Medicaid Innovation Accelerator Program Maternal and Infant Health Initiative
Value-Based Payment Technical Support Opportunity: National Dissemination Webinar #3
Transcript—Key Lessons in Transitioning to Value-Based Payment
to Improve Maternal and Infant Health Outcomes
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Webinar/Webinar Logistics

AVERY DESROSIERS: I am a research analyst at IBM Watson Health, the prime contractor for Medicaid IAP [Innovation Accelerator Program] contract for VBP [value-based payment] in maternal and infant health [MIH] and children's oral health. We work alongside our colleagues at the National Academy for State Health Policy (NASHP) to provide technical support to state teams.

[next slide: reviews logistics for webinar]

Now, I am pleased to pass the presentation over to William Olesiuk, Project Director for this Medicaid IAP technical support opportunity. Thank you, Bill.

Learning Objectives, Agenda, and Today's Presenters

WILLIAM OLESIUK: Hello, as Avery mentioned my name is Bill Olesiuk and I served as Project Director for IBM Watson Health on this contract. To begin, I will summarize today's learning objectives. We want to highlight at a high level the steps which Medicaid and CHIP [Children's Health Insurance Program] agencies have taken to implement VBP including selecting, designing, and testing a VBP approach, and also to highlight some key considerations and gain insight on the steps required to develop, implement, and sustain VBP approaches and related contracting approaches, specifically for maternal and infant health [MIH].

We begin with some introductions of our presenters, an introduction to the IAP program, an overview of this specific technical support opportunity in maternal and infant health [MIH] and overviews from two of our participating states, Maine and Mississippi, as well as information from the state of Pennsylvania, which has separately implemented VBP. We then provide time for facilitated questions and answers and we discuss any resources that will be made available through the CMS [Centers for Medicare & Medicaid Services] website.

Today's presenters are Nicole Harlaar, PhD, Senior Research Leader, maternal and infant health [MIH] expert, and IAP MIHI VBP Lead on this for the center for Maternal and Child Health Research, IBM Watson Health. We also have Kristen Zycherman, a maternal and infant health [MIH] subject matter expert for the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services [CMS].

From the state of Pennsylvania, we have Michelle Robison, the Director of the Division of Quality and Special Needs Coordination within the Bureau of Managed Care Operations for the Pennsylvania Department of Human Services.

From Mississippi we have Christy Lyle, the Nurse Office Director in the Office of Clinical Supports and Services in the Mississippi Division of Medicaid.

From the state of Maine, we have Maryann Harakall, who is the Senior Health Program Manager for the Maine Center for Disease Control and Prevention [CDC]. We have Maya Cates-Carney, VBP Data Integration and Policy Analyst within the Office of MaineCare Services.

With that, I will turn it over to Kristen Zycherman from the Center for Medicaid and CHIP Services to discuss the IAP program and the technical support provided through this opportunity.

Overview of Medicaid IAP and the MIHI VBP Technical Support

KRISTEN ZYCHERMAN: Thanks Bill. I first want to on behalf of all of CMS welcome all of you who are joining this call. We are very excited to share more about the Medicaid IAP VBP technical support opportunity and what has come out of it.

- CMS is committed to building state capacity and supporting ongoing innovation in Medicaid through targeted technical support.

- The IAP goal at large is to increase the number of states moving toward delivery system reform across a variety of program priorities.

- To be clear, IAP is not a grant program—it is a contract that provides targeted technical support to states to help them implement VBP.

Back to Nicole.

NICOLE HARLAAR: Thank you Kristin. The goal of the VBP technical support opportunity was to provide CMS and state Medicaid and CHIP programs with support in selecting, designing, and testing VBP models or contracting approaches to improve maternal and infant health [MIH] care delivery and outcomes. Four state Medicaid agencies participated in this 2-year opportunity. Most of our teams had a delivery partner or other key stakeholder. Each state had a distinct VBP goal shown on this slide. Starting with Maine and going clockwise.

