

Transcript

Medicaid Value-Based Payment Approaches for Maternal and Infant Health National Learning Webinar

November 2, 2017

[Intro]

I'd like to introduce Crystal Tyler, Research Leader in the Center for Maternal and Child Health at IBM Watson Health.

Crystal Tyler (CT): Thank you and welcome everyone. Next slide.

The purpose of this webinar is to:

- Elaborate on the potential impact of payment reform on maternal and infant health outcomes.
- Describe value based payment approaches that states can implement to improve maternal and infant health outcomes and care quality indicators.
- And finally, to provide examples of state Medicaid value-based payment (VBP) approaches in the maternal and infant health field.

Next slide. During our webinar, we'll start by introducing today's presenters. Next, we'll provide an overview of the Medicaid Innovation Accelerator Program (IAP) and VBP Webinar series. We will describe the importance of payment reform in the maternal and infant health fields, and provide an overview of Medicaid VBP approaches in the maternal and infant health fields. Finally, we will end with state perspectives from Louisiana and Arkansas who have implemented VBP approaches to address maternal and infant health outcomes.

To break up the presentations a bit, we will have two opportunities for the audience to ask questions.

Next slide. Today's presentation will include speakers with expertise in maternal and infant health and VBPs, and in implementing VBP approaches to address maternal and infant health outcomes within a Medicaid setting.

First, we'll have Katherine Griffith from the Medicaid IAP and Crystal Tyler from IBM Watson Health. Dr. Mark Smith is also from IBM Watson health.

Next slide. We also have representatives from Louisiana and Arkansas.

From Louisiana, we have Dr. Pooja Mehta from the Louisiana State University Health Sciences Center, and Dr. William Golden from the Arkansas Division of Medical Services.

Next slide. First up we have Katherine Griffith from the Medicaid IAP.

Katherine Griffith (KG): Thank you, Crystal. On behalf of the Medicaid IAP, I'd like to welcome everybody here. We are so pleased to have people on our last VBP webinar in a series we've held over the last month. Before we jump into the exciting stuff, I always like to provide a little background on the Medicaid IAP for those who are new to the series. It is a technical support program that is based out of the Centers for Medicare and Medicaid and CHIP Services, but we partner with the Center for Medicare and Medicaid Innovation. We provide technical support to state Medicaid programs around

their delivery system reform needs, around various topics such as maternal and infant health, and VBPs. It is not a grant program, it's purely technical support. What we define as technical support is one-on-one technical assistance and national webinars such as these.

As I mentioned, this is the fourth webinar in the series we've had around Medicaid VBP. All of the materials from these webinars, if you missed previous ones, will be on the Medicaid IAP website within a month of when they aired. So the first one on Medicaid VBP approaches will be posted in just a few days, because that happened at the beginning of October. Thank you all for joining and I'll pass it back to Crystal.

CT: Now I'd like to talk a bit about the importance of payment reform in maternal and infant health.

Next slide. But before we jump into the presentation, I'd like to get a sense for your familiarity of the topic for today's presentation.

Next slide. *How would you describe your familiarity with VBP?*

- Would you say you're well versed in VBP approaches?
- You're aware of VBP approaches but you don't consider yourself an expert?
- You're new to the term VBP?
- Or would you say that you participated in one of the previous three Medicaid IAP VBP Webinars in October?

You can select all that apply.

Can we view the results please?

- It looks like 14% of respondents said they are well versed in VBP approaches.
- Nearly 70% said they were aware of VBP but they don't consider themselves an expert.
- And 16% said they are new to the term VBP.
- Another 16% said they participated in one of the previous three webinars.

So we've got a few people who participated in the three previous webinars. Thanks everyone for your participation.

Next slide. Adverse outcomes such as preterm birth and low birthweight disproportionately affect Medicaid beneficiaries. Preterm births, specifically, account for one-third of all infant deaths. Average healthcare utilization costs are much higher for preterm births compared with uncomplicated deliveries. Consequently, preterm birth is a key cost driver and it accounts for nearly half of all pregnancy-related costs. In 2017 alone, costs are projected to top \$32 billion when adjusted for inflation.

Next slide. Medicaid is a key source of financing for births among families with low and modest incomes. Although there is variability across states, Medicaid pays for almost half of all births in the United States, and a higher proportion of preterm births than private insurers. For the fourteen states in dark blue, the darkest color, Medicaid finances between 54% and 72% of all births. A high number of Medicaid-financed births, particularly those that are complicated births, carry potentially avoidable health complications and high costs.

Next slide. Now I'd like to hand it over to Mark Smith from IBM Watson Health who will discuss Medicaid VBP approaches in maternal and infant health.

