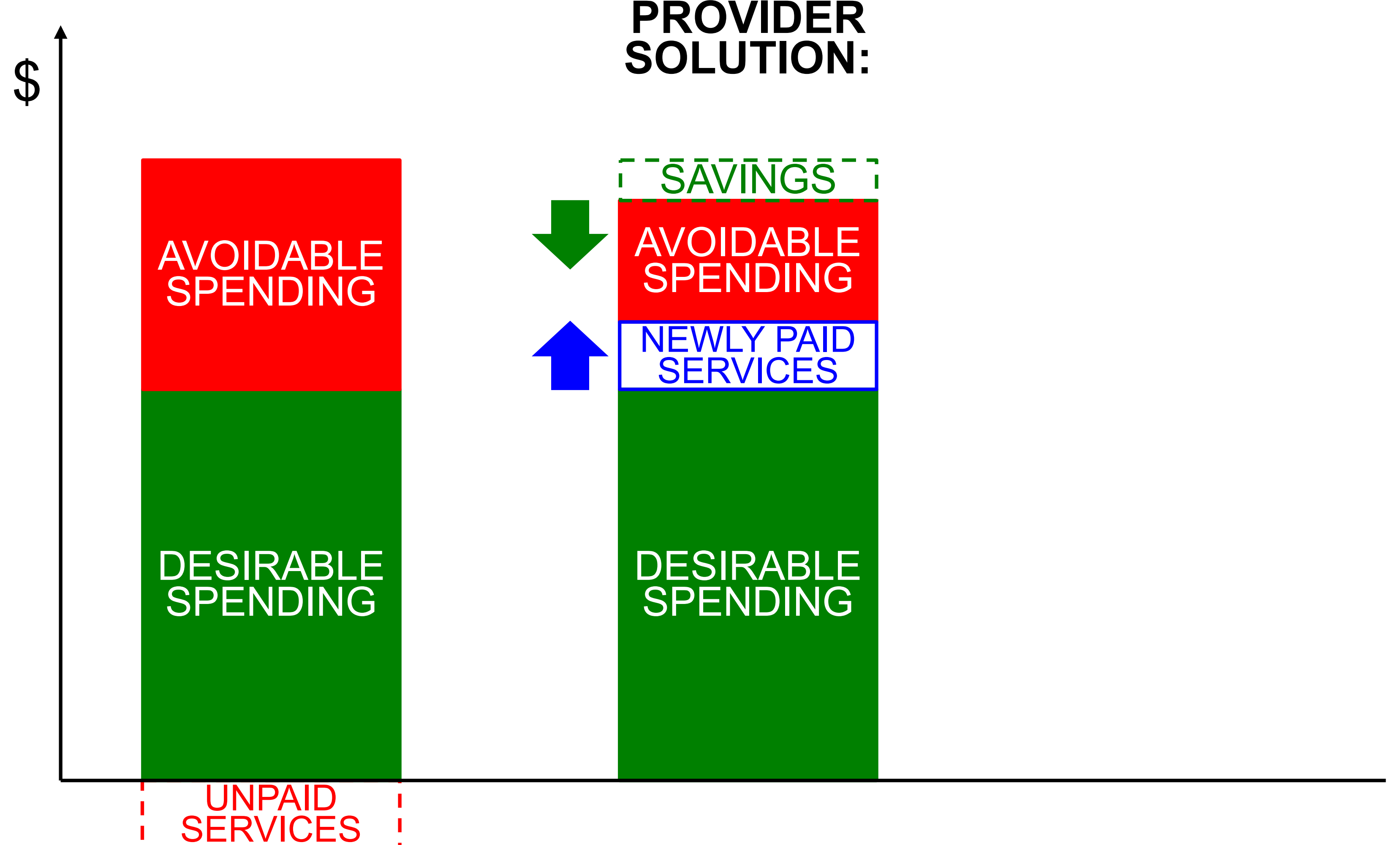
Today's Focus:
Paying for High-Value Services



Most Current “Payment Reform” Proposals Are Problematic

- Provider approach
- Payer approach

Provider Approach: "Trust Us" ("Studies Say It Will Save Money")



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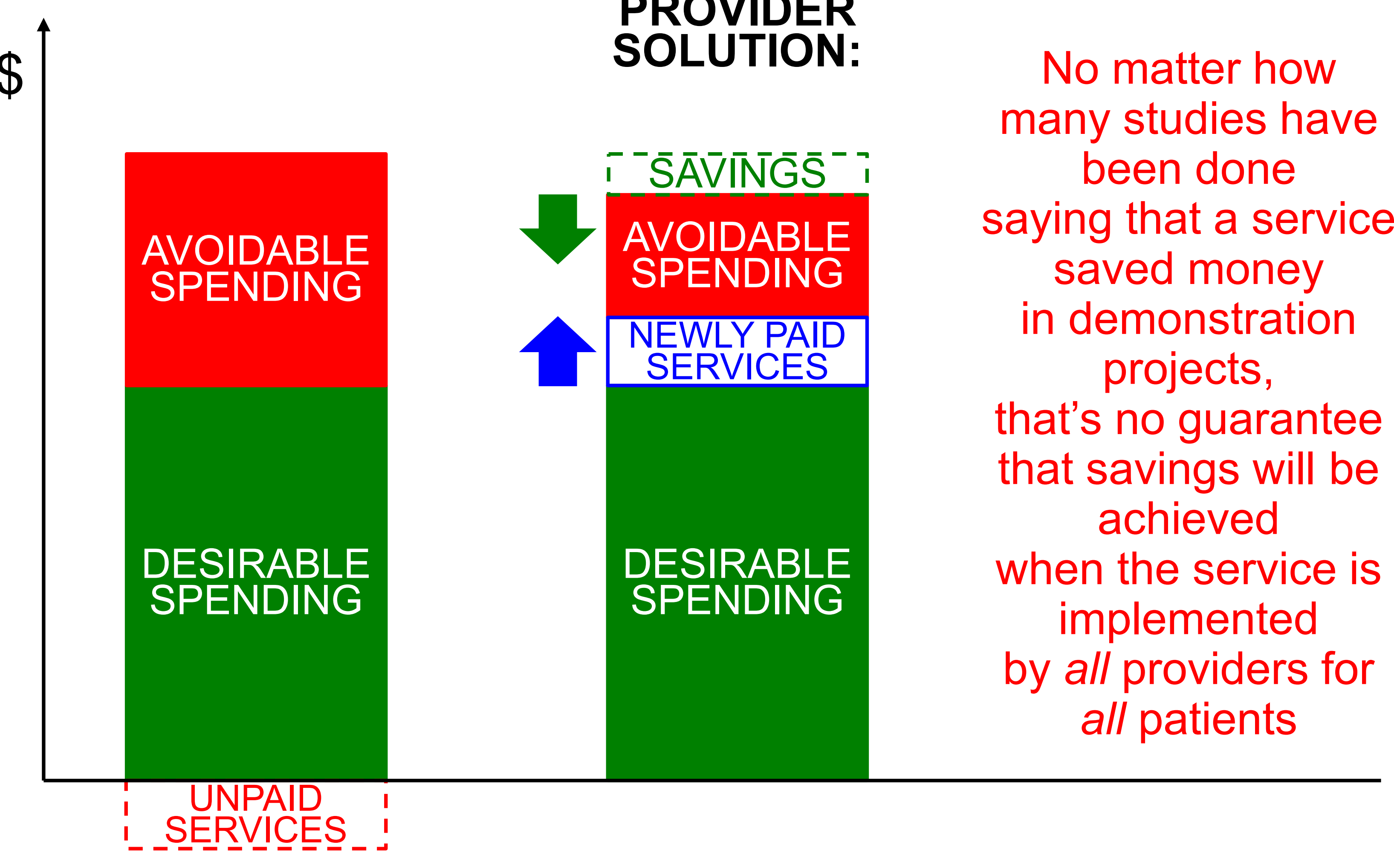
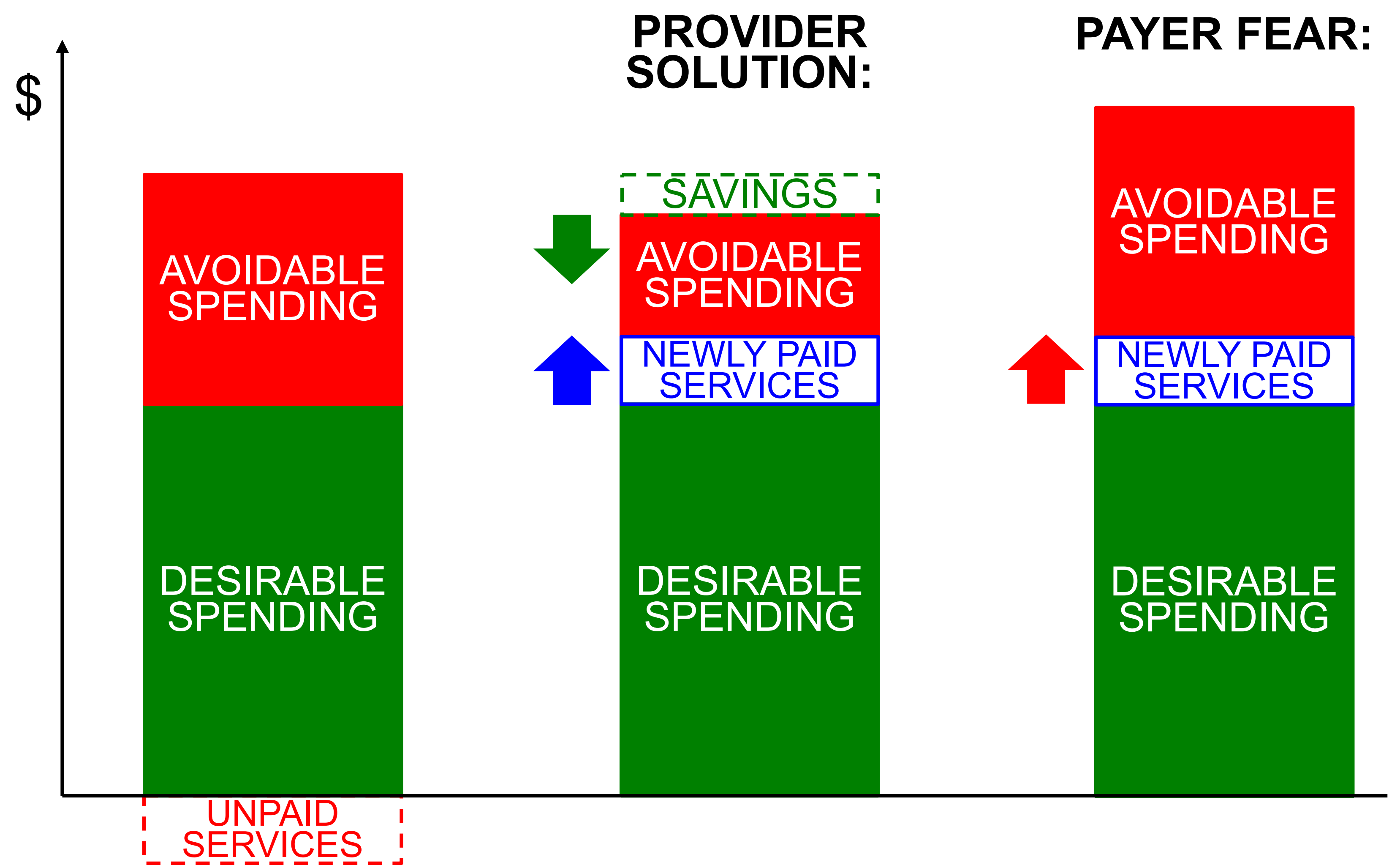
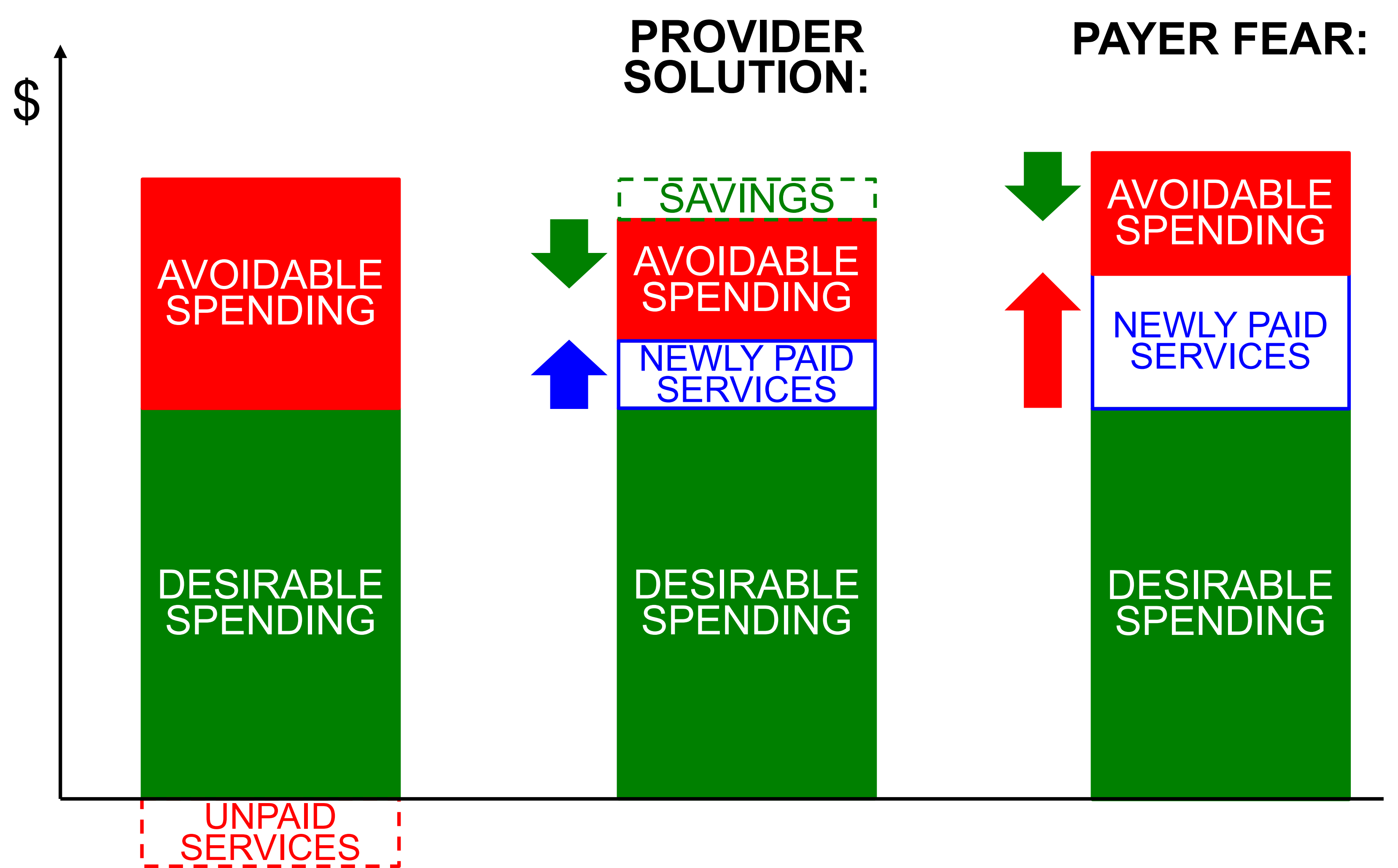


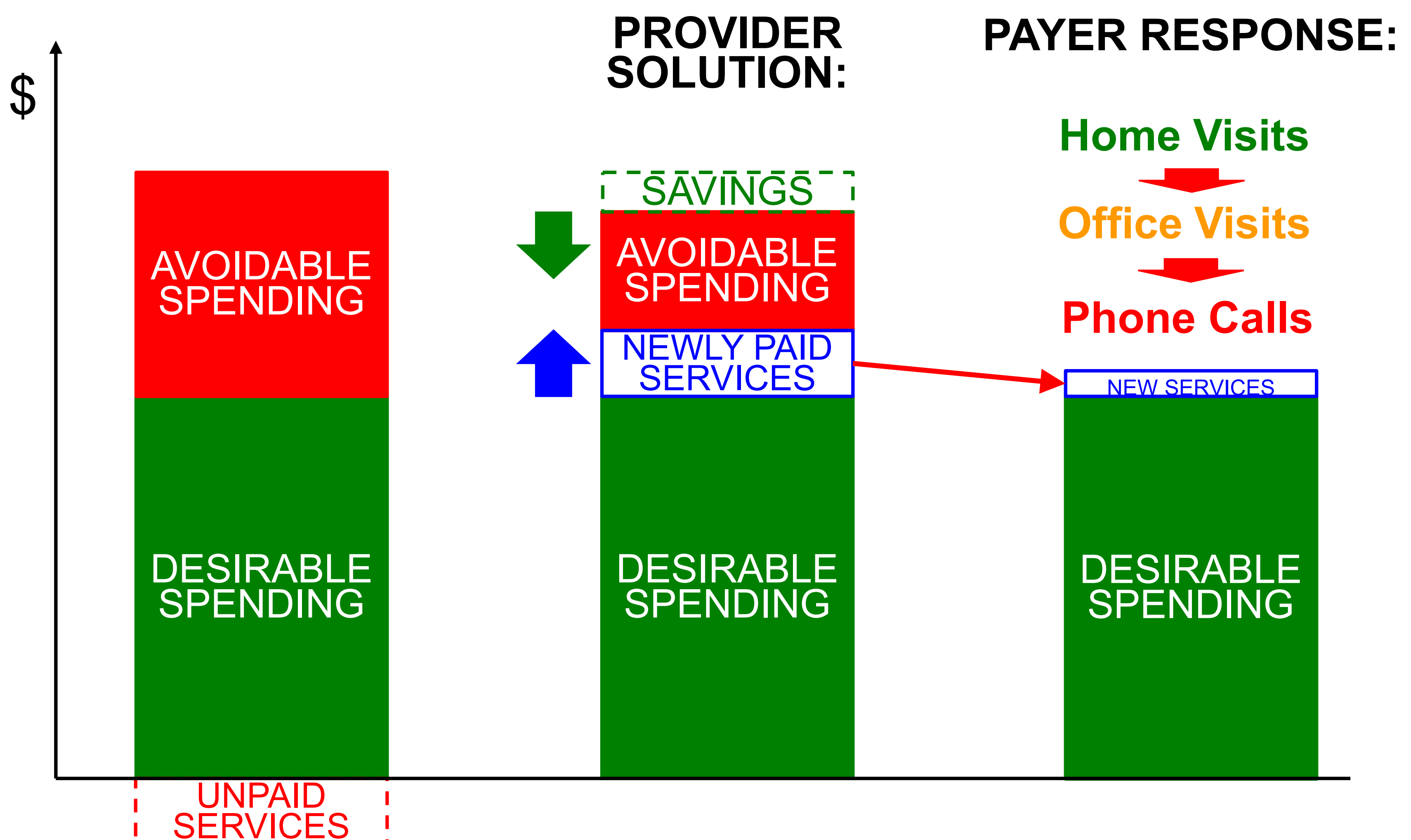
Payer Concern: No *Accountability* to Reduce Avoidable Spending