Maine's goal was to increase the proportion of mothers covered by Medicaid who are screened and receive medication-assisted treatment [MAT] for opioid use disorder [OUD]. Mississippi's was looking to reduce the preterm birth rate of women covered by Medicaid. Colorado was looking to increase screening and successful referral rates for postpartum depression among women covered by Medicaid. And finally, Nevada's goal was to reduce the proportion of infants admitted to the NICU [neonatal intensive care unit] among its Medicaid population.

This graphic provides an overview of the scope of technical support activities available to participating states. They can be grouped under three broad categories. First, we helped each state to clarify their goal and select a VBP approach that would enable them to achieve this goal. Specific activities during this phase included developing a driver diagram to conceptualize the changes needed to bring about payment reform and discussing the feasibility and fit of one or more VBP approaches in relation to the state's existing Medicaid care delivery and payment system.

In the second phase of technical support, we worked with states to design their payment program. States were encouraged to analyze baseline data, to use the benchmarking processes, examine the potential cost impact of their VBP approach, and identify quality metrics. These included not only outcome

measures but also process measures and balancing measures to examine any unintended consequences of their VBP approach.

The third phase involved implementation and evaluation. States conducted rapid cycle testing to assess the impact of their VBP approach and refine it as needed. Other activities included gathering stakeholder feedback and planning for the sustainability and spread of the state's VBP initiative. Technical support tailored to each state was provided through regular virtual meetings, in-person site visits, and shared learning opportunities, including peer-to-peer learning and state and national expert presentations.

The MIHI [Maternal and Infant Health Initiative] VBP state teams reached many milestones during the technical support period. Some of their achievements are highlighted on this slide, again starting with Maine and going clockwise.

Maine introduced a billing code for OUD to increase rates of OUD screening among pregnant women and is currently moving through rapid cycle tests of this strategy.

For Mississippi, who wanted to reduce their preterm birthrate, a major accomplishment has been the development of a universal notification and pregnancy form. They're hoping to eventually pair this with a pay-for-performance strategy to incentivize earlier prenatal care.

Colorado is in the process of developing a toolkit on postpartum depression screening for pediatric providers that will include information on payment. In the future, they hope to embed value-based payment [VBP] for screening and assessing in their accountable care collaborative model.

Finally, Nevada is considering the addition of a VBP approach to reduce NICU admissions to their upcoming managed care organization [MCO] procurement process.

There are a variety of lessons learned from the unique experiences, contexts and challenges that each state team has worked to overcome throughout the technical support period. In particular, we've seen that state and operational support and capacity can affect the process of implementing a value-based payment [VBP] approach for maternal and infant health [MIH]. All of our states have faced challenges in moving towards VBP, including changes in state administrative leadership, staff turnover, leadership buy-in, and alignment with other payment and delivery reform assets in the state Medicaid system.

One factor we've seen time and time again as being important to success is having a highly involved VBP champion at the state Medicaid agency who has been supported by leadership. These leaders have usually articulated a vision and shared goal that allowed stakeholders to work from a common foundation. Other factors related to successful implementation of a VBP approach include leveraging Medicaid managed care contracts to support VBP and identifying opportunities for payment reform based on a state's Medicaid authority such as state plan amendments for health homes.

Having a well-established data infrastructure and using data to develop benchmarks or standards against which to measure performance of VBP is also very important. We did a lot of work with states to identify appropriate data sources, determine quality metrics, and then use data on those metrics to refine a state's VBP approach.

Stakeholder engagement is also critical. Early contact with staff and organizations who have expertise in measurement, data analytics, managed care contracting, and other policy and operations issues facilitates the development of a VBP approach. States may want to include representatives from other state agencies such as departments of public health to provide input on how components of a VBP approach could impact present strategies and efforts that target social determinants of health.

Engaging health care provider organizations and providers is also critical. VBP incentives should be intense enough to motivate providers to invest in adopting new approaches to care delivery and payment without subjecting them to financial and clinical risks they are unable to manage. Thus, states need to understand health care providers' capacity for change.

Finally, engaging with patients at patient advocate organizations and patients themselves will help states develop a better understanding of patients' needs and priorities.

Through the MIHI VBP opportunity, several fact sheets and resource guides have been developed that you may find useful. Topics include a general overview of VBP approaches for MIH care, innovative care delivery models that could be implemented through VBP, and key considerations for using VBP to enhance care coordination in MIH care. The final fact sheets will disseminate the key technical support provided to help participating states during this technical support period. These fact sheets will be made available on the CMS website.