Mark Smith (MS): Thank you Crystal.

Next slide. This graph represents the continuum of alternative payment models or APMs. It's divided into four broad categories defined by the payment mechanism. Within each category, there are subcategories distinguished by the quality-based mechanism used, such as performance rewards and penalties, gain-sharing, and downside risk. There are four broad categories of the APM framework.

- Category 1 is fee for service (FFS) where there is no link to quality and value.
- In Category 2 there is FFS but with a link to quality and value. Examples would be paper reporting programs.
- In Category 3, the APMs are built on a Fee For Service architecture. These could include APMs with shared savings, and APMs with shared savings and downside risk.
- Finally, Category 4 is population-based payments.

Next slide. The design elements that go into a VBP approach tend to get more complex as you move from the left to the right of the previously shown framework. Here are some of the key elements when you design a VBP plan.

- The patient population of focus.
- Which services will be part of the VBP.
- Financial performance, measurement and benchmarking.
- Likewise, quality performance, measurement and alignment.
- How patients will be attributed to providers.
- Risk adjustment.
- How data will be shared across providers and systems.

Next slide. States have expressed interest in applying VBP to the field of maternal and infant health. You will hear examples from Arkansas and Louisiana next. There are several other examples that we won't have time to cover today. They include: South Carolina's non-payment policy for early elective deliveries, and pay for performance (P4P) for their Nurse-Family Partnership home visiting program; Ohio's perinatal bundled payment; and Oregon's implementation of global payments for early prenatal care initiation and post-partum care.

For this next phase of the presentation, we'll include state perspectives from Louisiana and Arkansas on the implementation of VBP approaches in the maternal and infant health field.

Next slide. Our first presenter is from Louisiana and it's Dr. Pooja Mehta. Dr. Mehta serves as the maternal and women's health policy director at the Consortium for Health Transformation at the Louisiana State University Health Sciences Center School of Public Health.

Dr. Pooja Mehta (PM): Thank you so much for this opportunity to share our experience with our pay-for-performance initiative around progesterone initiation for preterm birth prevention. As Crystal mentioned, I'm the maternal and women's health policy director for the Louisiana Department of Health, and I'll be summarizing some recent years of work under various leadership in Louisiana.

Our commitment to VBP in the state comes from our commitment to the triple aim, which you're all aware of. That is:

- to improve the patient experience of care, including quality and satisfaction;
- to improve the health of populations;
- to reduce the per capita cost of healthcare.

Next slide. As you've already heard today, VBP is a specific means to the end of improving quality and value. In our state, we're pursuing VBP as we also address assets with our Medicaid expansion, and

engage with managed care via our current proposed contract extension, and planning for our new RFP in two years.

Embedding VBP into our approach to our expansion and our MCO contracting reflects our commitment to broader payment and systems reform. Our quality strategy in Louisiana focuses health plans and providers on shared targets for population health improvement using a limited set of stakeholder-recommended quality measures. If you know Louisiana, you know Louisianans are very proud of their state and local culture, so it's also not surprising that our quality strategy includes a homegrown measure representing the rate of progesterone initiation in pregnant women with a prior preterm birth. In addition to a selection of NQF and HEDIS measures that were selected through broad stakeholder engagement.

Our VBP contracting approach attempts to align financial incentives for plans and providers, and our current approach is to add a 2% withhold of the monthly capitation rate. We're not complying with monitoring of key measures or achievement of quality targets in incentivized measures, putting real money on the table. This comes out to about \$140 million a year, equal to the profit margin that's built into our rate setting. We're planning to transition from the slightly more punitive approach that centers around contract compliance to a future incentive to earn back for high MCO performance on quality measures.

Next slide. To give a bit more background given the focus of today's webinar, I'm going to delve into this evolving approach to VBP a little bit more.

1. Thinking about our current strategy, we feature a 1% withhold for quality and health outcome improvement.
2. This current \$250,000 penalty was really the only contract lever to influence plan behavior on quality. We first focused on incentivizing plans to monitor certain quality measures and then phased into incentivizing achieving defined targets for a subset of both measures.
3. We hope that this will evolve into not simply withholding a specified penalty but also giving the plans the chance to earn back the withhold if they attain specific targets or stretch goal targets over time.
4. Point four is we would also like to move from a small penalty for not performing to expectation for a larger reward for behaving as expected. So, to add withhold earn back for development and submission of a strategic plan increase APM use over time.

We hope to add the withhold earn back for meeting implementation milestones in each MCO's strategic plan in calendar year '18 and '19. Next slide.