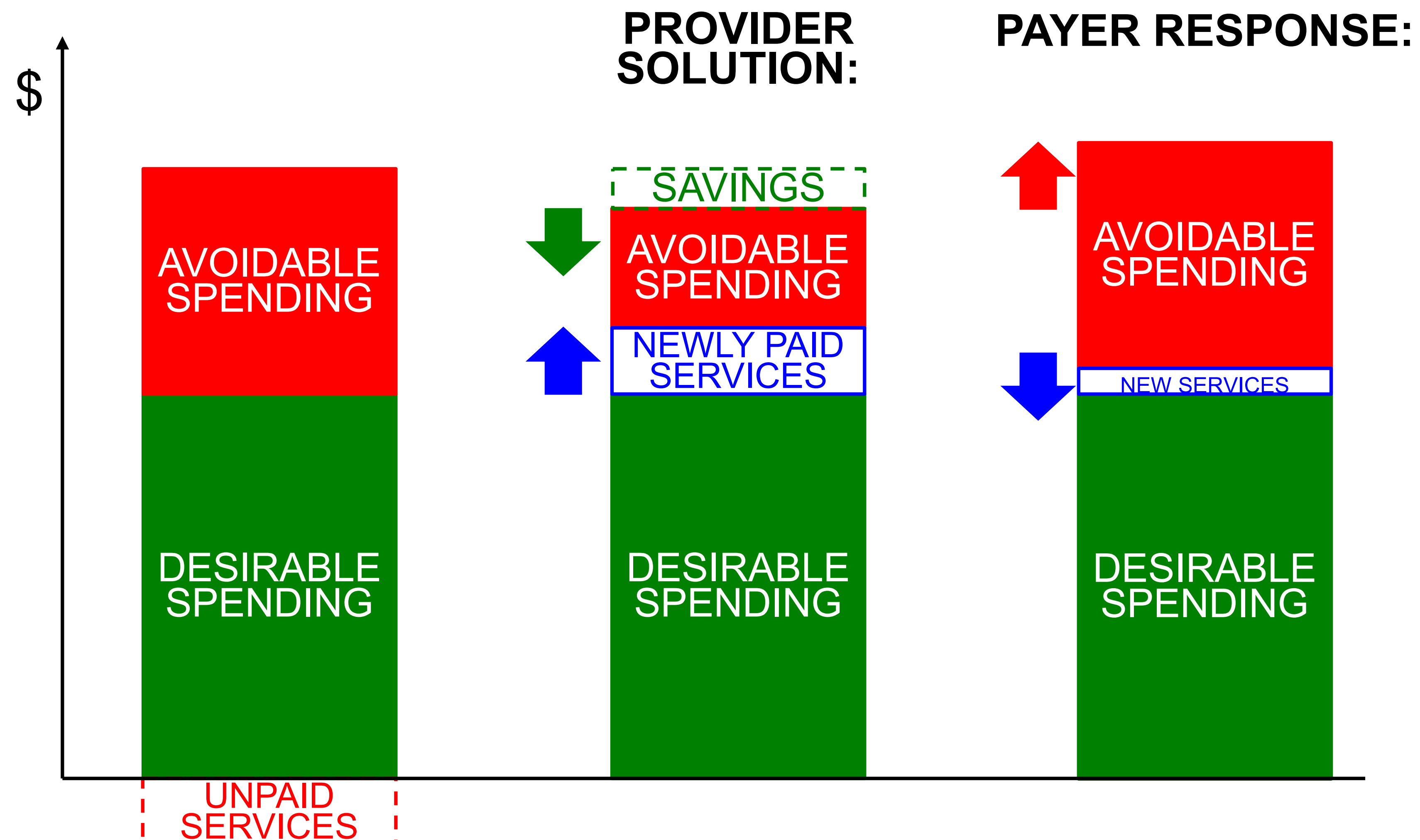
Payer Concern #2: New Services Will Be Used More Than Necessary



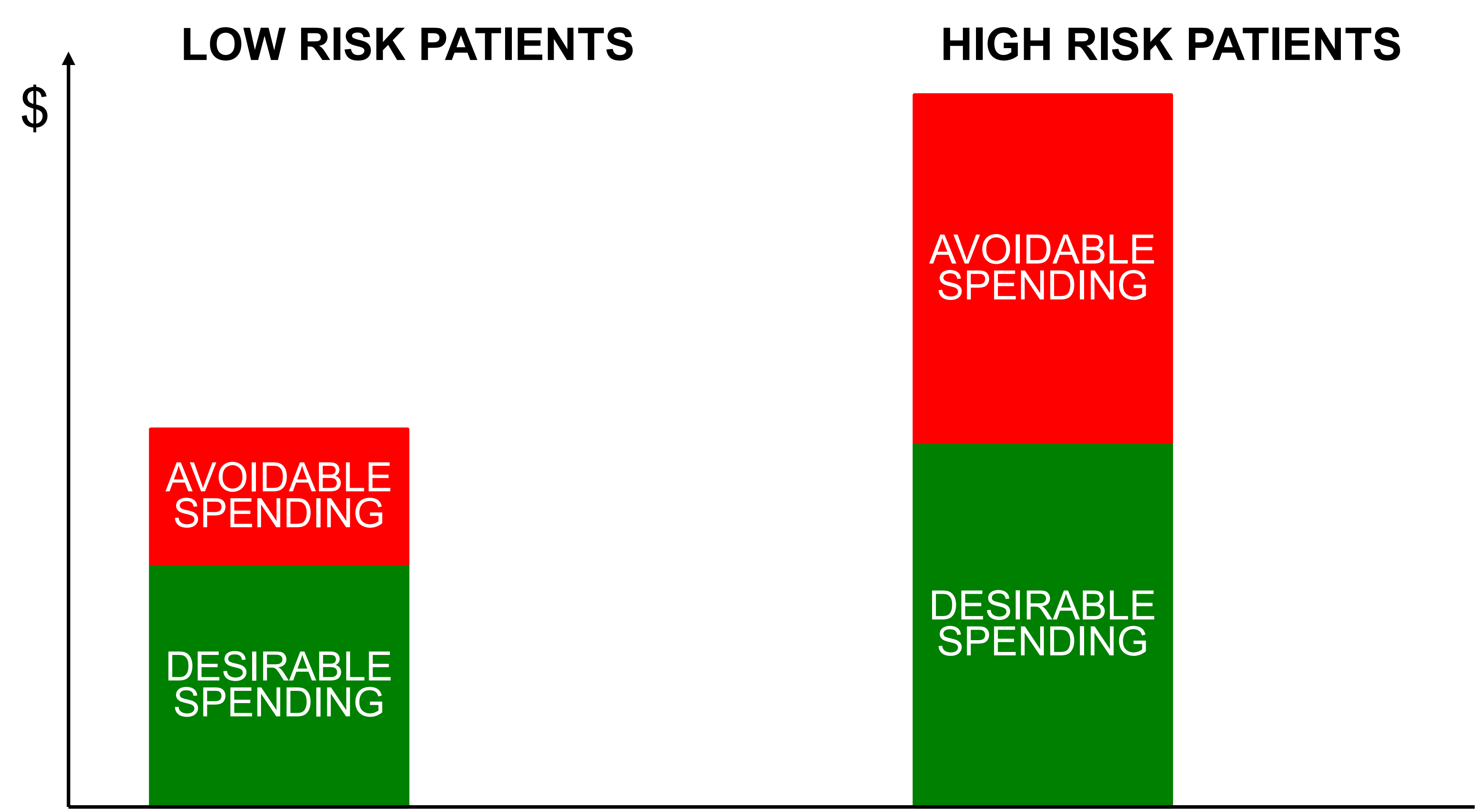
Payer Response:
Pay for Less Than What's Needed



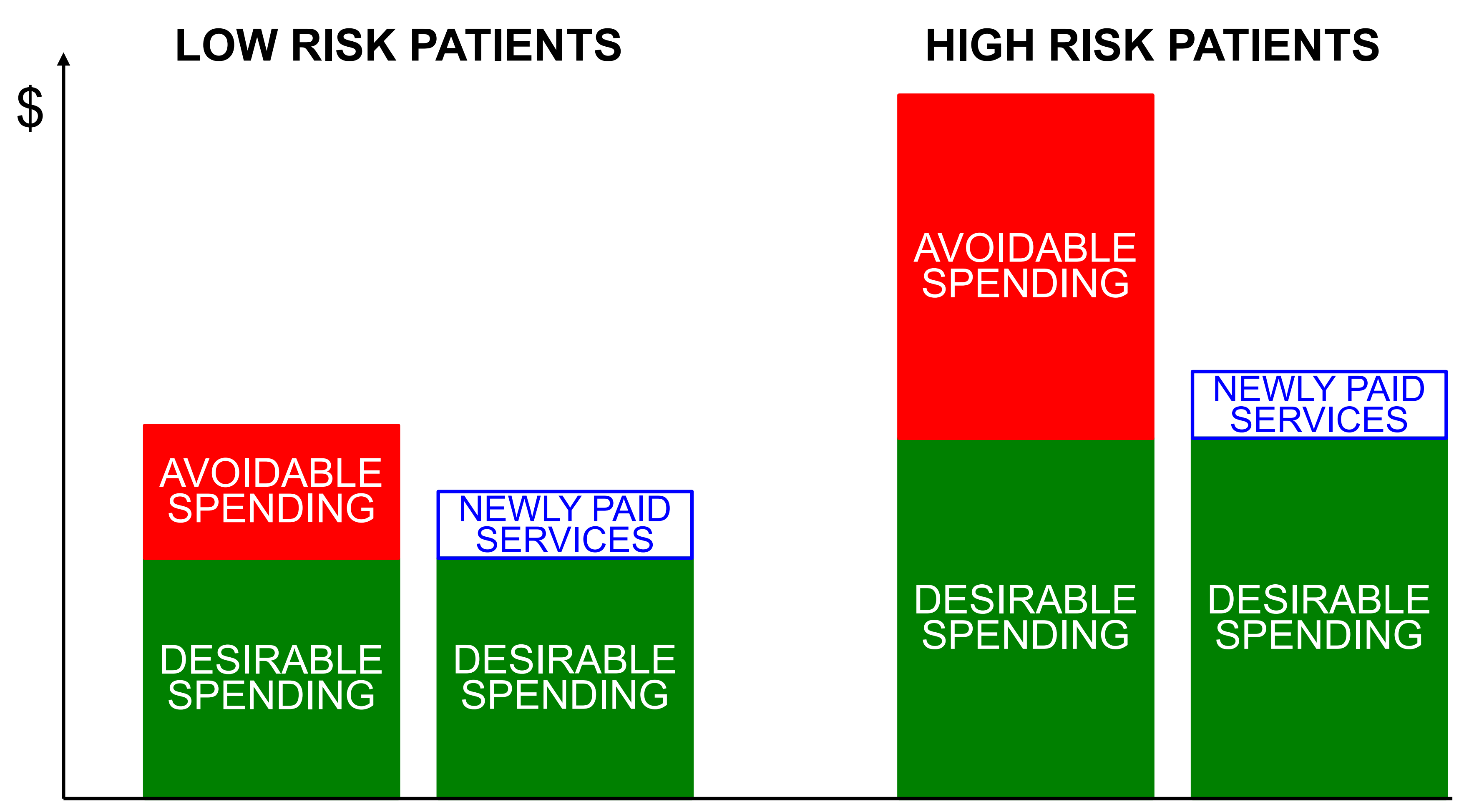
Result: Inadequate Services = Little or No Impact on Spending



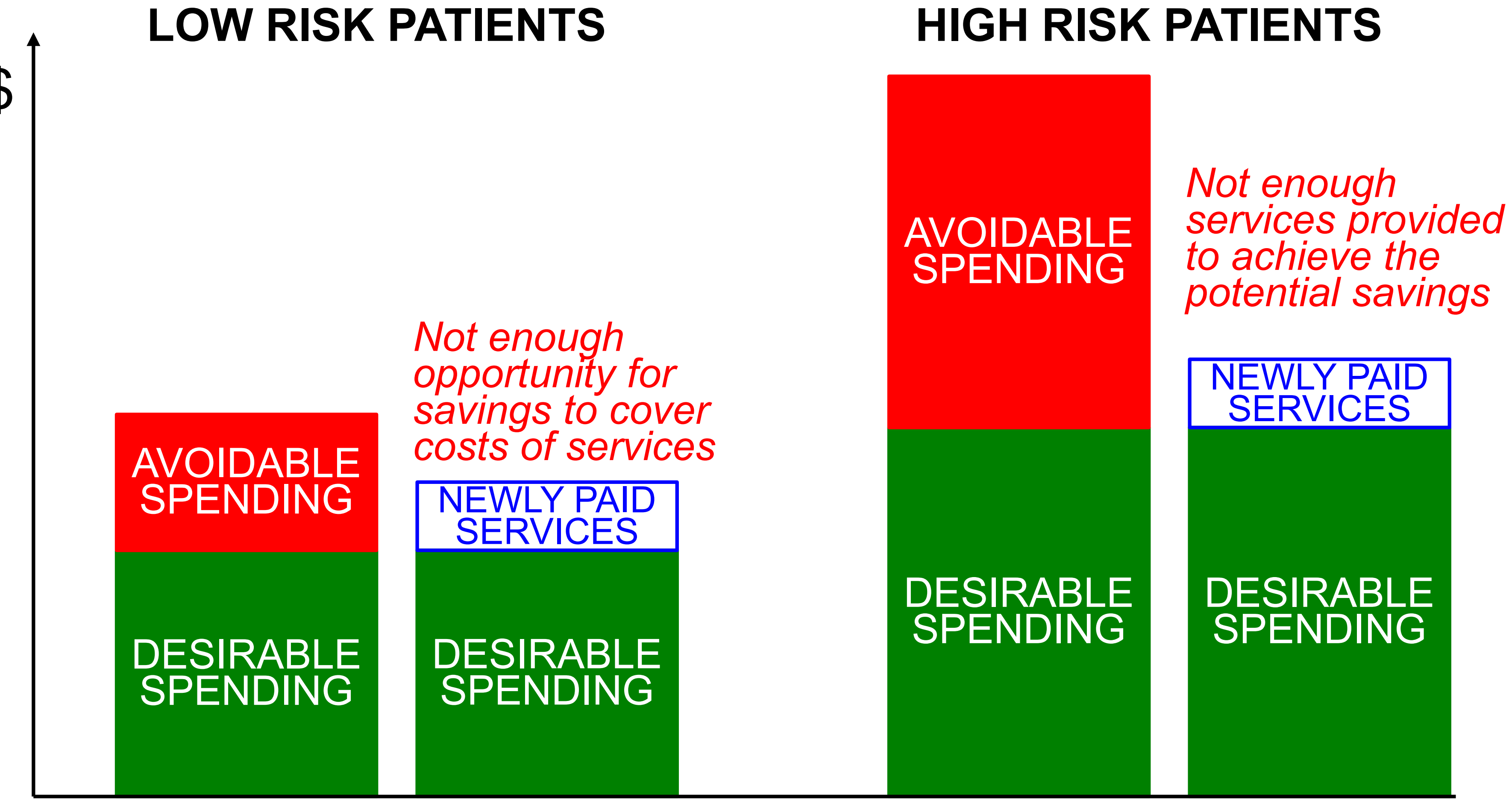
Limitations of FFS Codes: Not All Patients Are Alike



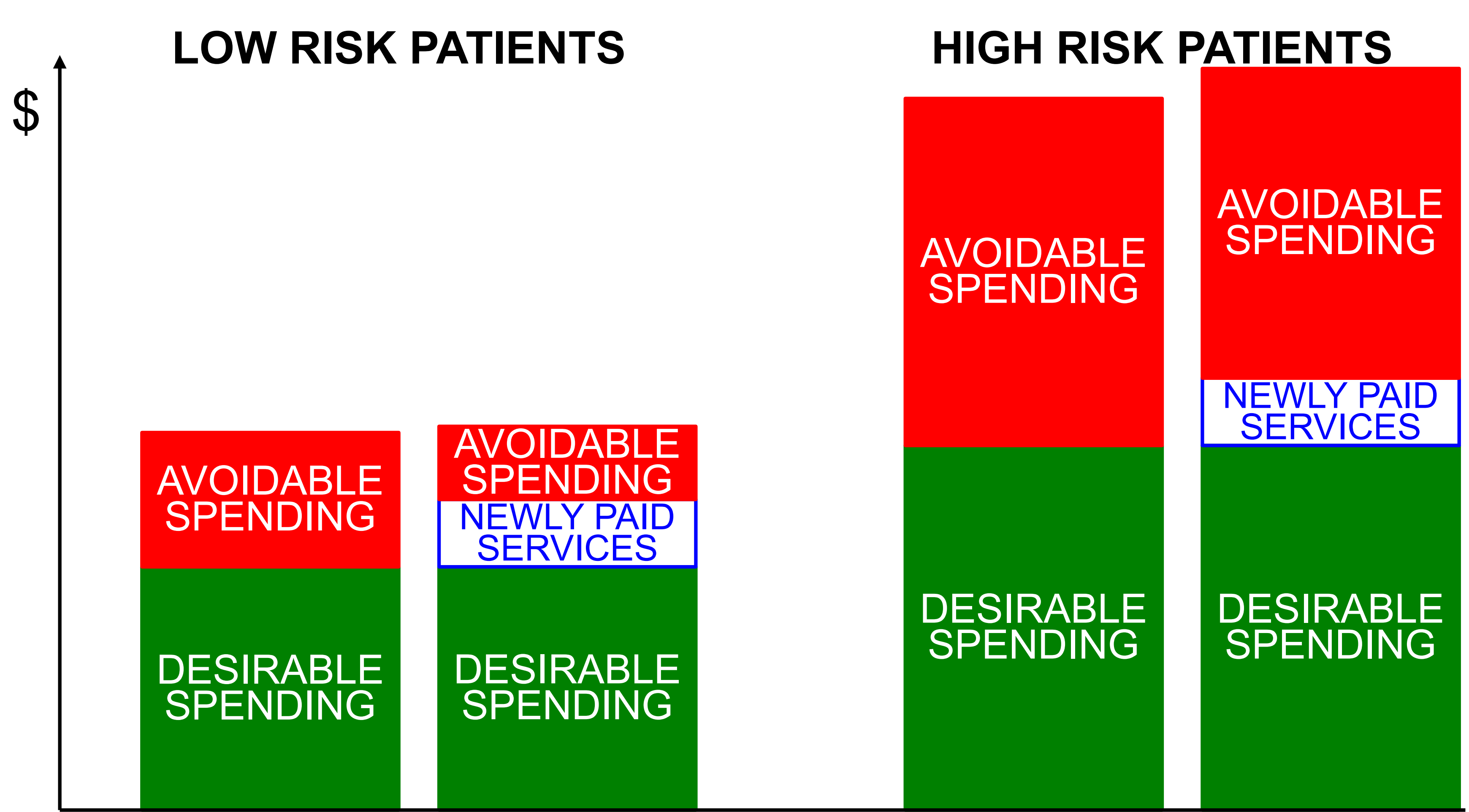
So It Doesn't Make Sense to Deliver the Same Services to Each