Today's webinar is the third in the MIHI VBP webinar series. The first national webinar included an introduction to VBP. This webinar featured speakers from Louisiana and Arkansas. The second national webinar focused on using VBP to incentivize innovative MIH care delivery models and featured speakers from New York and Ohio. Today's webinar serves as the culmination of lessons learned in transitioning to VBP to improve maternal and infant health care. We will hear from two of our MIHI VBP states, Maine and Mississippi, as well as from Pennsylvania, which has been an early adopter of VBP. Links to resources are included at the end of today's webinar.

We're fortunate to have a panel of excellent speakers on today's webinar. Maryann Harakall and Maya Cates-Carney will be discussing the work Maine has done as part of the MIHI VBP program. Michele Robison will be describing the work Pennsylvania has been doing to implement VBP for maternal and infant health [MIH]. The third state is Mississippi, whose work on the MIHI VBP program will be presented by Christy Lyle.

Once we've heard from all the speakers, we'll have a panel discussion followed by Q&A. While you are hearing from each state, please feel free to submit questions in the Q&A box that you should see on your screen. Questions will be addressed during the Q&A at the end of the webinar.

Poll Question

Before we hear from our speakers, we'd like to get an idea of the audience's experience of developing and implementing a VBP approach for maternal and infant health [MIH]. You should see the following question: Where are you currently in the design and implementation process of a VBP approach? Please

select one or more of the answers that appear on the right-hand side of your screen and then select submit:

1. We are selecting a VBP approach.
2. We are designing a VBP approach.
3. We are testing a VBP approach.
4. We are implementing a VBP approach.
5. We are sustaining a VBP approach.
6. We are not currently considering a VBP approach but are interested.
7. I am not part of an organization involved in implementing a VBP approach.

We will give just a few more seconds for people to respond.

Okay, we are closing the poll now. It looks like at least some of you are in the process of selecting, designing, or testing a VBP approach, which is very encouraging. I think we will all find today's webinar and today's speakers very interesting and informative.

State Overviews of the VBP Journey: Maine

We're going to learn first about Maine's experience. I'm delighted to present Maryann Harakall from the Maine CDC and Maya Cates-Carney from the Office of MaineCare Services who will summarize the work Maine has been doing. Over to you, Maryann and Maya.

MARYANN HARAKALL: Thank you, Nicole. As Nicole said, my name is Maryann Harakall and I'm the Maternal and Child Health Program Director here for Maine CDC. I have my colleagues from the Office of MaineCare Services, both Maya Cates-Carney, who you'll hear from, as well as Linda Riddell, who you'll also hear from throughout our presentation. With that, I'll just get started.

Our aim statement, as Nicole has said and read to you all, really our goal was to increase the number of pregnant women who are screened for opioid use disorder [OUD] and then to get those women into treatment. Our baseline was zero, so we thought we might be able to increase that by 5 percent within the 2 years of this project.

As we went through the process, we were given the opportunity to create the driver diagram, which really helped us map out where our project was going. We ended up with three primary drivers. As you can see on the screen, we wanted to incentivize folks to use the screening code during prenatal visits, which would or should, in turn, increase utilization of our medication-assisted treatment [MAT] programs that we have here in Maine.

The second primary driver for us was that we wanted to just raise basic awareness with our providers across the state of the use of medication-assisted treatment [MAT] for pregnant women. We wanted to make sure providers knew that that was an option that was available to our women in Maine.

The other thing we wanted to do was to make sure that there was access for treatment for women with OUD while they were pregnant and then also after they gave birth.

MAYA CATES-CARNEY: This is Maya Cates-Carney. We were able to open a code for OUD screening to be able to track that in our claims system and provide a reimbursement that went through the whole process

of review—that is, being reimbursed for providers. The hope in our original driver diagram had been to report use of the code publicly, which hasn't happened due to shifting priorities as well as what we learned about what that would all entail.