That provides some overall context on our approach to VBPs. In terms of the selection of specific quality measures, there are nine incentivized measures in the current contract. And we revised our quality strategy for our proposed contract extension with broad input from:

- external stakeholders, from regional town hall meetings, Medicaid medical advisory meetings, which in our state are called our Quality Committee, and our subcommittees in the state,
- industry-specific meetings,
- and also soliciting for public comments.

Next slide. In our proposed contract extension, there are 17 incentivized measures, including one homegrown measure that I've already mentioned, that capture the initiation of injectable progesterone or 17P for the prevention of a recurrent preterm birth in women who've experienced a prior preterm birth. So why add this homegrown measure to our overall quality strategy?

As Crystal started to speak about, we know that more than half of infant mortality occurs in babies born before 32 weeks. We also know that Louisiana ranks among the worst in the nation for preterm birth outcomes and infant mortality. What you see on the right of the slide is that our state preterm birthrate based on vital records is hovering at around 13%, and is essentially a flatline for the last 10 years. This flatline also conceals dramatic regional, ethnic, and geographic disparities in preterm birth.

17P, or progesterone, is an injectable medication that's been shown to decrease the risk of a recurrent preterm birth in women who've experienced a prior spontaneous preterm birth. And we see this 33% risk reduction when progesterone is administered on a weekly basis between 16 and 36 weeks gestational age.

It's one of only a few truly evidence-based interventions for the prevention of preterm birth. But as you can imagine, there are some major challenges in implementing this intervention given the nuances of who's eligible and how to get someone a medication on a weekly basis over the course of a pregnancy.

Next slide. Here is a timeline of that implementation journey, filled with challenges but also with a stream of passionate champions who've paved the path along the way, including Dr. Rebekah Gee, current Secretary of Health, and Dr. Kuya, former Medicaid medical director. In 2011, the Louisiana Birth Outcomes Initiative kicked off, creating a precedent for collaboration between hospitals on birth outcomes and also creating a scaffolding for the introduction of other forms of payment reform. For example, nonpayment for early elective deliveries before 39 weeks.

In 2014, Medicaid partnered with LAMMICO, a local insurer, to expand provider education on progesterone initiation. It follows partnerships with the Louisiana Hospital Association, hospitals in our most impacted regions and partnership between the Office of Public Health and Vital Records.

Our Vital Records Collaboration enabled the creation of a high-risk pregnancy registry available to our MCOs to they can correctly identify beneficiaries who've experienced a prior preterm birth at the time that they become pregnant again.

We also partnered with Optum to cover home administration of the progesterone injection, to overcome patient-side barriers.

In 2015, progesterone initiation became an incentivized quality measure and we started our path to VBP and the MCO performance improvement projects, empowering plans to achieve a 20% initiation rate in eligible patients by the end of calendar year 2017.

We also partnered with the March of Dimes and our State Perinatal Commission to explore provider-side barriers to progesterone initiation in order to inform MCO improvement efforts.

And currently we're seeing new opportunities to further our work by making our approach to VBP more sophisticated, reenergizing our Medicaid Quality Committee and launching our State Perinatal Quality Collaborative.

Next slide. So, breaking out to look at some of those design elements that Mark mentioned, some core components of our VBP strategy.

Our target population is women who specifically meet the criteria shown on this slide, i.e., those with a singleton prior preterm birth.

Next slide. Going into more detail on our identification of this target population using the high-risk pregnancy registry that I've already mentioned.

1. The registry pools vital record information, summarizing prior birth data with Medicaid claims data and a provider generated notice of pregnancy form, to provide MCOs with a real-time mechanism to identify eligible candidates for 17P when they initiate prenatal care.
2. The vital record information on gestational age and plurality from a prior birth is matched with all women and children ever enrolled in Medicaid by a cooperative agreement.
3. The registry is then provided to the Medicaid fiscal intermediary who parses the list out according to plan enrollment and distributes the sub-registry to MCOs.
4. Then the provides gives a notice of pregnancy with a screening assessment to plans at the time that the patient initiates prenatal care, in order to confirm that plans are able to monitor outcomes and claims, and those who are eligible for 17P initiation.

Next slide. In terms of benchmarking, MCOs report their quality performance to the NCQA and additionally, measures are validated by our external quality review organization (EQRO) under our current contract. The EQRO works with MCOs on an ongoing basis to confirm that data quality is high, that data matches FFS claims data, and that measures are constructed similarly across plans, which is a real challenge with this homegrown measure.