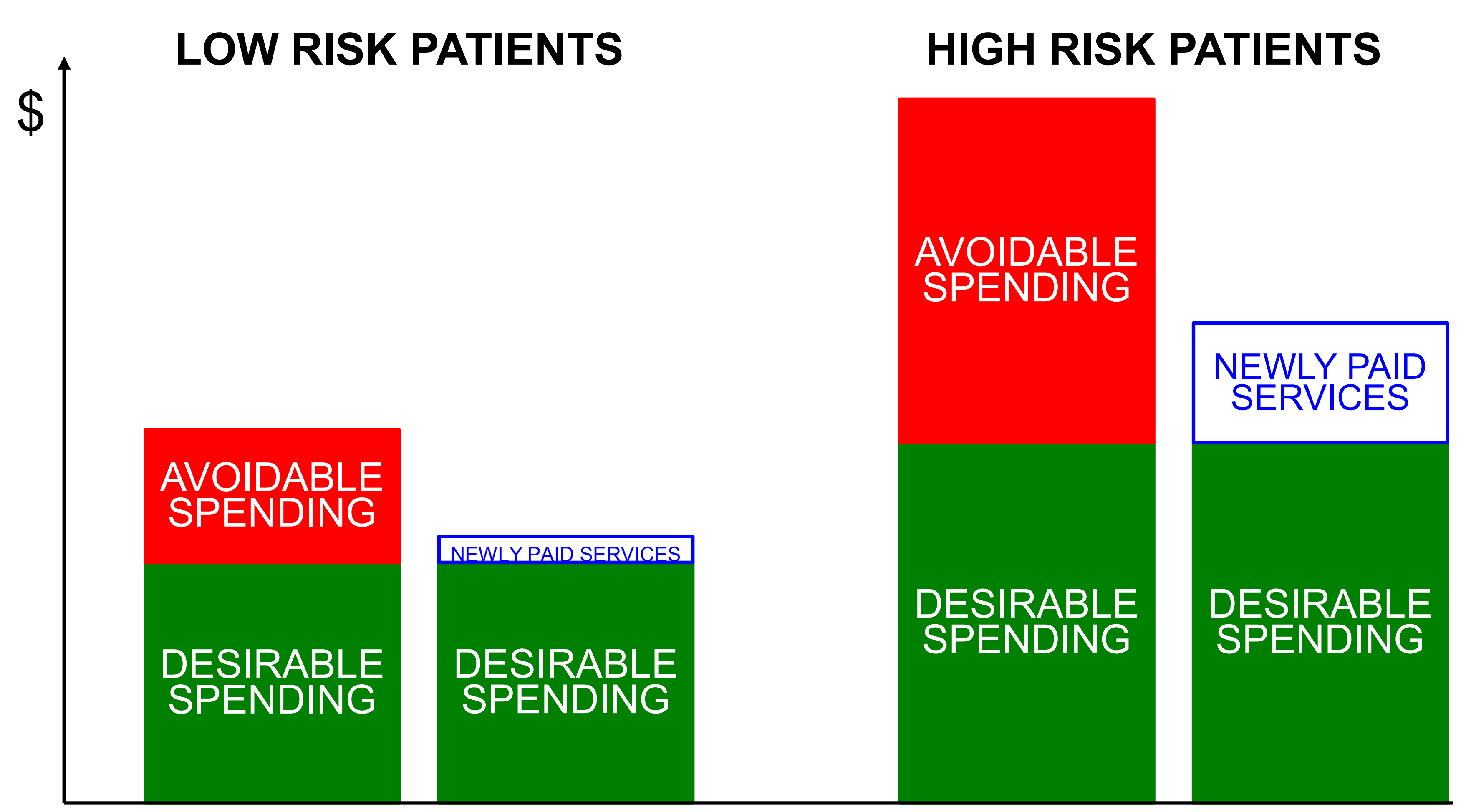
Failure to Target Spending Can Fail to Achieve Adequate Savings



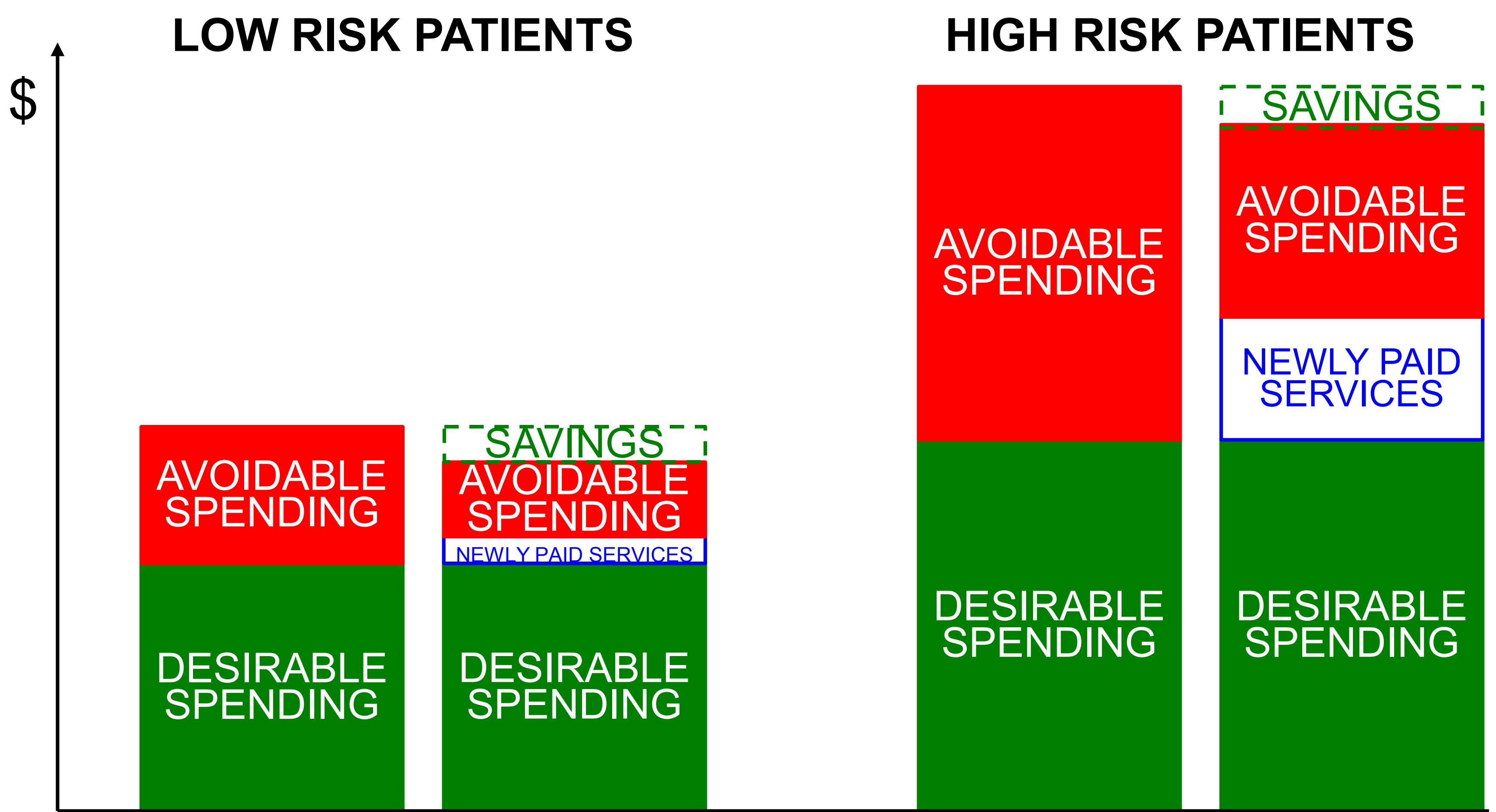
Result: Higher Spending Overall



A Better Approach: Flexibility to Target Services Based on Need



A Better Result: More Savings From Focusing on Higher Needs



Most Current "Payment Reform" Proposals Are Problematic

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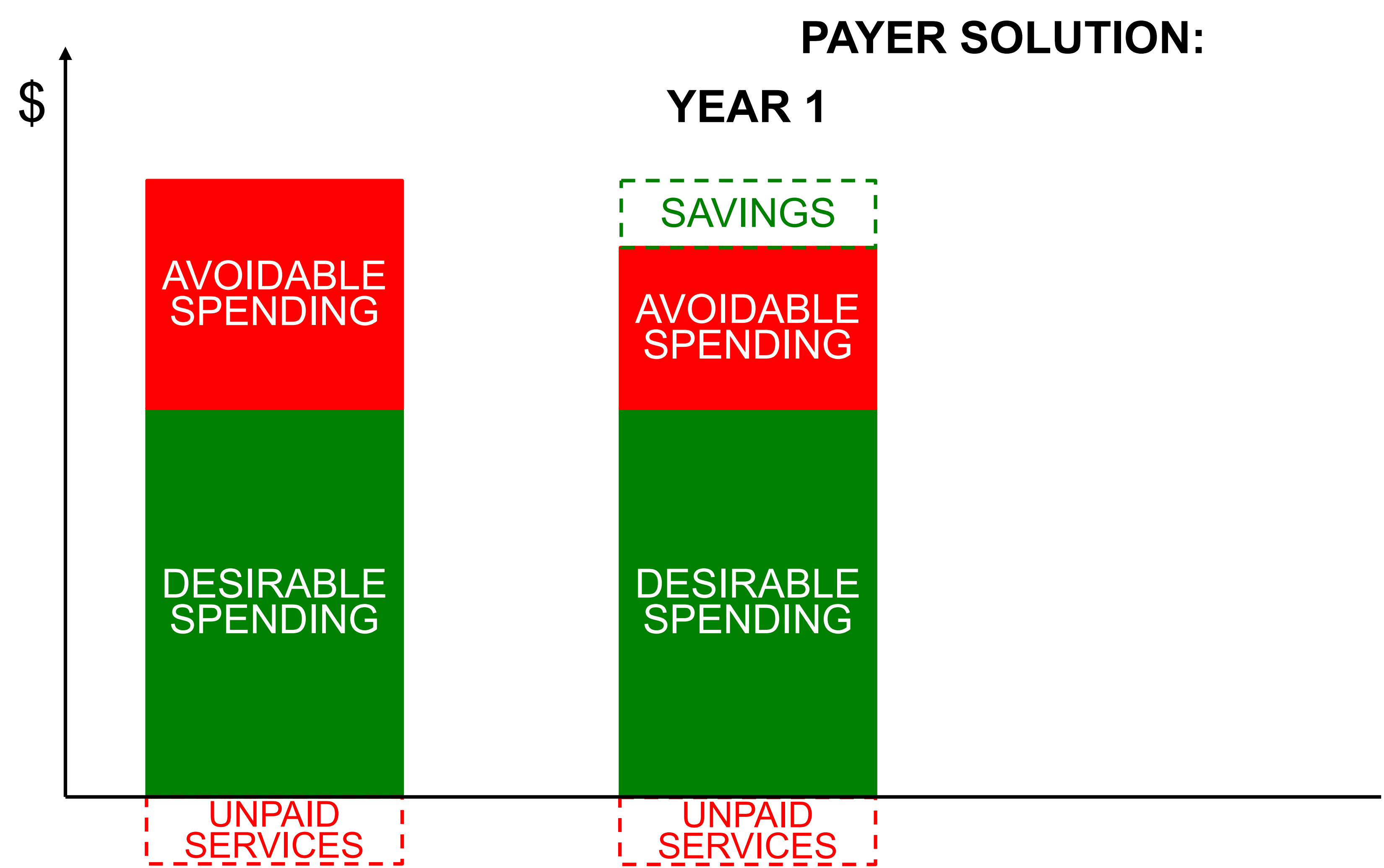
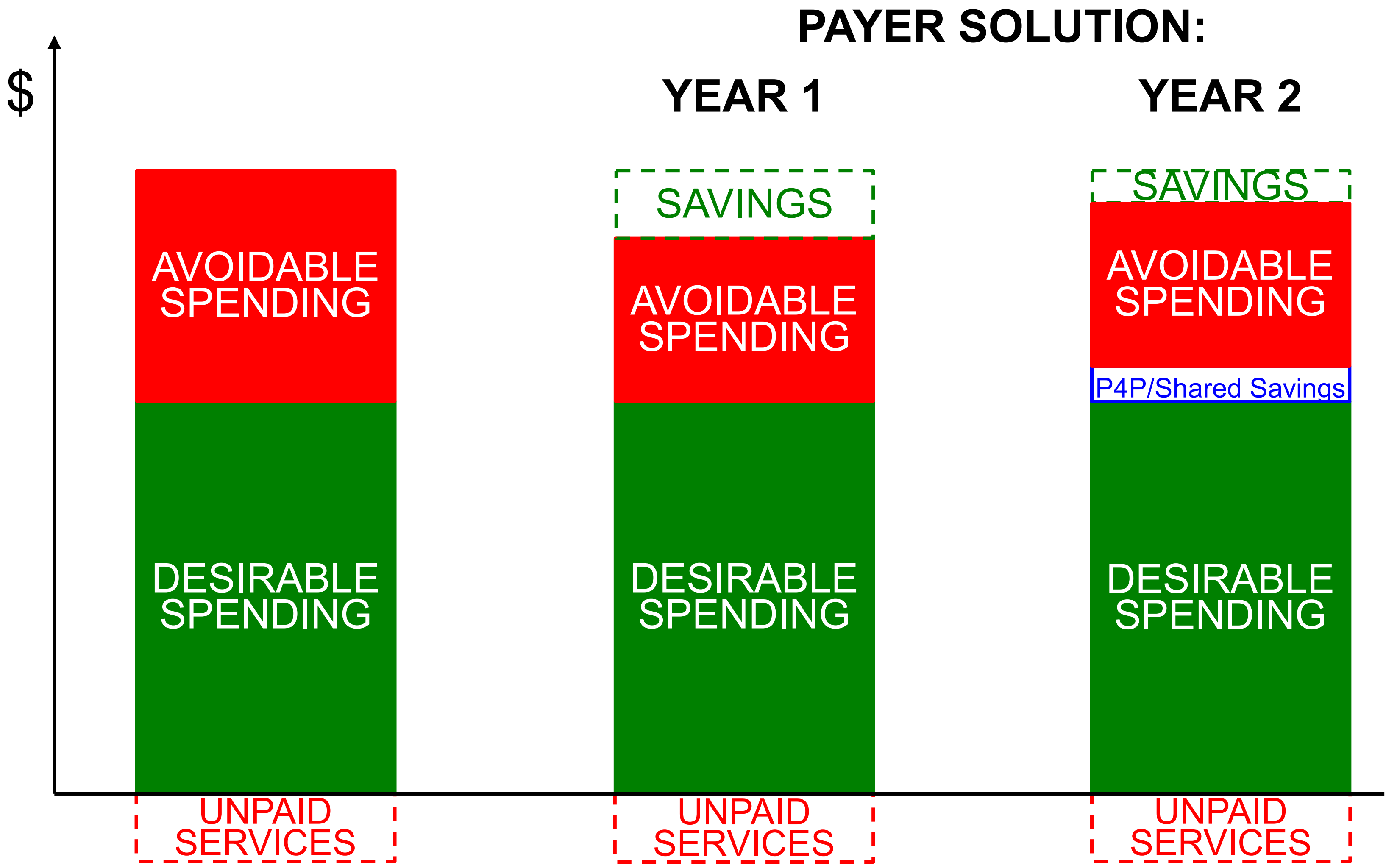
- Payer approach

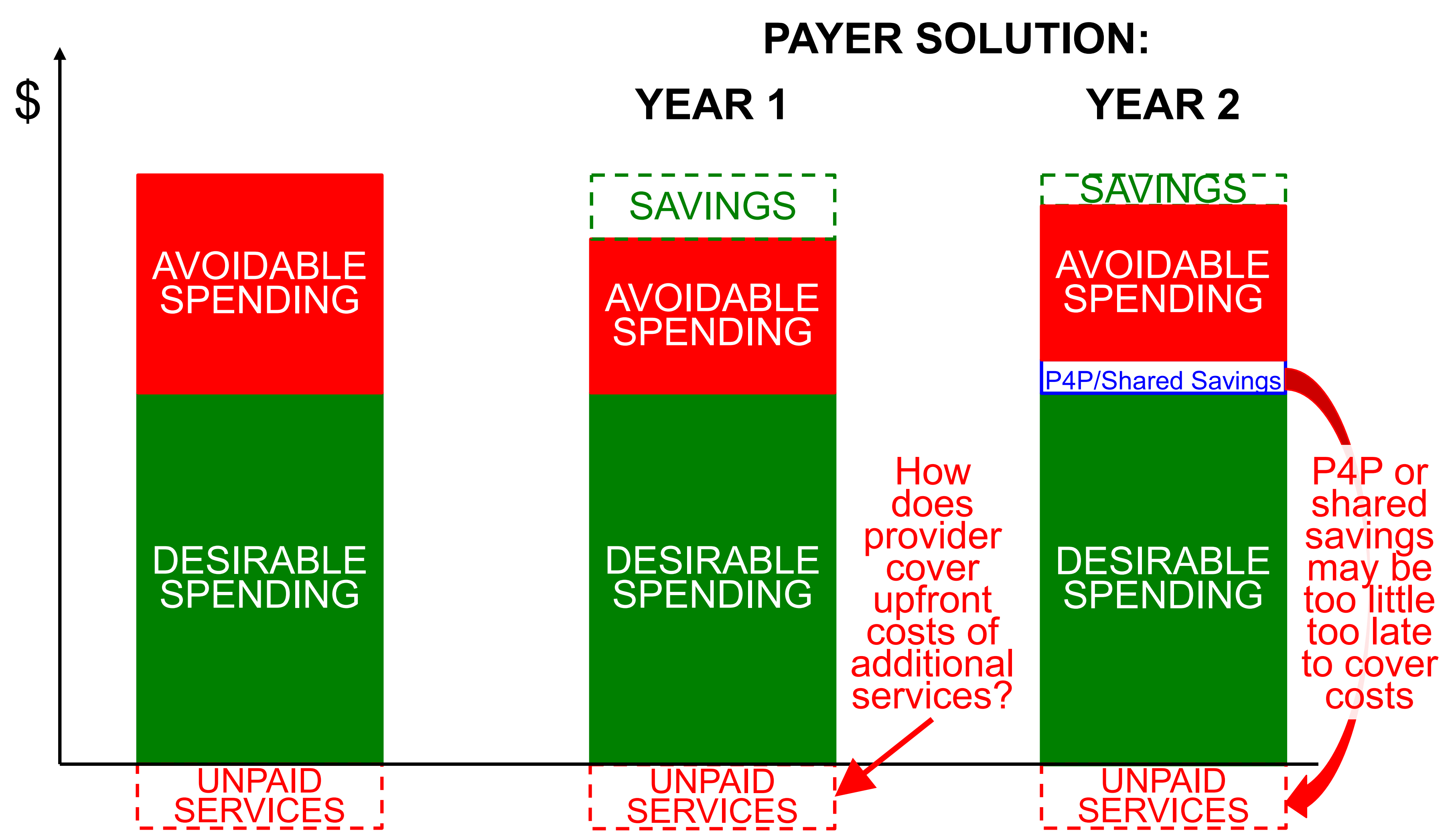
Payer Approach: Save Us Money and…



Payer Approach: Save Us Money and We'll You Pay More Next Year



Provider Concern: Shared Savings is Too Little, Too Late



Payer Approach #2: Global Budget for Services

PAYER SOLUTION #2:

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AVOIDABLE SPENDING

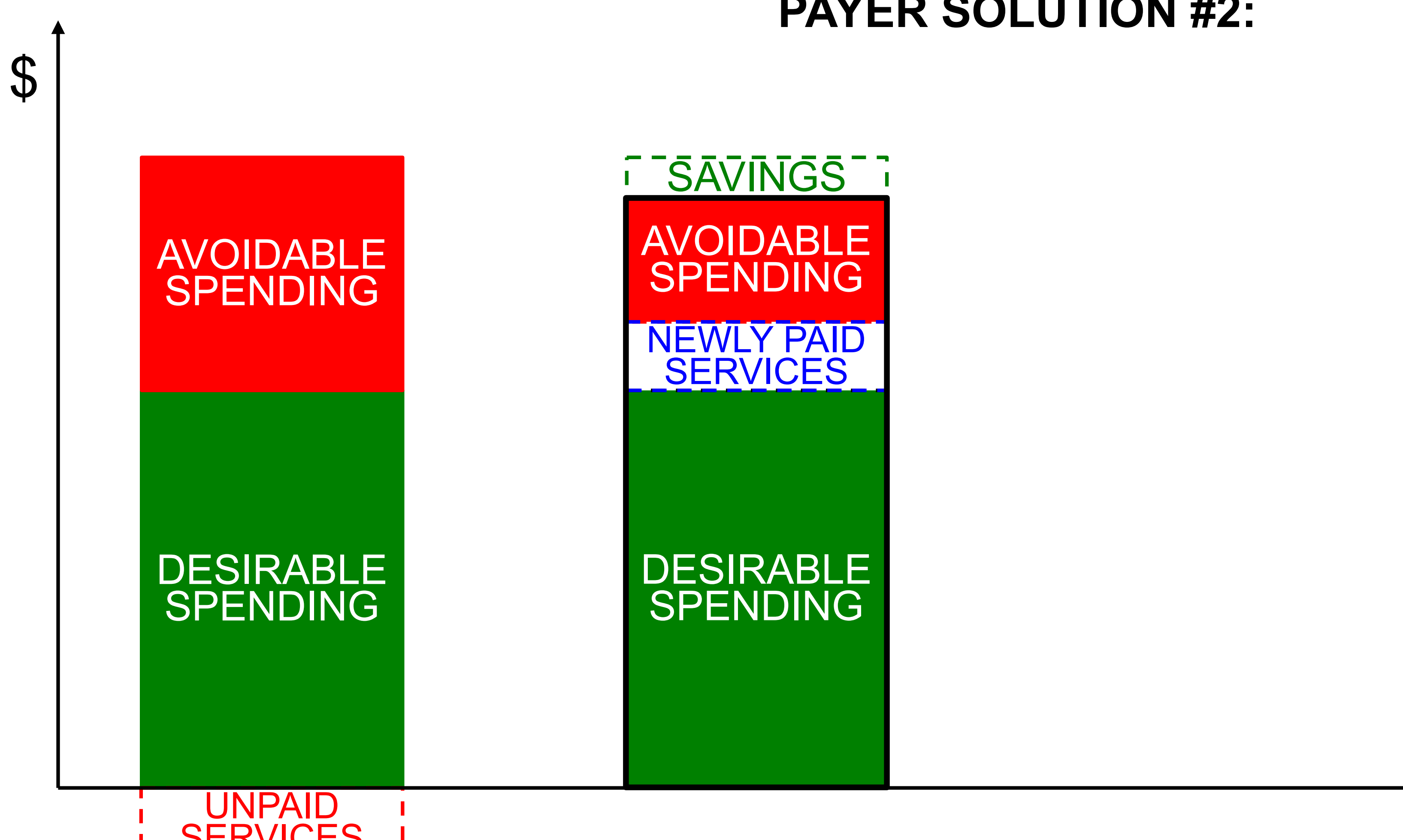
DESIRABLE SPENDING

UNPAID SERVICES

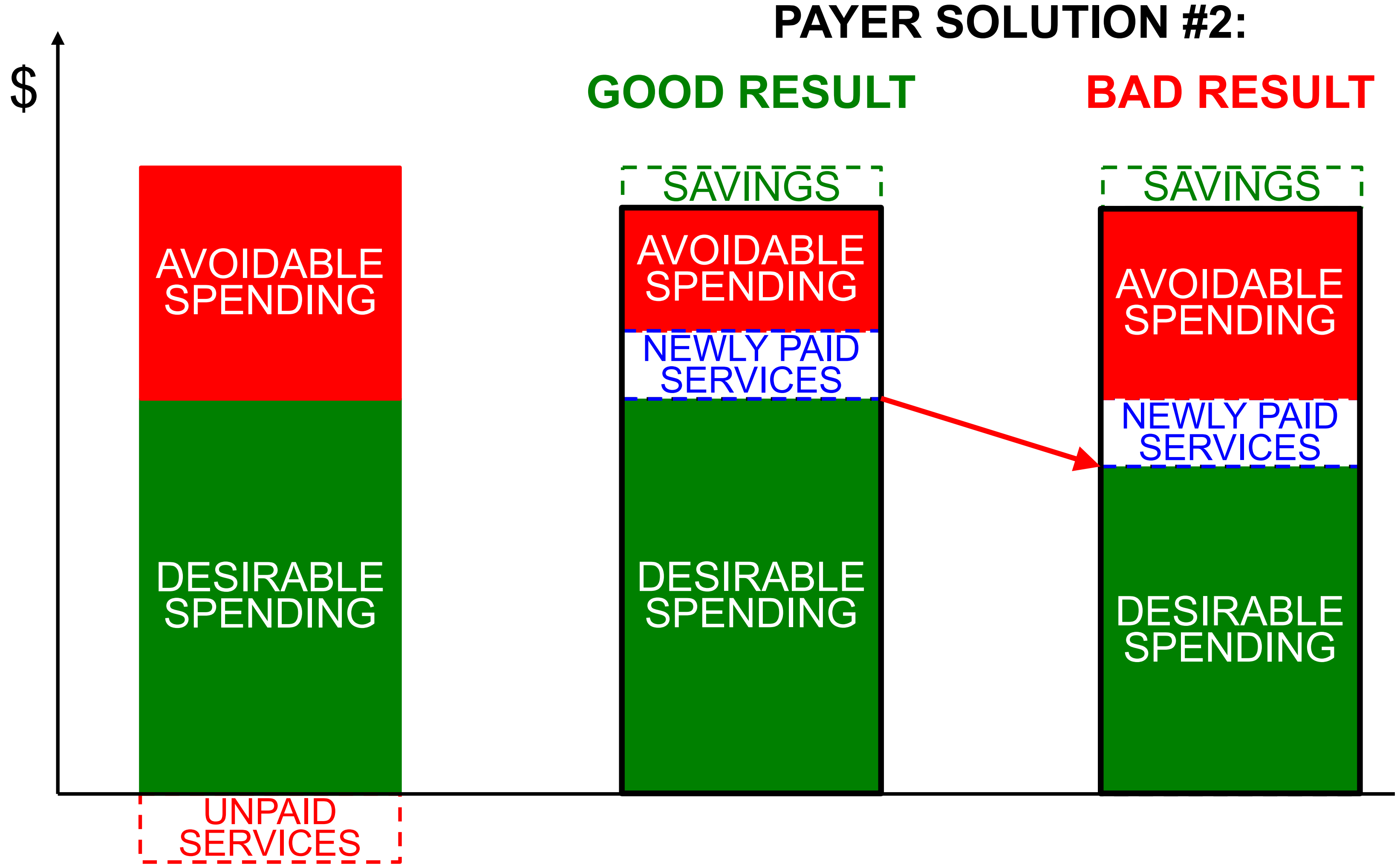
SAVINGS

GLOBAL BUDGET FOR SERVICES

Provider Has Flexibility to Provide Different Services Within Budget



Patient Concern: Will Global Budget Result in Stinting on Care?



The Four Key Elements of Accountable Payment Models

The Four Key Elements of Successful Payment Reforms

1. **Flexibility in Care Delivery.** The payment system should give providers freedom to deliver care in ways that will achieve high quality in the most efficient way and to adjust care delivery to the unique needs of individual patients.

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The Four Key Elements of Successful Payment Reforms

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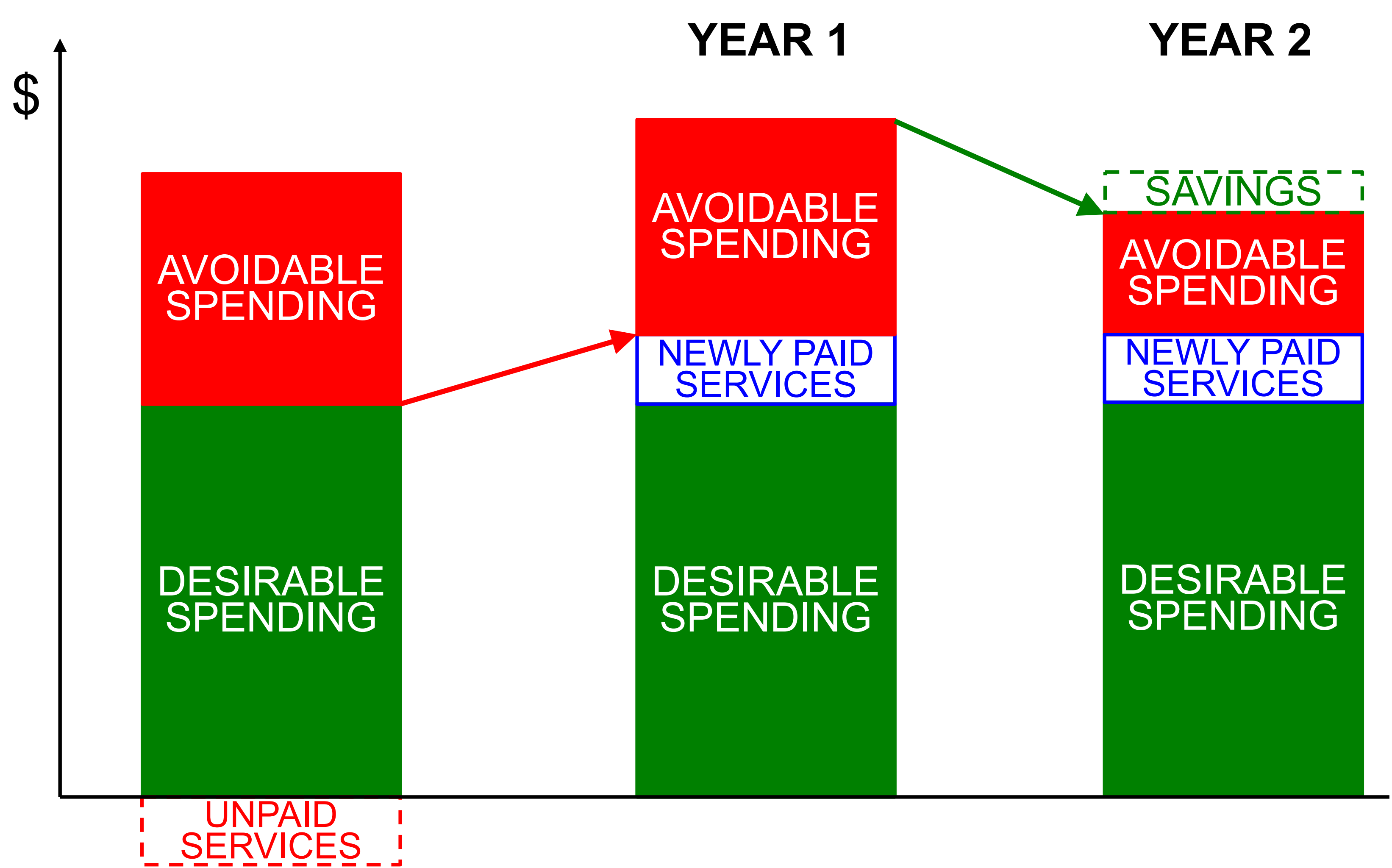
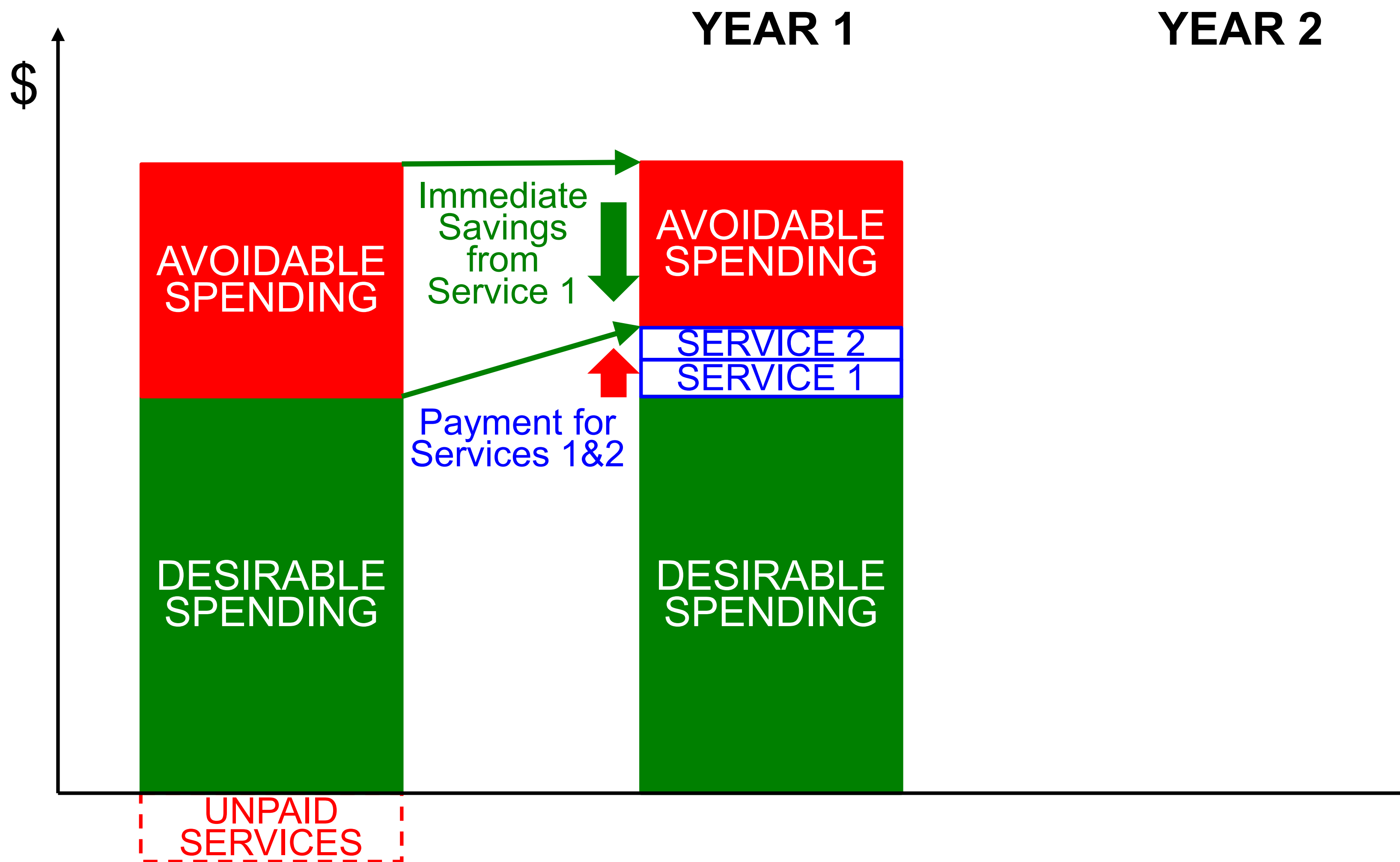
4. **Adequacy of Payment**. The size of the payments should be adequate to cover the providers' costs of delivering high quality care for the types of patients they see and at the levels of cost or efficiency that are feasible for them to achieve.