LINDA RIDDELL: Maya, this is Linda Riddell. I wanted to chime in on the screening code here. We'll make a big boost in this area in 2020 because the United States Preventive Services Taskforce has a recommendation currently out for public comment that the service for screening for illicit drug use be considered a preventive service, in which case all health insurance plans would need to cover it and charge a zero copay. So, I've been hoping to see more activity around that.

MAYA CATES-CARNEY: Thanks, Linda.

MARYANN HARAKALL: As we start thinking about our greatest accomplishments over the past few years, one of them really was getting that screening code open, and part of opening that screening code also entailed us making sure that there were some open source screening tools available for folks to be able to use. We ended up using our SnuggleME guidelines. Our SnuggleME guidelines [are] an existing document we have that outlines the evidence-based resources that are available. It's not specific to the substance use disorder world, if you will. It also includes intimate partner violence, mental health disorders, etc. So, it's really a multitasking kind of document, but we use that as our source document. In turn, we used disseminating the SnuggleME guidelines as a way for us to start promoting the screening codes.

A couple things that we did—I did a presentation that included some of the SnuggleME [guidelines] at a conference so we made sure that folks knew I had some of the guides with me, but we also put out some surveys for folks to give us feedback about if they'd even known that the code was open and how they're using it and that sort of thing. To date, unfortunately, we haven't gotten any responses on the survey. However, we have some plans for continuing to put out questions like that to our community providers, specifically, "Who's using the code?" and "How do we promote this even further?"

MAYA CATES-CARNEY: Another accomplishment of ours was the inclusion of an OUD screening quality measure into our Accountable Communities program, which is our Medicaid ACO [accountable care organization]. In Maine, we have four ACOs. In the fifth program year, we were able to incorporate a measure that wasn't specific to maternity but was about evaluation or interview for risk of opioid misuse, and the code is used in that. So, that was an exciting piece.

In terms of lessons learned, it was really exciting to be able to work with our DHHS [Department of Health and Human Services] sister agency, so I'm here in Medicaid and MaineCare, and I was able to work with Maryann and folks at the Maine CDC to build on those relationships, which has led to other collaborations as well in the last few years. It definitely hasn't gone as thoroughly as intended or planned, but we've been able to make adjustments along the way and had to re-evaluate amidst other shifting priorities and a shifting administration and all of those things. So, the relationships we've been able to build have been really valuable. Even though we weren't able to do the public reporting or other pieces along the way, just the continued reflection and evaluation [were] also valuable.

MARYANN HARAKALL: We're looking at the future work, so, obviously, as Nicole had said, this project is ending for us, but, as Maya had alluded to, our relationships certainly don't end. So, one of the things

we'll be doing next is implementing some more of the prevention activities [by] going back to what I said at the beginning—the driver diagram, which, for me, looks very similar to a logic model. The driver diagram really laid out for us what those activities are and how [they] would affect change and get at our overall goal of our project. Those prevention activities have started to come together, and we continue to work on those here at Maine CDC and pull in other partners as necessary.

MAYA CATES-CARNEY: As Maryann just mentioned and as mentioned in the previous slide, the cross-agency collaboration has been really beneficial. Maine applied for the Maternal Opioid Misuse Collaborative Agreement from CMS, which will be coming out in November, the notices. So, the work that we'd already been doing around this was really beneficial to that. We also will continue to promote use of the OUD screening code among providers. We continue to send out notifications and, as Linda mentioned, the federal guidance will be helpful to continue notifying folks about the code and improve the use of that among providers.

MARYANN HARAKALL: The other thing, and maybe we should have put it among our greatest accomplishments, is being able to leverage that support from other community partners, including not just the community partners but other state offices. [Partners including those] outside of MaineCare and Maine CDC, but just having those sorts of DHHS-wide initiatives, if you will, to continue working on some of the improved care for this very particular population. I'll give you a quick example of that. We now have what's called the Office of Opioid Reform, and they started pulling together a work group of all the different offices within DHHS to start figuring out what is everyone doing. Maya and I got the opportunity to talk about this project a little bit, and it was a nice little showcase and a model of how the different offices can have different focuses but come together to work together. So, we will continue to do that and use this as a model as we move forward.