Our current strategy is based on the reported MCO performance measure outcomes, a maximum of \$250,000 per measure is withheld as a specified performance measure falls below the established benchmark. With specifically the initiation of the progesterone measure, our established benchmark for our first year is a 20% initiation rate in the target population.

Next slide. To summarize, we have a data share between the Office of Public Health Vital Statistics and Medicaid to identify a target population.

Primary data from the MCOs is shared by the MCO performance improvement project (PIP) and reviewed by an EQRO, and also reported to NCQA

And then we also have global evaluation data that's available for Medicaid FFS claims.

Let's talk a little bit about some of this evaluation data in order to look at the impact of our strategy. I want to stress that what I'm presenting here is based on FFS claims data and so may vary if compared to plan-specific evaluation data.

Looking at the overall impact of our VBP approach and heightened attention to this issue, we've seen a four-fold increase in the rate of progesterone initiation for preterm birth prevention over time. So our Y-axis here shows the rate of initiation approaching out 20% target, and our X-axis shows each sequential year since we spearheaded this effort.

Our progesterone initiation rate in Medicaid in 2016 was about 16% and we are hoping for closer to 20% in 2017. We have much ground gained, and we also have work still to do, in terms of achieving population health outcome improvement in this area. I should also note that the denominator includes all women with a prior preterm birth, even if they had an iatrogenic preterm birth. So there are some women in this denominator who are not eligible for progesterone, and we can talk more about the construction of the measure in the Q&A if that's of interest.

When we break down some of our data we can also see that of the implement VBP we're not necessarily addressing disparity by race and ethnicity, despite overall improvements with Hispanic women significantly less likely than Asian, black and white women in 2016 to have had progesterone initiated based on our measure. This points to a need for efforts to prioritize an even implementation as we change Medicaid policy given existing significant disparities in perinatal outcome.

Next slide. As always, implementation of our P4P strategy has exposed barriers along the way that we've tried to address. On this slide, we've split barriers encountered up into: the first column, insurance and pricing barriers; the second column: supply chain barriers; the third column—the purple column—patient and provider-level barriers to adherence.

We've attempted to address these barriers in a variety of ways. For example:

- Addressing uninsurance through our Medicaid Expansion.
- Addressing cost barriers with full coverage with brand name progesterone Makena.
- Elimination of prior authorizations for progesterone across the MCOs.
- Coverage of the drug as both a medical and pharmacy benefit.
- Creation of an ordering and filling guide.
- And coverage of home administration of the drug to address community- and patient-side barriers. For example, with difficulty adhering to a weekly injection, transportation to a provider office, etc.

Next slide. We feel proud of our efforts, to date, but as always, much work needs to be done, and in terms of our next steps and future efforts:

- We do hope to improve communication between providers, patients and MCOs for more effective barrier analysis and continued improvement cycles in order to improve our initiation rates and ultimately decrease our preterm birth rate in the state.
- We hope to further align and synergize redundant efforts on improvement, so bringing MCO quality improvement strategy into alignment with provider quality improvement strategy.
- Understanding best practices from other states that have shown changes in outcomes with progesterone initiation and implementation.
- Continuing to shift from monitoring to incentivizing measures and refining our P4P approach so we move into further progress toward APM with an opportunity in the new MCO RFP coming up in two years.
- We hope to move from process evaluation of progesterone initiation to ultimate-outcome evaluation of our preterm birth rates and our low birth weight baby rates.
- And of course, we also hope to further engage with our Perinatal Quality Collaborative (LaPQC) in the state to further engage providers and practices and improvement efforts in system transformation.

Next slide. I want to thank our Medicaid director Jenn Steele and our data team at Medicaid, Larry Humble and Eddie Meyers, our Quality Director Pia Henson for their assistance in providing this data and these slides. I'm happy to take any questions, if we have time right now.

CT: Thank you so much, I have one question for you before Dr. Golden's presentation. The question is, where can we find the list of the nine incentive measures in your current contracts?

PM: Our contract is available on the Louisiana Medicaid website, in one of the appendices, and I'm happy to send out that link so that people can find it readily as part of this presentation.

Our draft contract extension is also online if you wanted to see the expanded list of measures that are in the proposed contract extension.

CT: One more question for you Dr. Mehta. Roughly how big is your denominator? How many women are eligible for 17P each year? That's the first half of the question.

PM: That is a great question. I don't have access to that number in front of me right now. We have about 60,000 births in the state—I'm doing some quick math—so we're talking in terms of order of magnitude, in several thousand births a year, and I apologize that I don't have the exact number right now. The point that I was trying to make is that of that large denominator of all women who are pregnant and have had a prior spontaneous preterm birth, some of those births were perhaps medically indicated or associated with a delivery decision from a provider. We haven't yet refined this measure that you're seeing presented today to have that more refined denominator, which we estimate about 20-30% of the total births perhaps would not need criteria for provider-prescribed progesterone in the current pregnancy.