A Final Problem: Some Programs Take Time To Generate Savings



A Solution: Combining Short-Term and Long-Term Savings Initiatives



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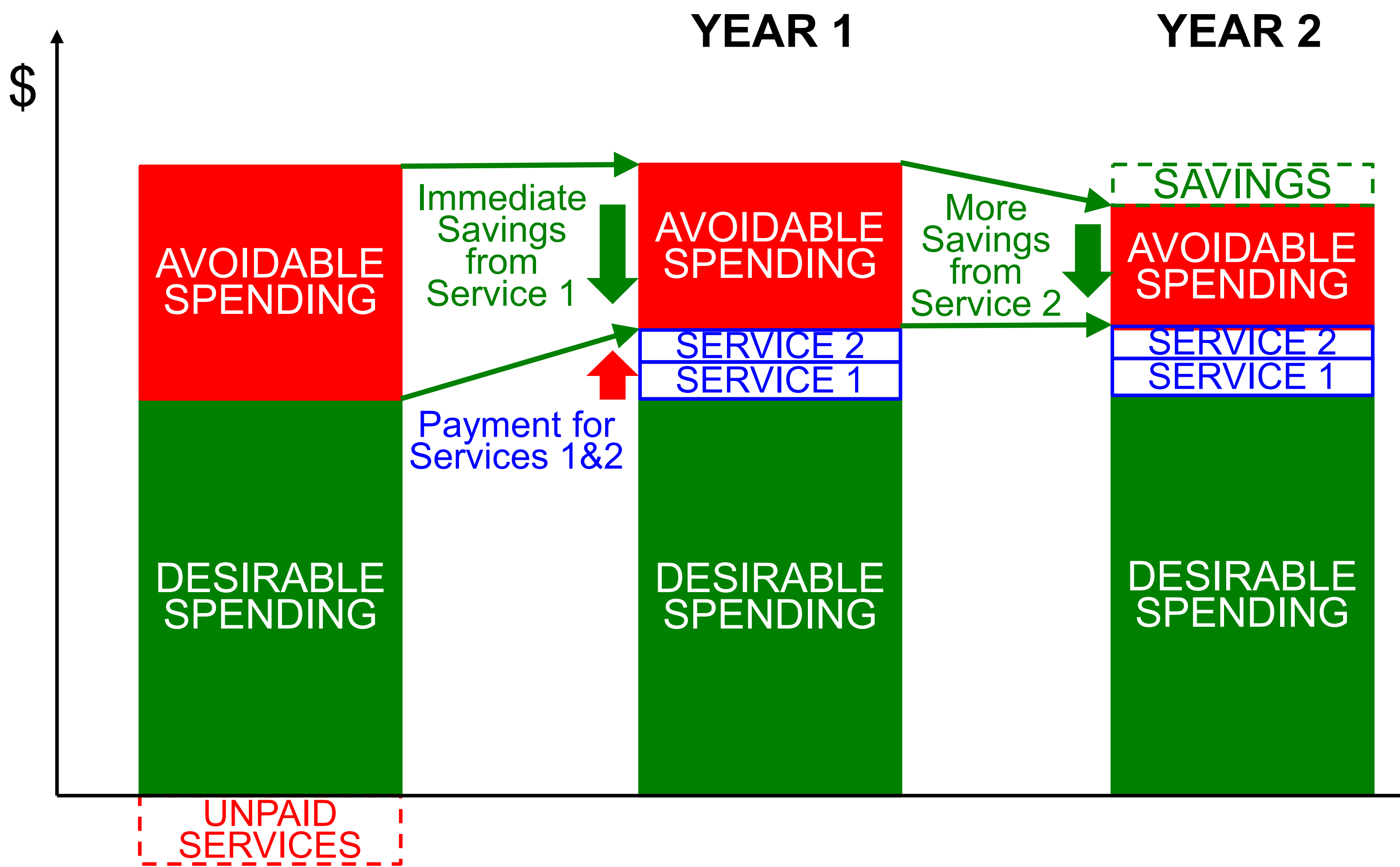


Example: Reducing Repeat Unplanned Pregnancies

		CURRENT		
		$/Service	#/Yr	Total $
Physician Svcs				
	1st Pregnancy	$1,500	100	$150,000
	Postpartum	$0	100	$0
	2nd Pregnancy	$1,500	30	$45,000
	Subtotal			$195,000
Hospital Pmt				
	1st Pregnancy	$3,500	100	$350,000
	2nd Pregnancy	$3,500	30	$105,000
Total Spending			100	$650,000

100
Pregnant Women on Medicaid

- Physician delivers babies in the hospital
- Postpartum care included in physician's global fee; no separate or additional payment made
- 30 percent of women have a subsequent unplanned pregnancy

Pay More for Postpartum Care After Initial Pregnancy?

		CURRENT			FUTURE			
		$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs								
	1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
	Postpartum	$0	100	$0	$350	100	$35,000	
	2nd Pregnancy	$1,500	30	$45,000				
	Subtotal			$195,000				
Hospital Pmt								
	1st Pregnancy	$3,500	100	$350,000				
	2nd Pregnancy	$3,500	30	$105,000				
Total Spending			100	$650,000				

More Payment Increases Costs If No Impact on 2nd Pregnancies

	CURRENT			FUTURE			
	$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$350	100	$35,000	
2nd Pregnancy	$1,500	30	$45,000	$1,500	30	$45,000	-0%
Subtotal			$195,000			$230,000	+18%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000	$3,500	100	$350,000	
2nd Pregnancy	$3,500	30	$105,000	$3,500	30	$105,000	-0%
Total Spending		100	$650,000		100	$685,000	+5%

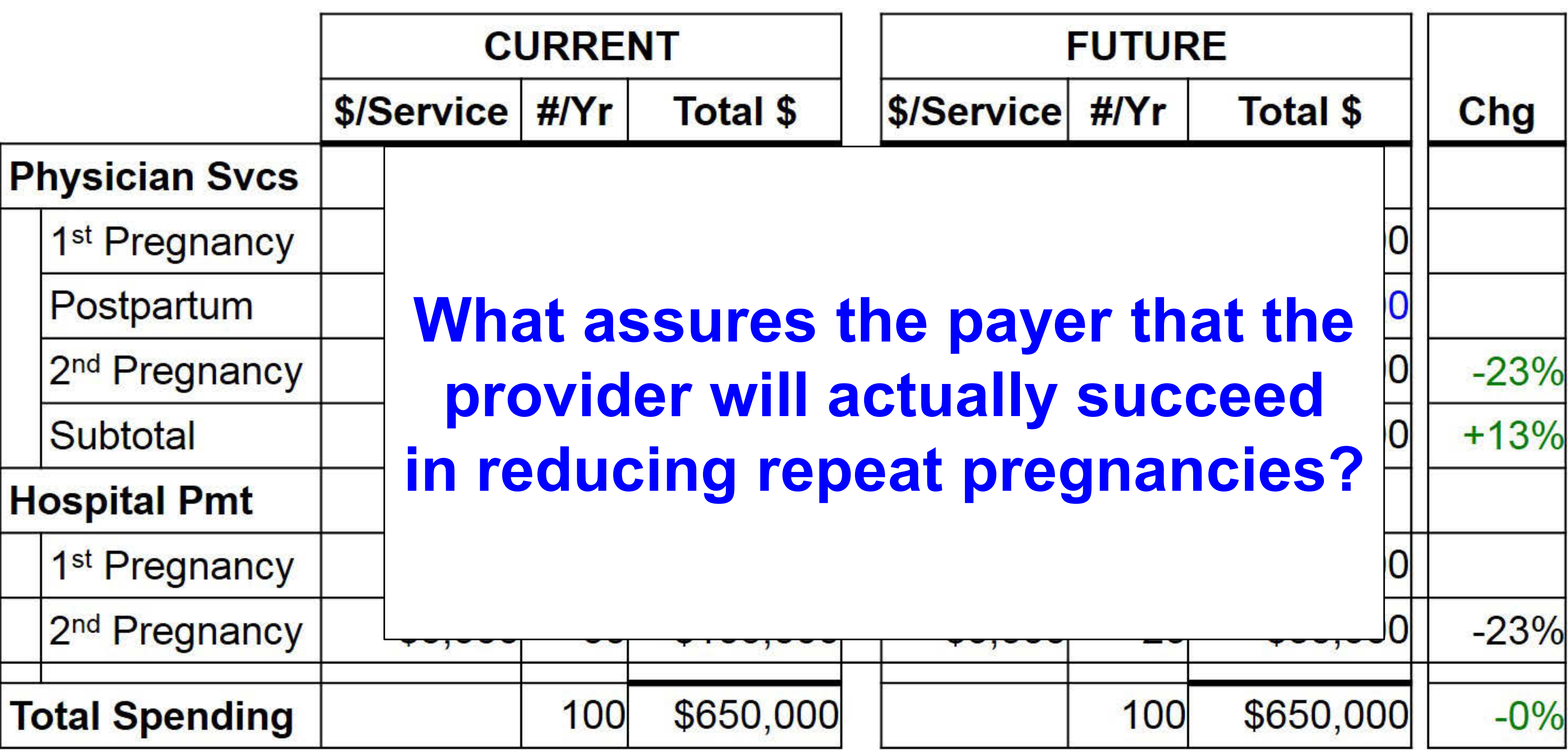
But Success in Reducing 2nd Pregnancies Reduces Total Costs

	CURRENT			FUTURE			
	$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$350	100	$35,000	
2nd Pregnancy	$1,500	30	$45,000	$1,500	15	$22,500	-50%
Subtotal			$195,000			$207,500	+6%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000	$3,500	100	$350,000	
2nd Pregnancy	$3,500	30	$105,000	$3,500	15	$52,500	-50%
Total Spending		100	$650,000		100	$610,000	-6%

Affordable Upfront Payment Depends on Minimum Results

	CURRENT			FUTURE			
	$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$350	100	$35,000	
2nd Pregnancy	$1,500	30	$45,000	$1,500	23	$34,500	-23%
Subtotal			$195,000			$219,500	+13%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000	$3,500	100	$350,000	
2nd Pregnancy	$3,500	30	$105,000	$3,500	23	$80,500	-23%
Total Spending		100	$650,000		100	$650,000	-0%

Affordable Upfront Payment Depends on Minimum Results



Solution: Lower Upfront Payment With Bonus for Success

	CURRENT			FUTURE			
	$/Service	**#/Yr**	**Total $**	**$/Service**	**#/Yr**	**Total $**	**Chg**
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$250	100	$25,000	
2nd Pregnancy	$1,500	30	$45,000	$1,500	20	$30,000	0%
Bonus				$1,000	10	$10,000	
Subtotal			$195,000			$215,000	+10%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000	$3,500	100	$350,000	
2nd Pregnancy	$3,500	30	$105,000	$3,500	20	$70,000	0%
Total Spending		100	$650,000		100	$635,000	-2%

Better Results = Higher Payment

		CURRENT			FUTURE			
		$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs								
	1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
	Postpartum	$0	100	$0	$250	100	$25,000	
	2nd Pregnancy	$1,500	30	$45,000	$1,500	15	$22,500	-50%
	Bonus				$1,000	15	$15,000	
	Subtotal			$195,000			$212,500	+9%
Hospital Pmt								
	1st Pregnancy	$3,500	100	$350,000	$3,500	100	$350,000	
	2nd Pregnancy	$3,500	30	$105,000	$3,500	15	$52,500	-50%
Total Spending			100	$650,000		100	$615,000	-5%

Better Results = Higher Payment

	CURRENT			FUTURE			
	$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs							
1st Pregnancy						0	
Postpartum						0	
2nd Pregnancy						0	-50%
Bonus						0	
Subtotal						0	+9%
Hospital Pmt							
1st Pregnancy						0	
2nd Pregnancy	$3,500	30	$105,000	$3,500	15	$52,500	-50%
Total Spending		100	$650,000		100	$615,000	-5%

What assures the payer that the provider will even try to reduce repeat pregnancies?

"Accountability" Means Penalty for Failure, Not Just Bonus for Success

	CURRENT			FUTURE			
	$/Service	**#/Yr**	**Total $**	**$/Service**	**#/Yr**	**Total $**	**Chg**
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$250	100	$25,000	
2nd Pregnancy	$1,500	30	$45,000	$1,500	30	$45,000	-0%
Bonus < 23%				$2,000	0	$0	
Penalty > 23%				($3,500)	7	($24,500)	
Subtotal			$195,000			$195,500	0%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000	$3,500	100	$350,000	
2nd Pregnancy	$3,500	30	$105,000	$3,500	30	$105,000	-0%
Total Spending		100	$650,000		100	$650,000	0%

Hitting the Target Rate (23%) Allows Provider & Payer to Win

		CURRENT			FUTURE			
		$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs								
	1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
	Postpartum	$0	100	$0	$250	100	$25,000	
	2nd Pregnancy	$1,500	30	$45,000	$1,500	23	$35,500	-23%
	Bonus < 23%				$2,000	4	$8,000	
	Penalty > 23%				($3,500)	0	$0	
	Subtotal			$195,000			$209,500	+7%
Hospital Pmt								
	1st Pregnancy	$3,500	100	$350,000	$3,500	100	$350,000	
	2nd Pregnancy	$3,500	30	$105,000	$3,500	23	$80,500	-23%
Total Spending			100	$650,000		100	$640,000	-2%

Beating the Target Rate Allows Both Provider & Payer to Win More

	CURRENT			FUTURE			
	$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$250	100	$25,000	
2nd Pregnancy	$1,500	30	$45,000	$1,500	15	$22,500	-50%
Bonus < 23%				$2,000	8	$16,000	
Penalty > 23%				($3,500)	0	$0	
Subtotal			$195,000			$213,500	+9%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000	$3,500	100	$350,000	
2nd Pregnancy	$3,500	30	$105,000	$3,500	15	$52,500	-50%
Total Spending		100	$650,000		100	$616,000	-5%

Targeting Higher-Risk Population Allows More Upfront Investment

	CURRENT			FUTURE			
	$/Service	**#/Yr**	**Total $**	**$/Service**	**#/Yr**	**Total $**	**Chg**
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000				
Postpartum	$0	100	$0				
2nd Pregnancy	$1,500	70	$105,000				
Subtotal			$255,000				
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000				
2nd Pregnancy	$3,500	70	$245,000				
Total Spending		100	$850,000				

Greater Upfront Investment Plus Expectation of Bigger Impact

	CURRENT			FUTURE			
	$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$1,000	100	$100,000	
2nd Pregnancy	$1,500	70	$105,000				
Bonus < 40%				$2,000	0	$0	
Penalty > 40%				($3,300)	0	$0	
Subtotal			$255,000				
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000				
2nd Pregnancy	$3,500	70	$245,000				
Total Spending		100	$850,000				

Win-Win-Win for Patient, Provider & Payer If Target is Met/Exceeded

	CURRENT			FUTURE			
	$/Service	**#/Yr**	**Total $**	**$/Service**	**#/Yr**	**Total $**	**Chg**
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$1,000	100	$100,000	
2nd Pregnancy	$1,500	70	$105,000	$1,500	40	$60,000	-43%
Bonus < 40%				$2,000	0	$0	
Penalty > 40%				[illegible]	0	$0	
Subtotal			$255,[illegible]			$310,000	+22%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000	$3,500	100	$350,000	
2nd Pregnancy	$3,500	70	$245,000	$3,500	40	$140,000	-43%
Total Spending		100	$850,000		100	$800,000	-6%

Patient Wins

Provider Wins

Payer Wins

Challenges With the FFS+P4P Model

Challenges With the FFS+P4P Model

- The amount of additional upfront payment needs to be determined in advance and it may or may not be adequate
- Stratifying the population based on risk requires stratifying the payment amounts, which adds complexity to coding and billing and increases the likelihood of mismatches between payment amounts and resources needed
- The target performance rates need to be established before it is clear what can be accomplished
- Random variation in patient characteristics can cause windfall bonuses and penalties and lack of predictability for both payers and providers
- The complexity and problematic incentives of FFS continue

Simply Paying More for “Postpartum Care” is Problematic

- There is little or no evidence that postpartum care services for all patients is cost-effective
- A payment that is too small or that is ineffectively targeted could fail to achieve the desired results, could increase net spending, and could cause failure of the overall initiative
- The goal should be achieving outcomes, not (simply) paying for specific services
- The strategy should be to target the right kinds of resources on the patients who will benefit from them

A Better Way: Condition-Based Payment

		CURRENT		
		$/Service	#/Yr	Total $
Physician Svcs				
	1st Pregnancy	$1,500	100	$150,000
	Postpartum	$0	100	$0
	2nd Pregnancy	$1,500	30	$45,000
	Subtotal			$195,000
Hospital Pmt				
	1st Pregnancy	$3,500	100	$350,000
	2nd Pregnancy	$3,500	30	$105,000
Total Spending		$6,500	100	$650,000

100
Pregnant Women on Medicaid

- Physician delivers babies in the hospital
- Postpartum care included in physician's global fee; no separate or additional payment made
- 30 percent of women have a subsequent unplanned pregnancy

Start With What's Being Spent Today…

		CURRENT		
		$/Service	#/Yr	Total $
Physician Svcs				
	1st Pregnancy	$1,500	100	$150,000
	Postpartum	$0	100	$0
	2nd Pregnancy	$1,500	30	$45,000
	Subtotal			$195,000
Hospital Pmt				
	1st Pregnancy	$3,500	100	$350,000
	2nd Pregnancy	$3,500	30	$105,000
Total Spending		$6,500	100	$650,000

…Agree to Do It for *Less*, But With Flexibility to Spend $ *Differently*

		CURRENT			FUTURE			
		$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs								
	1st Pregnancy	$1,500	100	$150,000				
	Postpartum	$0	100	$0				
	2nd Pregnancy	$1,500	30	$45,000				
	Margin							
	Subtotal			$195,000				
Hospital Pmt								
	1st Pregnancy	$3,500	100	$350,000				
	2nd Pregnancy	$3,500	30	$105,000				
Total Spending		$6,500	100	~~$650,000~~	$6,400	100	$640,000	-2%

Use the Payment as a Budget to Allocate Among Providers

		CURRENT			FUTURE			
		$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs								
	1st Pregnancy	$1,500	100	$150,000				
	Postpartum	$0	100	$0				
	2nd Pregnancy	$1,500	30	$45,000				
	Margin							
	Subtotal			$195,000			$209,500	+7%
Hospital Pmt								
	1st Pregnancy	$3,500	100	$350,000		100	$350,000	
	2nd Pregnancy	$3,500	30	$105,000		23	$80,500	23%
Total Spending		$6,500	100	$650,000	$6,400	100	$640,000	-2%

Providers "Pay" Themselves in Whatever Way Makes Sense

	CURRENT			FUTURE			
	$/Service	**#/Yr**	**Total $**	**$/Service**	**#/Yr**	**Total $**	**Chg**
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$250	100	$25,000	
2nd Pregnancy	$1,500	30	$45,000	$1,500	23	$34,500	-23%
Margin						$0	
Subtotal			$195,000			$209,500	+7%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000		100	$350,000	
2nd Pregnancy	$3,500	30	$105,000		23	$80,500	-23%
Total Spending	$6,500	100	$650,000	$6,400	100	$640,000	-2%

E.g. Provide Services Prior to Delivery as Well as After

	CURRENT			FUTURE			
	$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$150	100	$15,000	
2nd Pregnancy	$1,500	30	$45,000	$1,500	23	$34,500	-23%
Prenatal				$100	100	$10,000	
Margin						$0	
Subtotal			$195,000			$209,500	+7%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000		100	$350,000	
2nd Pregnancy	$3,500	30	$105,000		23	$80,500	-23%
Total Spending	$6,500	100	$650,000	$6,400	100	$640,000	-2%