State Overviews of the VBP Journey: Mississippi

NICOLE HARLAAR: Thank you. Next up is Mississippi. Our presenter is Christy Lyle from the Mississippi Division of Medicaid. Thank you, Christy.

CHRISTY LYLE: I'm the Nurse Office Director for Clinical Support Services at the Mississippi Division of Medicaid. We've had the pleasure of working with the VBP group throughout this IAP opportunity for the last 2 years. We've definitely seen a lot of progress and are excited to share that with you today. When we first started looking and developing our aims statement—we've refined this over the process—but looking at the preterm birthrate and looking at how they improve birth spacing among women covered under Medicaid in Mississippi, I don't think it's a secret that Mississippi has the highest preterm birthrate across the United States. We've been steady at 13.6% of our overall population having preterm births since 2016. Despite lots of work that goes on every year, it seems we persistently have this challenge before us. Even with 13.6%, we still have pockets of specific counties across Mississippi who have as high as 40% of that population in those pockets that have preterm birth. Looking at the work related, the primary driver of our project was to increase the frequency of first and second trimester prenatal visits for pregnant women who become eligible as a result of their pregnancy or who are already enrolled in Medicaid at the time of pregnancy. What we find is that it's very challenging to make improvements in health outcomes because a large number of our beneficiaries roll on and off our rolls because pregnancy is what drives their eligibility. During that pregnancy eligibility is the only time you really have to make

improvements in their health outcomes, and then they roll off until the next time when they're rolled back on. There is a very small population who is consistently enrolled at the time of pregnancy. We find that poor or absent prenatal care significantly increases the risk for preterm births and looking at strategies to address these clinical drivers of preterm birth has been our goal throughout this project.

Looking at ways that we can approach the VBP arrangement, our CCOs [coordinated care organizations], our managed care organizations [MCOs], which they're called CCOs in the state of Mississippi, worked tirelessly with the Medicaid agency to roll out universal notification of pregnancy form. We now have three managed care organizations [MCOs]. All of them individually had NOP [notice of pregnancy] forms. They were all different, and what we found was it's kind of hit or miss with providers filling out those forms and getting them back in. Our approach was to have a universal form that would be used by not only fee-for-service Medicaid—we still have a small population that is in fee for service—and also the managed care population that the form would be universal across all parties.

Looking at this, we would establish a scaled incentive program that would be paid out to the providers with highest reimbursement occurring in the first trimester and then progressively lowering payments in the second and third trimesters. Our goal was to have this form submitted within 10 days of the first prenatal visit. Our struggle is that a lot of times we do not know that a beneficiary is pregnant until we get claims data in, and we have missed significant timing for care management opportunities until we get the claims data in.

Our greatest accomplishment of course has been finalizing the universal notification of pregnancy [NOP] form. I have to give credit to our CCOs. One of our CCOs took the lead on this project and coordinated efforts across all the MCOs and refined that form. I'm sure it's not unique to just the state of Mississippi but having that collaboration across the CCOs was phenomenal. We also brought in other state partners, which is a huge opportunity for us. This also wouldn't be unique to Mississippi, but we find that we're very siloed in our approach to a lot of projects.

Our lessons learned, definitely early communication with key stakeholders; when we talk about stakeholders specifically, our internal partners here at the Division of Medicaid; [and] even before that, our elected officials, a lot of times our elected officials, in getting the language that we need in our technical bills to be able to leverage in our managed care contracts. It starts there for us.

Then our other state partners—the Mississippi State Department of Health has been a huge stakeholder for us, and most significantly we have been able to engage with Blue Cross Blue Shield, who is the primary private payer in the state of Mississippi to do a launch at the same time for this notification of pregnancy [NOP] form so it will not just be for our Medicaid population, it will also be for the private pay population, too.

Establishing a common agenda and understanding the work needed to surpass the legal and data-related barriers—I can't say enough about that as far as our internal partners and legal and looking at the data barriers of getting these forms in, and then having an overload of data and what data you're going to use to drive the change are issues that starting that early communication is key.