CT: I'll ask the second half of this question and then we'll turn to our next presenter and then have our second Q&A session at the end.

This question asks, if the MCOs are penalized for not reaching 20%, then do you think you're discouraging them by continuing to penalize them even if they're making improvements?

PM: I think that is a really great point and it is definitely a delicate balance, especially if people are further away from the target in terms of incentivizing continued PDSAs and improvement cycles. And I think that's really why we want to move out of this more rigid approach to VBP into what I would think of as a more evolved stage where we're actually rewarding improvements or achievement of stretched targets. I think that this strategy, going back to the category that Mark was outlining before, this is kind of an early Category 2-based strategy and we hope to move further along the spectrum into a Category 3. Along the way we would prefer to reward MCOs for improvement efforts rather than this all-or-nothing withhold that is actually for a pretty finite sum of money. Because you're right, it doesn't necessarily incentivize continued PDSAs and commitments to improvement depending on where a plan is starting. I think that's a really great point.

We're continuing to work on our performance improvement projects to continue that spirit of coaching and collaboration, to keep that at the core of our strategy, with the financial penalty as a rap on the knuckles that comes along with a more profound sort of culture change about how to achieve forward progress.

CT: Next slide. Our next presenter is Dr. William Golden. Dr. Golden is a professor of medicine and public health at the University of Arkansas for Medical Sciences. He's also medical director of Arkansas Medicaid at the Arkansas Department of Human Services.

Dr. William Golden (WG): Thank you, thank you everybody for spending part of your Thursday with us. I'm going to give you a bit of background about our journey in Alternative Based Payments over the last several years of which maternal and infant care is one piece of a bigger picture.

Next slide. A little bit about Arkansas Medicaid and the Arkansas Healthcare System. We do not have managed care. We're putting our toe in the water with provider-led managed care for BH in the very near future, so we have basically a very large integrated data set. All our patients are assigned to a PCP so there's direct attribution, and so prior to the Affordable Care Act (ACA), we paid for about 65-67% of pregnancies. Now that we expanded Medicaid and did it with a private option, patients can purchase health insurance with a Medicaid support.

A large number of people who previously became eligible for Medicaid by becoming pregnant are covered prior to becoming pregnant. So our current direct coverage of pregnancies has gone from about two-thirds to about one-third over that period of time. We also covered a huge chunk of pediatric costs and we still do. We have a lot of interest in the care of well children, mental health of children, and children with chronic disease and disabilities.

Next slide. We have been very interested in using our data to improve our health statistics and our health system performance. For many years, like Louisiana and many southern states, we lagged many other parts of the country on performance measures, and so have been using our data sets and our potential for financial leverage to try to improve care and make care more effective and efficient. Especially later, in the last seven or eight years, we wanted to come up with ways to reward outcomes, effectiveness and quality, but internationally everyone has the same problem. There was more demand for resources than we have resources, there are more services we can provide. So we want to make sure that we use our resources appropriately and we incentivize all providers to be engaged stakeholders. It's going to take providers, payers, patients and policy makers to manage the system so that we do not have to go through the painful process of trying to either raise taxes, premiums, copays, or limit access. Because neither of those four items have a lot of appeal, especially as financial pressures grow.

Next slide. We've gone through a couple of stages, and I'll go over with you some of these activities. Back in 2008 or so we developed the P4P, which I will give you some details about. That's in many ways a level 2 or a stage 2 APM, and we focused on things like early elective delivery, breastfeeding, timely submission of newborn screenings to health departments, that kind of thing.

We then evolved to episodes of care, 2012 to present, we were a pre-cursor to CMMI's initiative. We were one of the first states to receive a CMMI implementation grant and our activities were actually central to the development of the RFP for episodes of care that were offered, and bundles of the payment by CMMI. I will describe the pregnancy episode a little bit.

Then we developed patient-centered medical homes (PCMHs), a large, successful initiative that deals with a lot of well children, chronic disease in kids—a major effort to try to improve things like immunizations and well-child visits.

I want to describe to you for a second the P4P program. What we did there was we had a raise in the per diem rates for hospital services and it was designed to withhold 5% of the per diem. That was put into a large pool and we developed a basket of measures that the hospitals would have to pass in order to qualify for a 5% bonus on their entire book of business. Hospitals that were successful got six-figure checks very often, depending on the size of the hospital.