Win-Win-Win for Patients, Provider, and Payer

	CURRENT			FUTURE			
	$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs							
1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
Postpartum	$0	100	$0	$250	100	$25,000	
2nd Pregnancy	$1,500	30	$45,000	$1,500	23	$34,500	-23%
Margin						$0	
Subtotal			$195,[illegible]			$209,500	+7%
Hospital Pmt							
1st Pregnancy	$3,500	100	$350,000		100	$350,000	
2nd Pregnancy	$3,500	30	$105,000		23	$80,500	-23%
Total Spending	$6,500	100	$650,000	$6,400	100	$640,000	-2%

Patient Wins

Provider Wins

Payer Wins

Better Performance for Patients, Bigger Win for Provider

		CURRENT			FUTURE			
		$/Service	#/Yr	Total $	$/Service	#/Yr	Total $	Chg
Physician Svcs								
	1st Pregnancy	$1,500	100	$150,000	$1,500	100	$150,000	
	Postpartum	$0	100	$0	$250	100	$25,000	
	2nd Pregnancy	$1,500	30	$45,000	$1,500	15	$22,500	-50%
	Margin						$40,000	
	Subtotal			$195,[illegible]			$237,500	+22%
Hospital Pmt								
	1st Pregnancy	$3,500	100	$350,000		100	$350,000	
	2nd Pregnancy	$3,500	30	$105,000		15	$52,500	-50%
Total Spending		$6,500	100	$650,000	$6,400	100	$640,000	-2%

Patient Wins

Provider Wins

Payer Wins

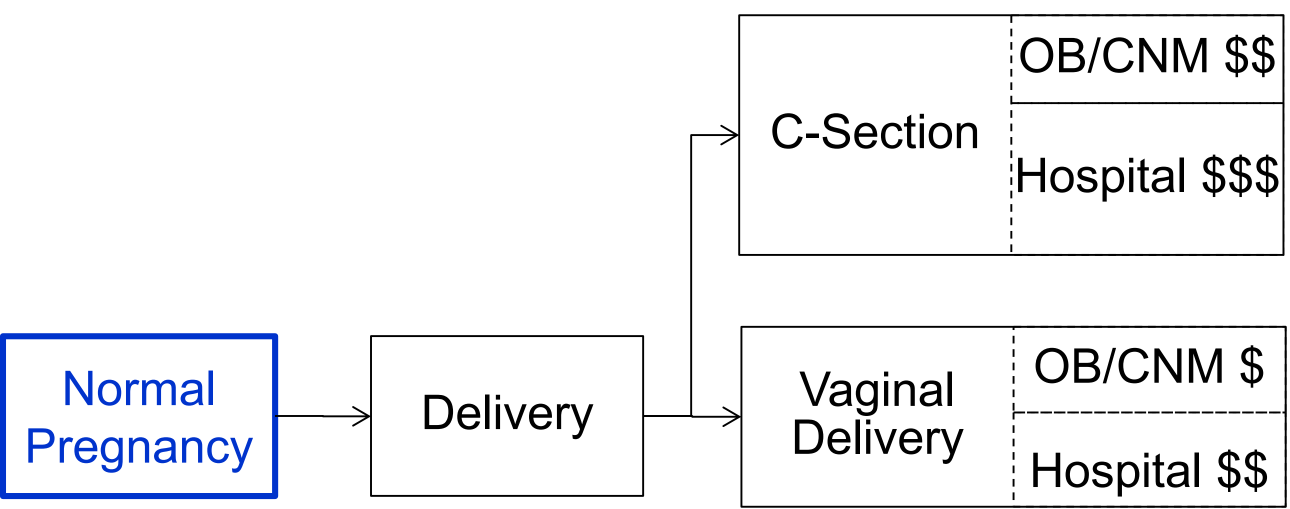
Accountable Payment Models Provide Flexibility + Accountability

BUILDING BLOCKS	HOW IT WORKS
Bundled Payment	Single payment to 2+ providers who are now paid separately (e.g., hospital + physician)
Warrantied Payment	Higher payment for quality care, no extra payment for avoiding complications
Condition-Based Payment	Payment based on the patient's condition, rather than on the procedure used

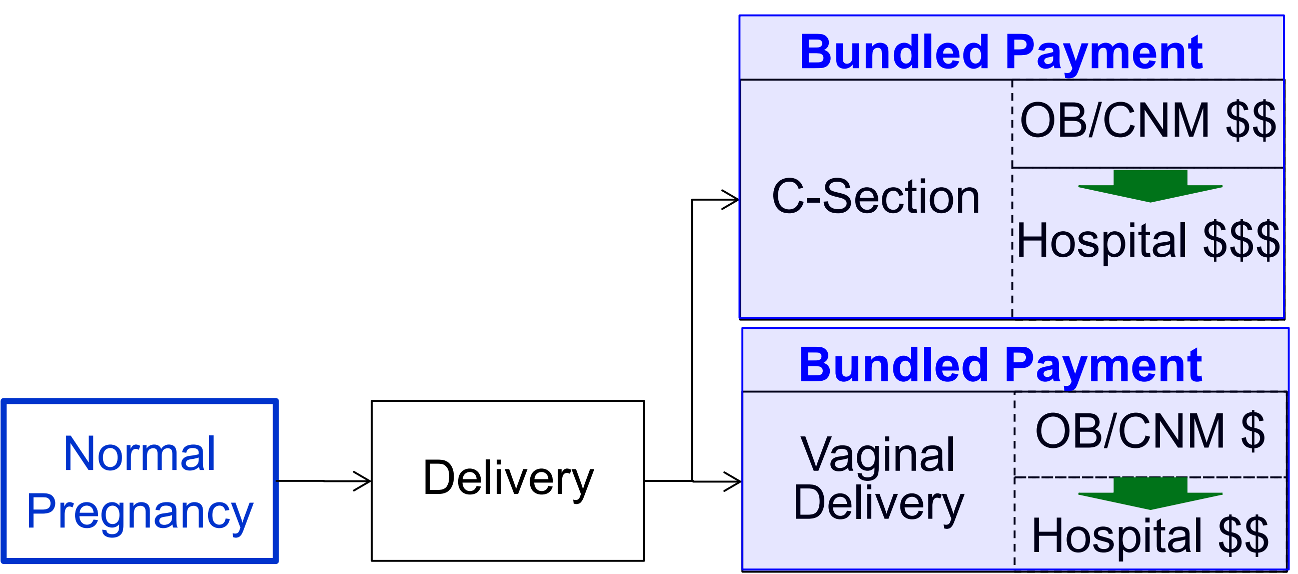
Accountable Payment Models Allow Win-Win-Win Approaches

BUILDING BLOCKS	HOW IT WORKS	HOW PHYSICIANS AND HOSPITALS CAN BENEFIT	HOW PAYERS CAN BENEFIT
Bundled Payment	Single payment to 2+ providers who are now paid separately (e.g., hospital + physician)	Higher payment for physicians if they reduce costs paid by hospitals	Physician and hospital offer a lower total price to Medicaid or health plan than today
Warrantied Payment	Higher payment for quality care, no extra payment for avoiding complications	Higher payment for physicians and hospitals with low rates of complications	Medicaid or health plan no longer pays more for high rates of complications
Condition-Based Payment	Payment based on the patient's condition, rather than on the procedure used	No loss of payment for physicians and hospitals using fewer tests and procedures	Medicaid or health plan no longer pays more for unnecessary procedures

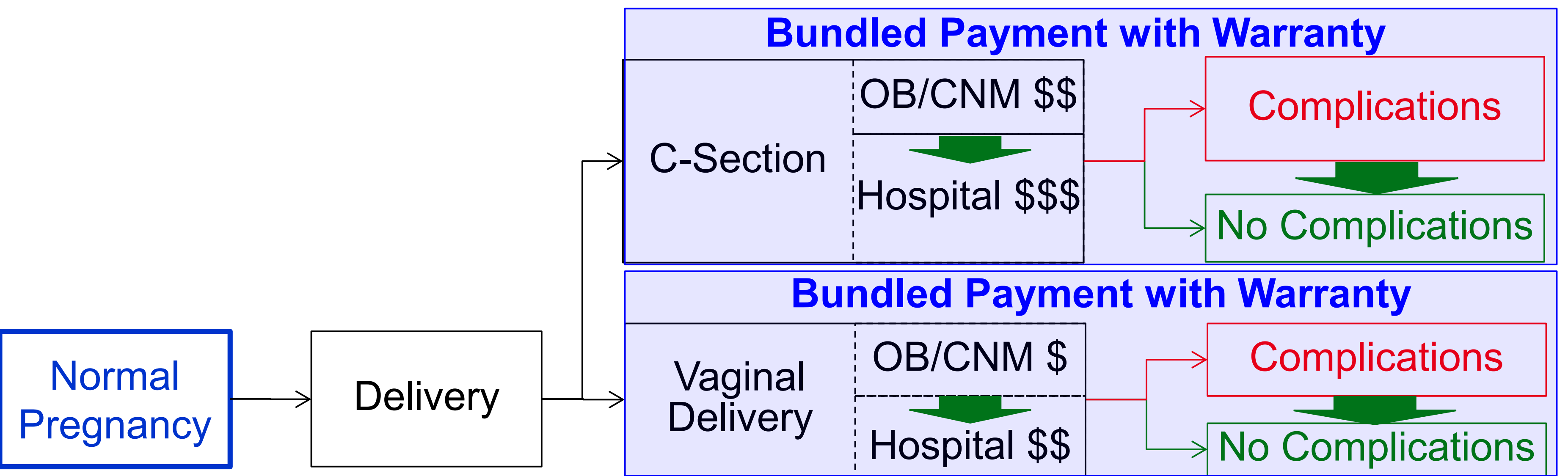
Many Opportunities for Savings With Appropriate Payment Reforms



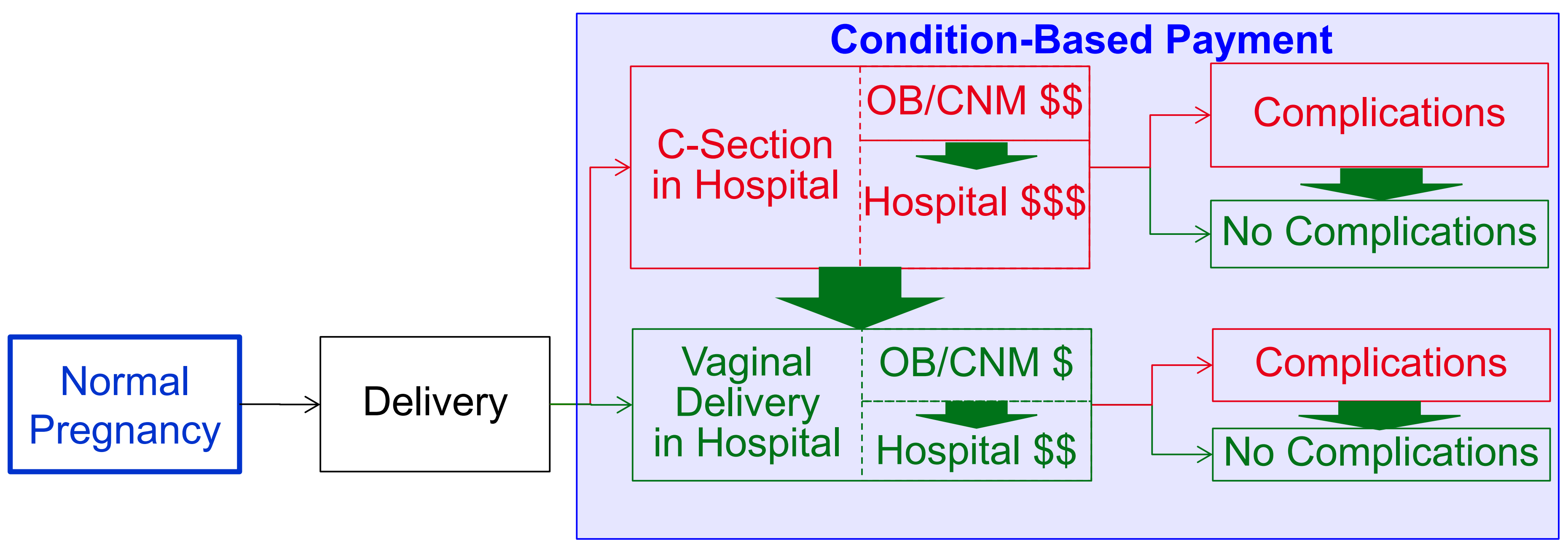
Bundles to Encourage Physicians to Reduce Hospital Costs



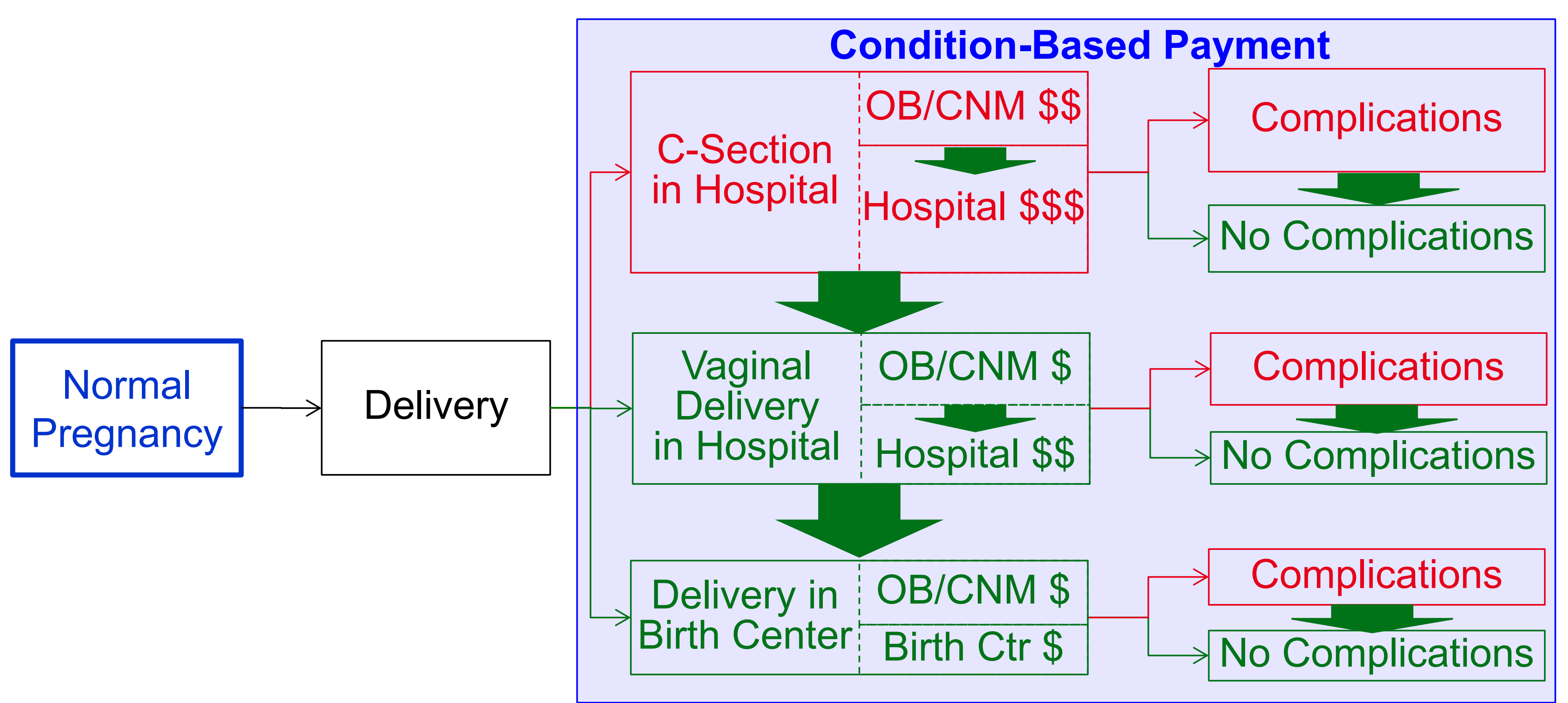
Warranties to Support Reductions in Delivery-Related Complications



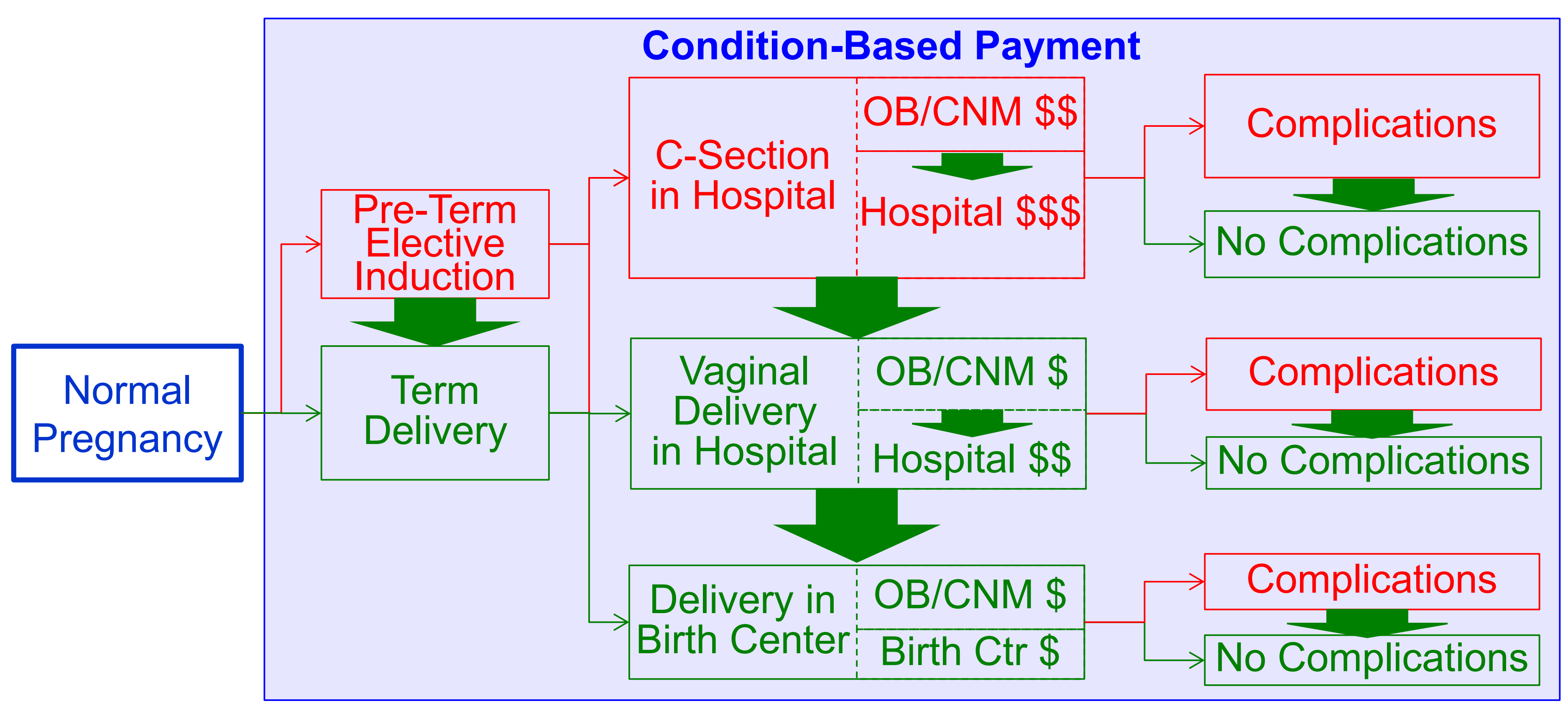
Condition-Based Payment to Encourage More Vaginal Deliveries