This was a voluntary program, so on the maternal and child materials that was mandatory. If you were delivering babies, you had to participate on the maternal measures in order to be qualified for the bonuses. Otherwise you had a select bonus metric and you either had to reach the 75th percentile of the previous year's state average, or you had to have a substantial reduction in your previous year's failure rate to qualify for that measure. And you had to pass several measures.

We then went on to the episodes of care, which you see there, which included all medical services pre- and post- an episode of care. In hip surgery, for example, it would be pre-op and post-op care. In pregnancy, it was the entire pregnancy and a period of time after the pregnancy, and we captured maternal costs. We tried to develop something for neonatal ICU costs. That proved very complex but gave us tremendous data analytics that helped us then design a utilization review in a targeted way to improve our purchasing of neonatal ICU services. The medical home I will describe in a little bit.

Next slide. On the episodes of care, that was the framework you see there and this has been adopted by Tennessee and Ohio. You may have seen this slide in other state presentations.

Each of those vertical bars is the risk-adjusted average cost for an episode. In this case, the average risk-adjusted cost of a pregnancy, provided that you took care of the baby or the mom for at least the last eight weeks of the pregnancy, we would cover all costs involved with the pregnancy.

If you were in the lighter green zone, you got 50% of the shared savings between the commendable and the gains-sharing limit.

If you were in the gray zone, between acceptable and commendable, you got your FFS but no other money.

And if you were in the pink zone there, above acceptable, you owed us 50% of the cost above the acceptable line. So this was sort of a level 3, level 3+` heading toward 4 kind of an APM.

Next slide. To make sure people knew what they were doing, we launched this in 2012 so this was quite a while back, and we have a portal. This was a multi-payer effort, so the private payers were involved as well as us, so were the qualified health plans. At the beginning of the episode in 2012, all providers got their previous year's data that included their average cost per case, where they stood and compared to peers, how their costs broke down, whether they were consuming extra ER visits, radiology, pathology, laboratory, they knew exactly where their patient journeys spent money. They were able to get updates on their performance portfolio, quarterly, with about a six-month lag in their data. This was all put on a common portal that all the major payers shared, so it was one-stop shopping for all the providers.

We had coaches out in the field to get people to be able to access the portal and know where to find the data. That was the mechanism for perinatal care.

Next slide. The medical home program, we did PMPM and shared-savings dollars. Again, if you reach certain thresholds on your PMPM costs, primary care got 50% of their savings below that threshold. But we also paid PMPM as an investment and we required things like 24/7 access to care, i.e. moms can call people at night and on weekends and not get an answering machine. They have gotten rid of answering machines in Arkansas. We have had people identify high-risk cases. We developed care plans for high-risk patients. A variety of structural improvement in their medical home environment. As well as then to qualify for shared savings, they had to reach certain quality thresholds like well-child visit rates, and eventually we want to use immunization rate when we have better and more reliable immunization data from our public health registries for immunization data.

Next slide. To accomplish all this, it's been a long journey. It's truly taken a village of outreach and data analysis and stakeholder engagement.

- We've had the governor's office prepare the vision.
- We've had our department host meetings, develop the framework, data mine our data as well as our multipayer data which was mined by the payers.
- The legislature had to approve regulations and our playbook, if you will.
- We had contractors with outreach teams.
- We have a lot of big data management; the same thing is true for private insurers.

Clinical leaders, they liked the fact that it wasn't managed care so they gave us cautious acceptance of these new models, and then we had ongoing town halls as the models were rolled out to get feedback from clinical leaders, and then take their feedback, rearrange the requirements and then re-present the material to folks, both pre-initiation and during the implementation phase itself.

Next slide. It obviously required a lot of data. We have—as does Blue Cross have their own—a robust data warehouse. We've now shown that we can document and create reports on practice variation and then tie that to financial incentive. We use national homegrown measures. In the P4P program with hospitals, they report the data but we then go out and validate their submissions to make sure

that they qualify for bonuses. And as I've just said, we have all sorts of data reports to our provider community and the more data we give them, the more data they want.

Next slide. That's a lot of data. Just Medicaid alone, we've processed over the last several years 2 billion claims, millions of episodes, large numbers of reports. It's really big data and we can make it better if we can harness data out of clinical EMRs. This is all administrative data and we'd love to integrate EMR data into this kind of framework.

Next slide. Here are some results. Up on top there, since we did the early elective delivery P4P starting in 2011-2012, you can see on the bottom left corner, the first year we paid for reporting 70% of non-spontaneous deliveries before 39 weeks, between 37 and 39 weeks were elective. Scared the heck out of everybody. The providers woke up.

We then began to ratchet down the framework that you would qualify for bonus, and over a couple of cycles we have eliminated 95-99% of early elective deliveries by merely data reporting and financial incentives on a single metric.

You can see in the top slide the births after 39 weeks went from 55% to 64% over the next period of time. Deliveries between 37 and 39 weeks went from 33-34% down to 26% and it stayed there. And real prematurity has stayed at 9.8%. This results in 3,000 fewer deliveries every year in our state before 39 weeks. That's quite an accomplishment, we think, in a very short period of time.

We went on to breastfeeding at discharge from one of the lowest states in the country at 25% for Medicaid recipients to 33% over time. A much tougher lift but that's an increase of about 30% with the P4P program.

We've tackled low-risk C-sections, so if you get rid of the initial C-section you don't get the second C-section. We've gone from 28% to 23% and we're now below the Healthy People 2020 goal by this P4P program.

Next slide. Things that we've learned:

- Analytics are essential, but that's a very demanding garden. There are lots of gremlins as you do this and you have to be very careful with your data.
- People love to have real-time data but we don't have that, we only have claims data. That's why we want to get our hands on EMR data.
- We are giving people the patient journey, not just what's in their system. So people get data not just from their hospital, not just from their practice, but from wherever the patient gets care. That's extremely valuable.
- But you can miss data. People get services that don't get paid for. Patients move. All sorts of very problematic things you have to be on guard for. People gaining the metrics, we have to watch for that as well.
- How do you know when you get there? Well, you have concept outreach, you do implementation, but until you actually pay out bonus money, or take back money, you don't know how good your data are. Because once you start putting money on the table, people start pointing out flaws in your data.
- That's the big warning to everybody. Until payments are finalized, you're only in transit in your program.

We had problems that national payers, self-insured payers often don't want to play. We've had Walmart involved, but it's very hard to get others involved. They want a free ride and they don't want to invest in these kinds of APMs with bonus incentive money.

Next slide. Some of the challenges we've had, well we have a very low payment system so we've reached a ceiling in what we can get away with in terms of achieving incentives per episodes whereas the private payers have much more variation in their cost structure. Their impact on perinatal care has been quite substantial. I think it's recently published by Mike Chernew at Harvard that there's been a substantial reduction in some of their costs on a perinatal episode.

Our C-section rate for Medicaid has gone from about 37% to 32% and our length of stay for pregnancies has gone down about a half a day.

EMR is very much a limitation area, we'd like to have it better. We are now developing practice snapshots for people to help people guide decisions as to who they make referrals to and how they manage their medical neighborhoods.

Next slide. The key thing in designing VPMs, the whole thing is patient journeys, which populations, social determinants of health. The future of metrics really is about stewardship and rewarding total cost of care, patient satisfaction, managing the medical neighborhood. So you really need financial incentives and timely and valid data to give to the stakeholders.

That's the end of my presentation, thank you for listening.

CT: We have a few questions for you and then we will open it up to all presenters to answer questions.

The first question is, how does VBP work for low-risk caesarian deliveries? How would you discern whether the C-sections are appropriately medically indicated?

WG: We're using the Joint Commission national metric, they have used that now for their program. We have given the hospitals that as their playbook and then we go in later and validate to make sure they've collected the data appropriately. We do a random selection on those cases that we identify through our claim data.

CT: The next question is: What are the barriers to integrating EMRs?

WG: The EMRs, many of them cannot extract data. We have done surveys, we have given our data to ONC and CMMI and CMS. We've had them on speed dial. We've asked them to demonstrate, can they pull diabetes data? A lot of them thought they couldn't. They can't pull it at a practice level, they can pull it at a provider level. There's been a tremendous lag in the capacity of many EMR vendors to really provide the capacity to do quality metric extraction. It is a technical issue, not a provider. It's not the lack of interest or willingness of the providers, it's very often a technical problem that's at the software level at this time.

CT: The last question: Does your portal include information on the total cost of their members' care, including costs outside of the pregnancy like pharmacy utilization, BH care, or emergency utilization that may not have been associated with the pregnancy?

WG: That is correct, we do total cost of care, we do certain exclusion. We do exclude certain very high-risk cases like cystic fibrosis patients and that kind of thing. We tried to prune away certain expenses that were not pregnancy related. But they see everything that the patient experiences and they get a total cost snapshot both from their practice and where the patient wanders off to, including ER and so forth. So we do include most expenses, with a few exclusions.

CT: I have a couple of questions for Dr. Mehta in Louisiana. the first question is: How do you supply data to your EQR for their evaluation of performance?