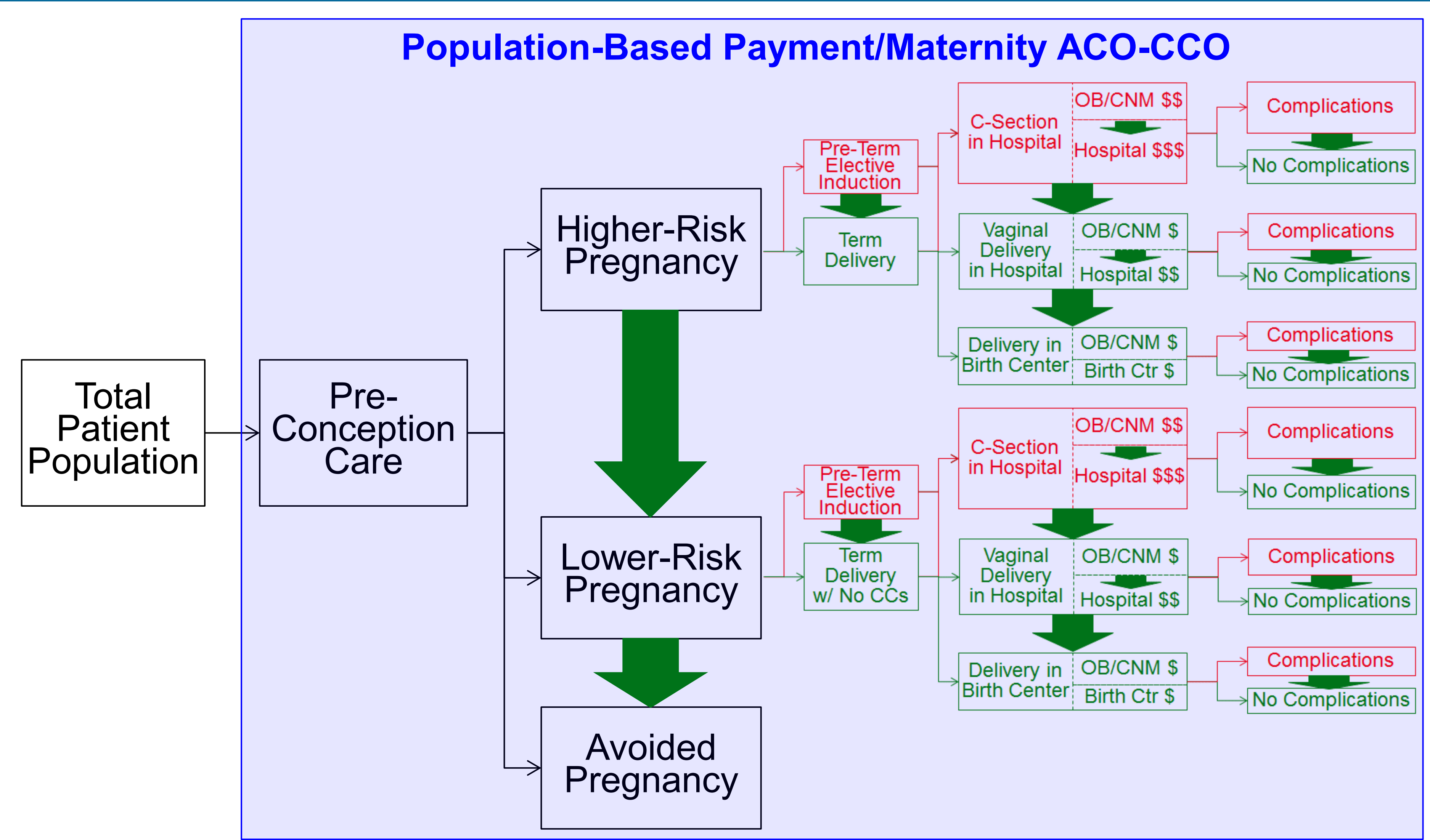
Condition-Based Payment Can Encourage Lower-Cost Settings



Risk-Adjusted Payment Can Help Reduce Inappropriate Care



Payment Can Also Move Upstream to Improve Outcomes



How Do You Develop Win-Win-Win Solutions?

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1. **Defining the Change in Care Delivery**
   - How can care be redesigned to improve quality and reduce costs?

How Do You Develop Win-Win-Win Solutions?

1. **Defining the Change in Care Delivery**
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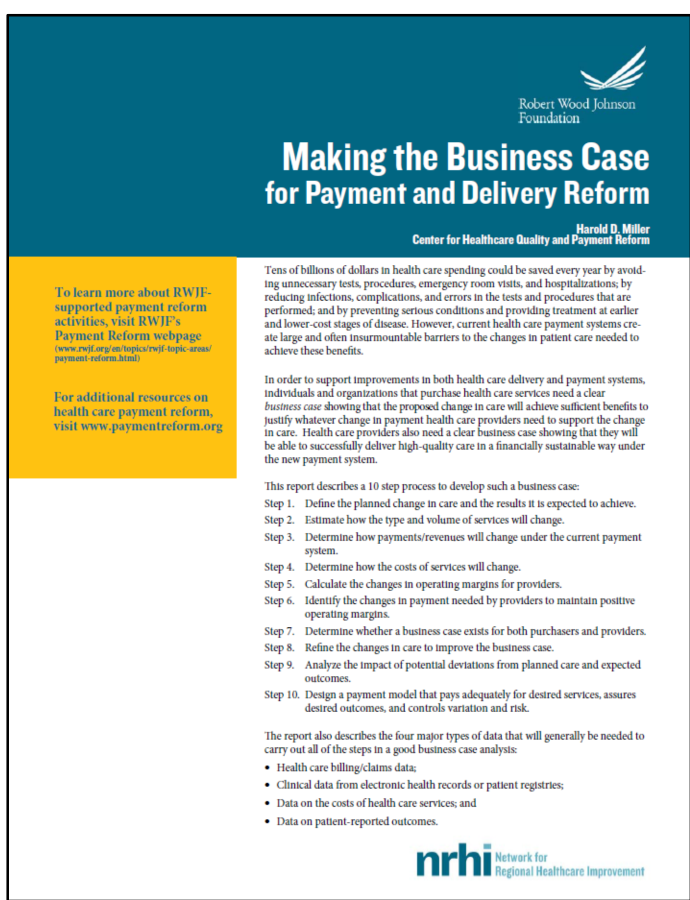
2. **Analyzing Expected Costs and Savings**
   - What will there be less of, and how much does that save?
   - What will there be more of, and how much does that cost?
   - Will the savings offset the costs on average?

More Detail on How to Create a Business Case for Payment Reform



Robert Wood Johnson Foundation

Making the Business Case for Payment and Delivery Reform

Harold D. Miller
Center for Healthcare Quality and Payment Reform

To learn more about RWJF-supported payment reform activities, visit RWJF's Payment Reform webpage (www.rwjf.org/en/topics/rwjf-topic-areas/payment-reform.html)

For additional resources on health care payment reform, visit www.paymentreform.org

Tens of billions of dollars in health care spending could be saved every year by avoiding unnecessary tests, procedures, emergency room visits, and hospitalizations; by reducing infections, complications, and errors in the tests and procedures that are performed; and by preventing serious conditions and providing treatment at earlier and lower-cost stages of disease. However, current health care payment systems create large and often insurmountable barriers to the changes in patient care needed to achieve these benefits.

In order to support improvements in both health care delivery and payment systems, individuals and organizations that purchase health care services need a clear *business case* showing that the proposed change in care will achieve sufficient benefits to justify whatever change in payment health care providers need to support the change in care. Health care providers also need a clear business case showing that they will be able to successfully deliver high-quality care in a financially sustainable way under the new payment system.

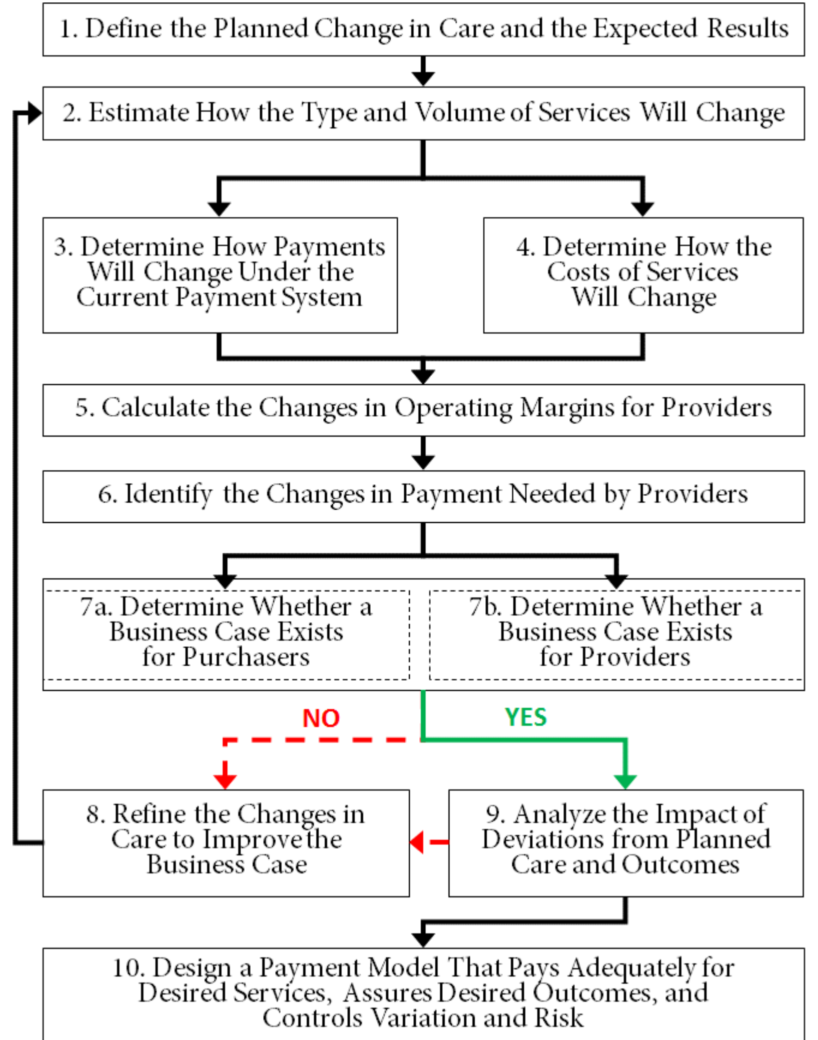
This report describes a 10 step process to develop such a business case:

- Step 1. Define the planned change in care and the results it is expected to achieve.
- Step 2. Estimate how the type and volume of services will change.
- Step 3. Determine how payments/revenues will change under the current payment system.
- Step 4. Determine how the costs of services will change.
- Step 5. Calculate the changes in operating margins for providers.
- Step 6. Identify the changes in payment needed by providers to maintain positive operating margins.
- Step 7. Determine whether a business case exists for both purchasers and providers.
- Step 8. Refine the changes in care to improve the business case.
- Step 9. Analyze the impact of potential deviations from planned care and expected outcomes.
- Step 10. Design a payment model that pays adequately for desired services, assures desired outcomes, and controls variation and risk.

The report also describes the four major types of data that will generally be needed to carry out all of the steps in a good business case analysis:

- Health care billing/claims data;
- Clinical data from electronic health records or patient registries;
- Data on the costs of health care services; and
- Data on patient-reported outcomes.

nrhi Network for Regional Healthcare Improvement



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A Critical Element is Shared, Trusted Data

- **Providers** need to know the current utilization and costs for their patients to know whether the condition-based or bundled/warrantied payment amount will cover the costs of delivering effective care to the patients
- **Purchaser/Payer** needs to know the current utilization and costs to know whether the condition-based or bundled/warrantied payment amount is a better deal than they have today
- **Both** sets of data have to match in order for providers and payers to agree on the new approach!

How Do You Develop Win-Win-Win Solutions?

1. **Defining the Change in Care Delivery**
   - How can care be redesigned to improve quality and reduce costs?
2. **Analyzing Expected Costs and Savings**
   - What will there be less of, and how much does that save?
   - What will there be more of, and how much does that cost?
   - Will the savings offset the costs on average?
3. **Designing a Payment Model That Supports Change**
   - Flexibility to change the way care is delivered
   - Accountability for costs and quality/outcomes related to care
   - Adequate payment to cover lowest-achievable costs
   - Protection for the provider against unmanageable risk

The Four Key Elements of Successful Payment Reforms

1. **Flexibility in Care Delivery.** The payment system should give providers freedom to deliver care in ways that will achieve high quality in the most efficient way and to adjust care delivery to the unique needs of individual patients.
2. **Appropriate Accountability for Spending.** The payment system should assure purchasers and payers that spending will decrease (or grow more slowly). The payment system should hold providers accountable for utilization and spending they can control, but not for services or costs they cannot control or influence.
3. **Appropriate Accountability for Quality.** The payment system should assure patients and payers that the quality of care will remain the same or improve. The payment system should hold providers accountable for quality they can control, but not for aspects of quality or outcomes they cannot control or influence.
4. **Adequacy of Payment**. The size of the payments should be adequate to cover the providers' costs of delivering high quality care for the types of patients they see and at the levels of cost or efficiency that are feasible for them to achieve.

Protections For Providers Against Taking Unmanageable Risk

- **Risk Adjustment:** The payment rates to the provider would be adjusted based on objective characteristics of the patient and treatment that would be expected to result in the need for more services or increase the risk of complications.
- **Outlier Payment or Individual Stop Loss Insurance:** The payment to the provider from the payer would be increased if spending on an individual patient exceeds a pre-defined threshold. An alternative would be for the provider to purchase individual stop loss insurance (sometimes referred to as reinsurance) and include the cost of the insurance in the payment bundle.
- **Risk Corridors or Aggregate Stop Loss Insurance:** The payment to the provider would be increased if spending on all patients exceeds a pre-defined percentage above the payments. An alternative would be for the provider to purchase aggregate stop loss insurance and include the cost of the insurance in the payment bundle.
- **Adjustment for External Price Changes:** The payment to the provider would be adjusted for changes in the prices of drugs or services from other providers that are beyond the control of the provider accepting the payment.
- **Excluded Services:** Services the provider does not deliver, or order, or otherwise have the ability to influence would not be included as part of accountability measures in the payment system.

Quality Measures Should Focus on Protecting Against *Underuse*

- ***Eliminate* measures that impede or duplicate the incentives in the new payment system**
  - Process measures that dictate specific approaches without strong evidence of necessity
  - Overused and expensive services
- ***Emphasize* measures that protect against underuse**
  - Preventive services with longer-term benefits
  - Expensive services with strong evidence of benefit and serious impacts from failure to use when appropriate
- **Implement *appropriate use* criteria wherever possible**
  - Help providers *avoid unnecessary* services
  - Ensure patients *receive necessary* services

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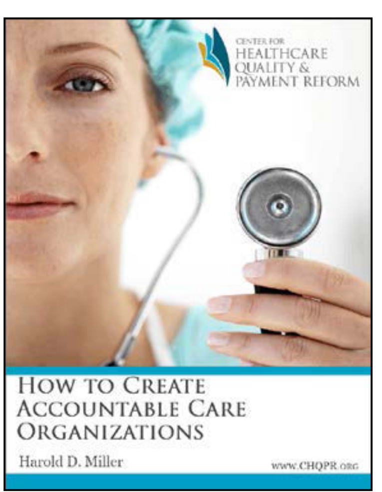
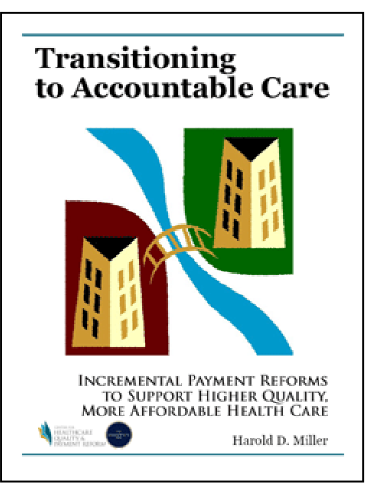
   - Accountability for costs and quality/outcomes related to care
   - Adequate payment to cover lowest-achievable costs
   - Protection for the provider
4. **Trust, Transparency, and Collaborative Problem-Solving**
   - Recognition that only win-win-win solutions are sustainable
   - Willingness to share accurate information on costs in order to develop win-win-win approaches
   - Commitment to revise payments as necessary when costs, utilization, etc. do not turn out as expected

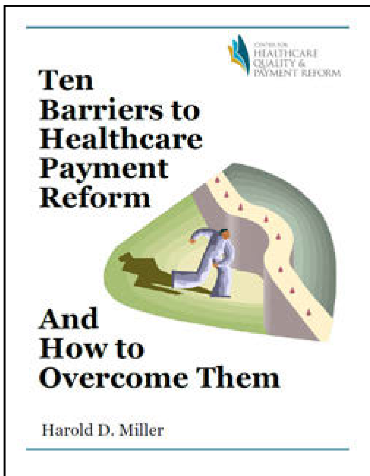
The Result: Better Maternity Care

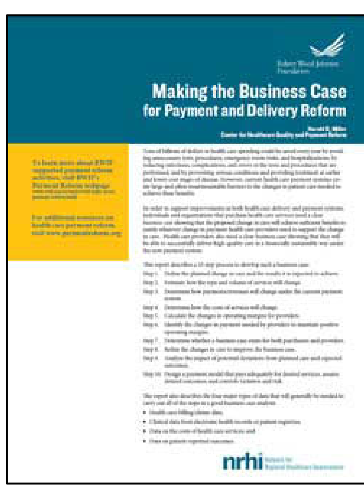
- **Better Care for Patients**
  - Providers having the flexibility to design care that matches patient needs
- **Lower Spending for Payers**
  - Providers able to use the best combination of services for patients without worrying about which service generates more profits
- **Financially Viable Healthcare Providers**
  - Physicians, hospitals, hospice agencies, and other providers paid adequately to deliver high-quality care

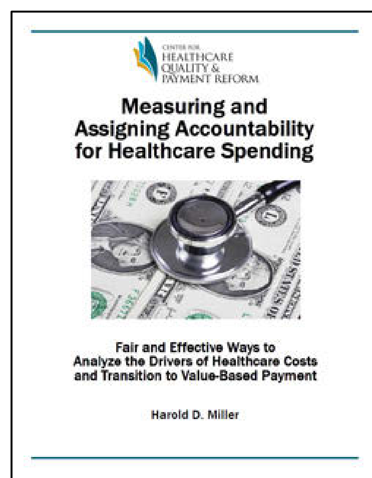
Learn More About Win-Win-Win Payment and Delivery Reform











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For More Information:

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www.PaymentReform.org

Questions?

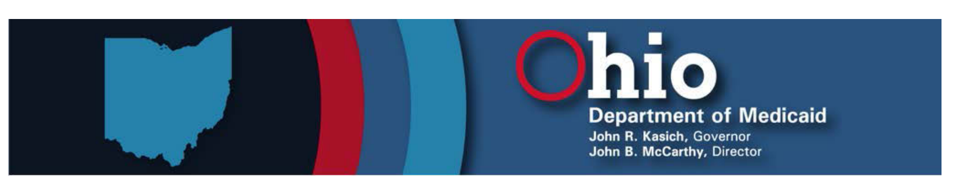
- To pose a question to the presenters or to the group, click on the “Q&A” widget at the bottom and submit your question.
- Please note, your questions can only be seen by our presentation team and are not viewable by other attendees.

State Perspective:
Improving Post Partum Visit Rates through Value Based Purchasing

Mary Applegate, MD, FAAP, FACP

Medical Director

Ohio Department of Medicaid



Ohio's Postpartum Care Rates by County, 2013

WILLIAMS
FULTON
LUCAS
OTTAWA
DEFIANCE
HENRY
WOOD
SANDUSKY
ERIE
LORAIN
CUYAHOGA
LAKE
GEAUGA
ASHTABULA
TRUMBULL
PAULDING
PUTNAM
HANCOCK
SENECA
HURON
MEDINA
SUMMIT
PORTAGE
MAHONING
VAN WERT
ALLEN
WYANDOT
CRAWFORD
RICHLAND
ASHLAND
WAYNE
STARK
COLUMBIANA
MERCER
AUGLAIZE
HARDIN
MARION
MORROW
KNOX
HOLMES
TUSCAR-AWAS
CARROLL
JEFFER-SON
SHELBY
LOGAN
UNION
DELAWARE
COSHOCTON
HARRISON
DARKE
MIAMI
CHAMPAIGN
CLARK
MADISON
FRANKLIN
LICKING
MUSKINGUM
GUERNSEY
BELMONT
PREBLE
MONTGO-MERY
GREENE
PICKAWAY
FAIRFIELD
PERRY
NOBLE
MONROE
MORGAN
FAYETTE
HOCKING
WASHINGTON
BUTLER
WARREN
CLINTON
ROSS
ATHENS
VINTON
HAMILTON
CLER-MONT
HIGHLAND
PIKE
JACKSON
MEIGS
GALLIA
BROWN
ADAMS
SCIOTO
LAWRENCE

Postpartum Rate by County Legend

- 70% to 76%
- 65% to 69%
- 60% to 64%
- 50% to 59%
- 45.5% to 49%

Why Ohio Needs a Different Approach

- **Postpartum visit rates have not improved much despite efforts**
  - Managed care plan contracting changes
  - Performance Improvement Projects
  - P4P/bonus payment at plan and provider levels
  - Local MCH efforts
  - Grants, including **disparity-focused** efforts
  - Outreach, including the use of community health workers
  - Decades of historic payment after the delivery of the infant creating a culture of expectations and roles/responsibilities
- **Conclusion: There will be no significant change in postpartum care visits unless we change how we pay for value in health care**, honoring the “life course” perspective, covering critical transitions with culturally competent engagement and ongoing connectivity.

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Ohio: Delivering the BEST BABY BUNDLE
that includes the postpartum visit

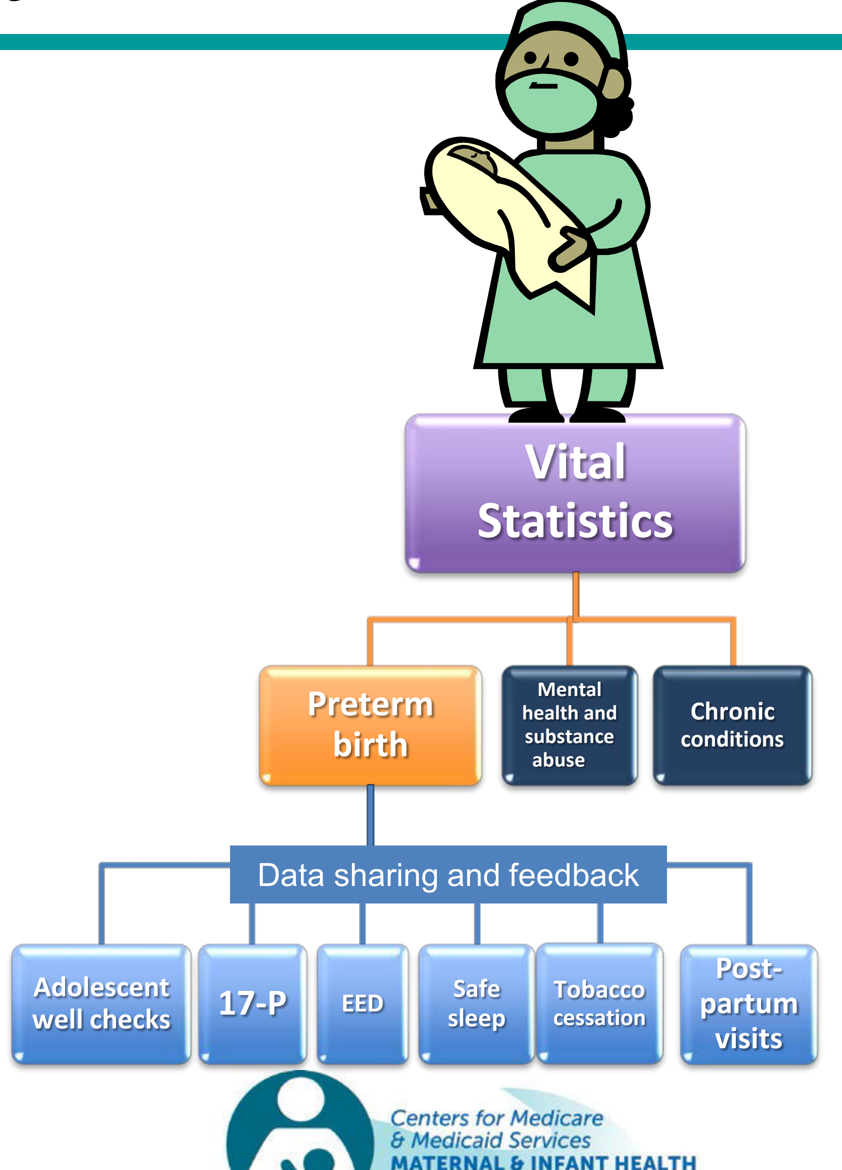
Develop system
- Affordable Care Act and insurance coverage

Get everyone in the system
- Enrollment
- Outreach

Identify risk
- Timely identification of pregnancy
- Non-pregnant high risk (pre- and inter-conception populations)

Provide enhanced services
- Pregnant
- Non-pregnant (pre- and inter-conception populations)

Maintain and support life course
- Community health workers
- Centering, integrated care models
- Policy and value-based purchasing



Shift to population- and episode-based payment for 80 to 90 percent of the population in 5 years

Payment approach

- **Fee-for-service** (including pay for performance)
- **Episode-based**
- **Population-based** (PCMH, ACOs, capitation)

Most applicable for

- Discrete services correlated with favorable outcomes or lower cost

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- Acute procedures or outpatient care (CABG, TJR, stent, fractures)
- Most inpatient (newborn delivery) stays including post-acute care, readmissions

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- Primary prevention for healthy population
- Care for chronically ill (e.g., managing obesity, CHF)

Elements of the episode definition

Category	Description
1 Episode trigger	▪ Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window 3 Claims included	▪ **Pre-trigger window:** Time period prior to the trigger event; relevant care for the patient is included in the episode ▪ **Trigger window:** Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included ▪ **Post-trigger window:** Time period following trigger event; relevant care and complications are included in the episode
4 Principal accountable provider	▪ **Physician or physician group delivering the baby** – Identified as the billing provider on the professional claim with the delivery procedure

Elements of the episode definition, cont'd.

Category	Description
5 Quality metrics	▪ **Linked to gain sharing** – Percent of episodes with HIV screening – Percent of episodes with GBS screening – C-section gate – Percent of episodes with follow-up visit within 60 days (postpartum visit) ▪ **For reporting only** – Percent of episodes with gestational diabetes screening – Percent of episodes with hepatitis B screening – Number of ultrasounds – Percent of episodes with chlamydia screening
6 Potential risk factors	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted

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Perinatal: Patient Journey

Patient suspects pregnancy, may take a home test; 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

Potential episode trigger event:

Delivery
- The delivery, either vaginal or C-section, typically occurs in an inpatient 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 includes care only for the mother after delivery
Source: Clinical experts, team analysis

Source: Ohio Episode-Based Payment Model Clinical Design Team.

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Perinatal: Sources of Value

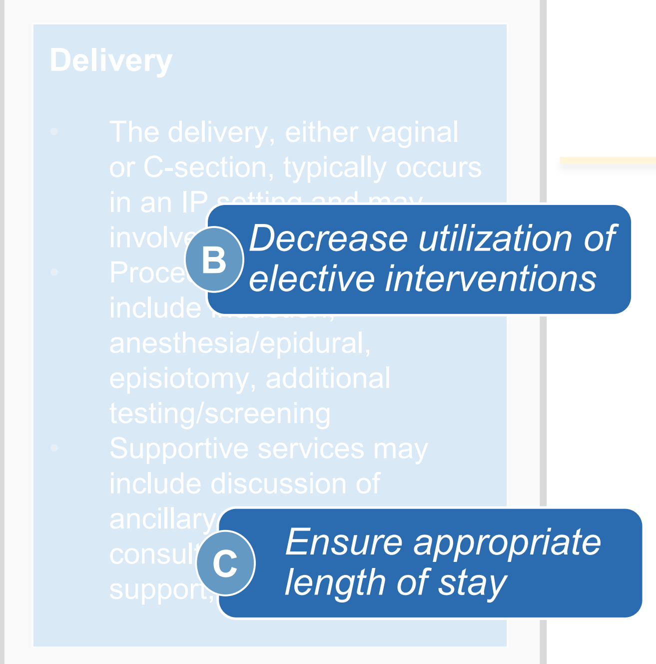
Patient suspects pregnancy, may take a home test; makes appointment to confirm pregnancy

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 E…
- Supportive … include p… evaluation, … education o… nutrition and breast feeding

A *Appropriate and effective mix of prenatal care*

Potential episode trigger event:



Postpartum care[1]

- Th… p… f… ev… education and counseling on topics including breast feeding and reproductive health planning including contraception

D *Increase promotion of desired post-natal practices*

Potential complications[1]

(e.g… postp… readmissions)

E *Reduce unnecessary readmissions*

Source: Ohio Episode-Based Payment Model Clinical Design Team.

Variation across the perinatal episode

Average cost ($) per episode, risk adjusted, excluding outliers

10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0

One driver of variation is the frequency and type of imaging, specifically ultrasounds

Principal Accountable Providers (PAPs)

Notes: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
Source: Analysis of Ohio Medicaid claims data, 2013-14.

Retrospective episode model mechanics

Patients and providers continue to deliver care as they do today

1

Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

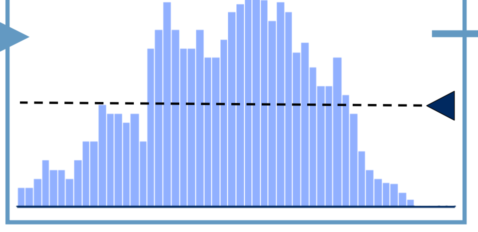
Payers reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from the performance period to identify a '**Principal Accountable Provider**' (PAP) for each episode

5 **Payers** calculate **average cost per episode** for each PAP

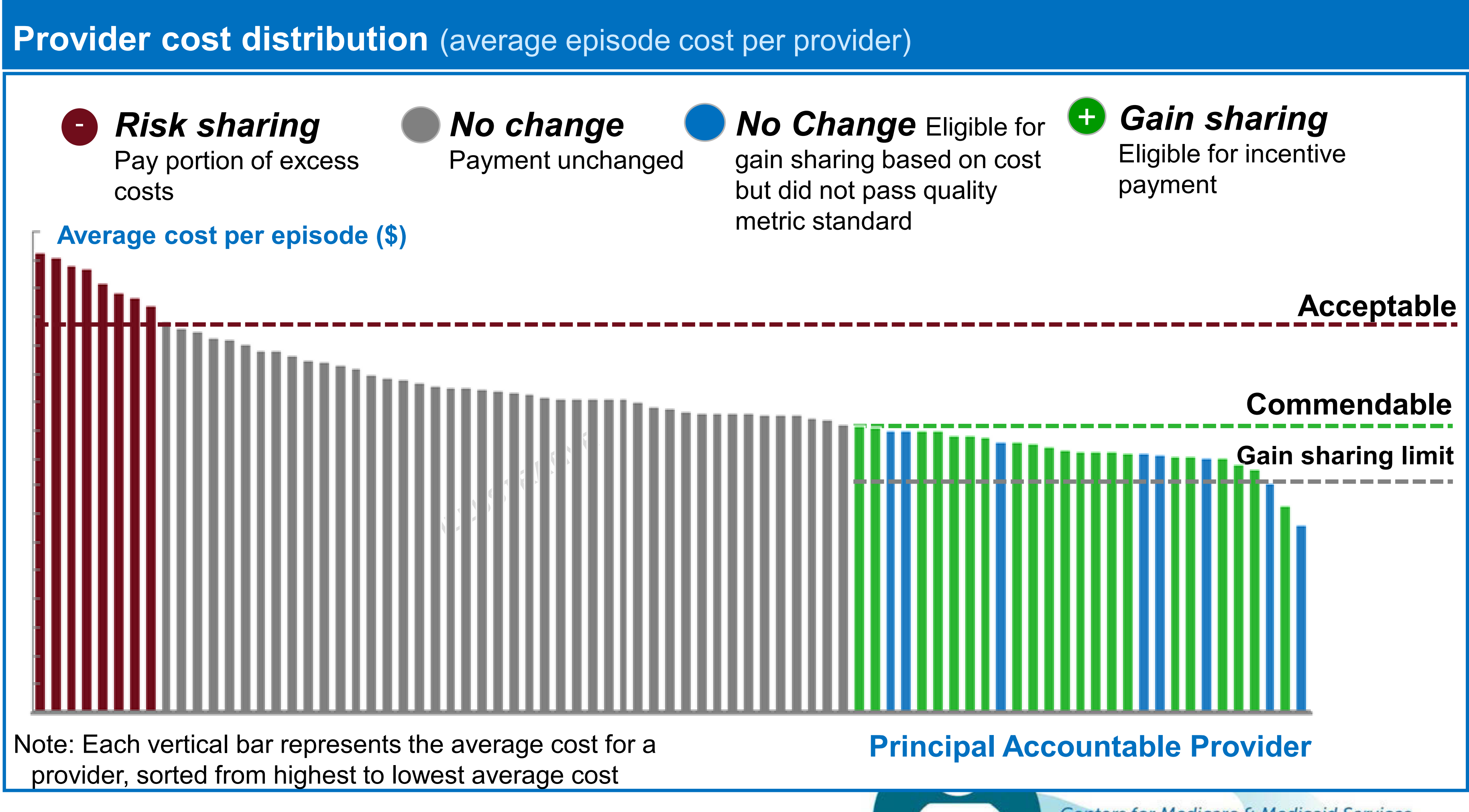


Compare average costs to predetermined "commendable" and "acceptable" levels

6 **Providers may**

- **Share savings** if average costs below commendable levels and quality targets are met
- **Pay part of excess cost** if average costs are above acceptable level
- **See no change in pay** if average costs are between commendable and acceptable levels

Retrospective thresholds reward cost-efficient, high-quality care



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Anthem

aetna

This is a sample report; actual reports will be released in 2015

EPISODE of CARE PAYMENT REPORT

PERINATAL — Jul 1, 2013 to Jun 30, 2014

Reporting period covering episodes that ended between July 1, 2013 and June 30, 2014

PAYER NAME: Ohio – Medicaid FFS PROVIDER CODE: 1234567 PROVIDER NAME: XYZ Women's Health Center

You would be eligible for gain or risk sharing of N/A[1]

Episodes inclusion and exclusion

Total episodes: 154

48% Excluded 74 Episodes

52% Included 80 Episodes

Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)

Avg. risk-adj. episode spend ($,000)

You are here $4,159

Episodes risk adjustment

95% of your episodes have been risk adjusted

Quality metrics

Your performance on quality metrics that will be ultimately linked to gain sharing

Metric	Performance
HIV screening	53%
GBS screening	71%
C-section	31%
Follow-up visit	30%

Potential gain/risk share

N/A[1]

1 Not applicable during reporting-only period

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Value Based Purchasing

- The postpartum visit is a REQUIRED quality measure to be eligible for gain sharing for perinatal (delivery) payments
- Ohio's first provider reports were posted March 2015, although payments based on performance will not begin until 2016
- Different communications, relationships and contracts between hospitals and obstetrical providers are expected, along with the engagement of non-traditional partners who may contribute to improved health outcomes

Questions?

- Stay tuned!
- Contact information

  Mary.applegate@Medicaid.ohio.gov

- To pose a question to the presenters or to the group, click on the “Q&A” widget at the bottom and submit your question.
- Please note, your questions can only be seen by our presentation team and are not viewable by other attendees.

State Perspective:
Perinatal Payment Strategies

Rebekah E Gee, MD, MPH, FACOG

Medicaid Medical Director, Louisiana

CMCS
Maternal and Infant Health Initiative
Next Steps

Lekisha Daniel-Robinson, MSPH
Coordinator, CMCS Maternal and Infant Health Initiative

CMCS Maternal and Infant Health Initiative Next Steps

- In collaboration with the Center for Medicare & Medicaid Innovation and the Medicaid Innovation Accelerator Program we will explore new payment models to support improved perinatal payment outcomes
- Issue guidance on payment strategies to achieve the MIHI goals
- Next webinar TBD in June/July 2015

Thank You and Survey

- Thank you for participating in today's webinar!
- Your opinion counts! Please complete the survey as you exit the webinar. The survey will appear in your browser window once the webinar ends.