PM: That's a great question. The PIP protocol is defined loosely in the contract with CMS. We tried not to enter into that too much as FFS Medicaid, so the MCOs are self-reporting outcome measures and process measures to the EQRO in the form of reports that the EQR then responds to with queries, and then there's this back and forth conversation. We are present in that conversation but we are trying not to dominate the improvement process, and with the EQR kind of brokering the improvement journey for each MCO. It is all self-reported by the MCO. What we then are able to do is provide any aggregate figures to the EQRO from FFS claims, so there's a way to some degree validating the quality of the data that's coming out of the MCO, or at least to generate questions about where discrepancies in those two sets of claims may be coming from.

CT: One more question for you. It appears from the graph that the preterm birthrate in Louisiana actually increased, despite the recent increase in 17P delivery. Is that correct?

PM: There was a slight increase and that's a great point. I want to point out that the source of the two sets of data that we showed were two different sources, so the total preterm birthrate as you saw on that slide has been calculated from our vital records in our office of public health. We use a set of checkboxes on birth certificates to look at gestational age, and the data coming out of Medicaid claims focused on progesterone initiation is obviously claims data.

What we haven't been able to do yet, which is a current effort of ours, is to do an analysis similar to what came out of the improvement work in Ohio, where we actually look at changes in the preterm birthrate over time, focusing on the group of preterm births that we expect to see going down as a result of progesterone. Progesterone has only been shown to work in pregnancies where there was a prior spontaneous preterm birth and it differentially has a higher impact depending on the gestational age of the prior birth. In order to really see if our uptake of progesterone is directly impacting our prevalence of preterm birth, we would need to do a more stratified analysis which isn't reflected in the data that we looked at here. You are completely correct about that.

And since I have the floor, I wanted to share Helen's question about the denominators. We're looking at a denominator of about 3,200 births in 2016 and that number has been pretty consistent over time, ranging between 3,100 and 3,200 births per year. Just to reiterate what that denominator actually is, that's women who were pregnant in 2016 who had a previous preterm singleton birth between 24 and 36 weeks, and who met a continuous enrollment criteria in Medicaid from week 16 of pregnancy through the date of delivery.

CT: I now have a question for all of the presenters. Is there a role for state HIEs in the data querying? Anyone can answer this question.

WG: The answer is absolutely yes, but it's all part of building their capacity. We're in close contact with David Kendrick in Oklahoma, who has one of the better systems in the country in that regard. But the issues I had talked about earlier about data extraction from EMRs remains a problem all over the country. So yes, the holy grail is to actually develop this so that this kind of HIE can feed into these VBP activities. Let people identify, get feedback about the care gaps because the care gaps can be filled in slices more than just an individual provider. But at the same time help guide the provider community in developing VBC and also help the payers understand how the system is performing. But it's going to take a few more years.

PM: I would just completely agree with that. I think that our high-risk pregnancy registry reflects that, but there's a certain level of stratification of risk and then determination of adequacy of response that we can only get at if there's partnership between different entities in order to validate different data sources. And also establish a longitudinal system to identify those who would benefit most from a particular intervention. I absolutely agree that it's about capacity building. The amount of capacity

building that had to happen to create that registry, even just tailored toward the identification of one population for one quality measure was enormous. So thinking about how to create larger collaborations so we don't have to reinvent that wheel every time we want to focus on a new target is really, really important.

WG: I will say, in Arkansas it's a multipayer effort. The private payers in our state realize we can't build a HIE off of user fees. Increasingly the payers are looking to actually help fund the HIE to take the financial burden off of the doctors and hospitals because they often get dinged not just by the HIE but also by the vendors. We hope to avoid those financial burdens and create a robust system that's more of a public utility that meets everybody's needs.

CT: In terms of our key presentation takeaways, we've heard that there's really a need for payment reform within the maternal and infant health field, and there's also an opportunity for state Medicaid agencies to improve health outcomes by considering the use of VBPs. As we've heard from our state presenters, those design elements that Dr. Mark Smith discussed earlier such as financial incentives and performance measures are key.

It's also important to get buy-in from stakeholders first, share best practices whenever available, ensure that measurement tools are timely and accurate, utilize financial incentives, start small and build up to scale, sustain political action, and finally, take accountability for the patient journey.

In conclusion, VBP stands to improve the quality of care, improve access to care, and reduce the cost of care.

Next slide. A resource list which includes general information and information specific to maternal and infant health is available for download in the widget. I want to thank our audience members and our presenters again for participating in today's webinar. Please take a minute and complete the short feedback survey that will pop up on your screen at the end.

[End of webcast.]