We definitely still have lots of work ahead of us. It doesn't stop here. Looking at what our next steps are for outcome measures, we have some baseline data from the CCOs but then looking at what our

submission rates are across trimesters and seeing how change occurs as a result of that, and then a sustainability plan for the provider incentive payment, looking at [that] possibly in the future. Right now pay for performance (P4P), we're looking at starting out with a soft launch and having a payment that is going to be an incentive to get this submitted. But somewhere down the road, it may be that if they don't submit it, then they're not going to get payment for the whole entire pregnancy. We've got lots of opportunities in front of us to look at what our next steps will be. Of course, during the process and seeing what barriers we have will determine what our next steps are.

Ok. I'll turn it back over for questions.

State Overviews of the VBP Journey: Pennsylvania

NICOLE HAARLAR: It's a pleasure to introduce Michele Robison from the Pennsylvania Department of Human Services.

MICHELE ROBISON: Thank you and good afternoon. I am the Director of the Division of Quality and Special Needs Coordination within the Bureau of Managed Care Operations for the Pennsylvania Department of Human Services.

In Pennsylvania the HealthChoices program is our statewide Medicaid managed care program. Our program operates in all counties across Pennsylvania, and we're divided into five zones: Southeast, Southwest, Lehigh Cap, Northeast, and Northwest. To get a picture within the Commonwealth of which areas that encompass each zone, the Southeast is Philadelphia and the surroundings counties. The Southwest would be out towards Pittsburgh and those surrounding counties. The Lehigh Capital area would be from Harrisburg/York up towards Allentown. The Northeast would be Wilkes-Barre/Scranton area towards the middle of the state, and obviously the Northwest then would be Erie and those surrounding counties in the middle of the state that aren't in the Northeast. We currently serve approximately 2.8 million enrollees and that was as of February of this year, and we have nine MCOs that provide services to our MA [Medicare Advantage] beneficiaries.

Our MCO pay-for-performance [P4P] program was implemented in July of 2005. The measures that we included are a subset of HEDIS [Healthcare Effectiveness Data and Information Set] measures, which was our Healthcare Effectiveness Data and Information Set and PA[Pennsylvania]-specific performance measures, which we classify as PAPMs. Our MCOs are able to earn an incentive payout by meeting benchmarks and achieving incremental improvements from the previous years. The benchmarks we set for the HEDIS measures, we used the NCQA [National Committee for Quality Assurance] HEDIS percentile benchmarks, and for the PA performance measures, the department sets a goal for those measures.

We also have a provider pay-for-performance [P4P] program which was implemented in 2007 and consists of both again HEDIS measures and PA performance measures similar to those that are in our MCO pay for performance [P4P] program. Providers are able to earn incentive payments for closing gaps in care for their patient panel.

In designing our MCO P4P program, our overarching goal is to align measures with payment and quality, access, and efficiency. Specifically, for maternal and infant health, our goal was to increase early identification of pregnant women to promote healthy birth outcomes for both mom and baby. How we

monitor this is by focusing on the following three HEDIS measures and one PA performance measure: the HEDIS measures consist of prenatal care in the first trimester, postpartum care, and well-child visits in the first 15 months, 6 or more visits, and the PAPM is frequency of prenatal care.

Some barriers and challenges that we encountered initially when implementing our MCO P4P program in 2005 was that it was very complex. There was a total of 12 measures, 10 of them HEDIS and 2 PA performance measures. However, we classified the measures as *core* and *sustaining.* Those core measures were measures selected based on past data indicating the need for improvement across the program, while the sustaining measures were those that the overall performance rates were good—however continued improvement was necessary as they were important to the HealthChoice's population.

The goals were set for each MCO and measured on previous year's performance. However, when it came to the payment calculation, for each set of unique and sustaining measures it was unique. It was based on a set of criteria. The MCOs had to meet performance goals first, and then payment logic was applied.

What we did to make the MCO P4P program easier to understand and less complex was we organized an MCO P4P summit with all our MCOs. As a result of the feedback we received from the summit, we simplified the measures, both the HEDIS and PAPMs, by removing the core sustaining descriptors. We agreed to use the NCQA benchmarks for measuring performance for the HEDIS measures, and we developed a goal for the PA performance measures. In addition, we implemented an offset to discourage poor performance.

Barriers and challenges with our provider P4P program initially when we implemented in 2007 was, we had minimal direction initially. The MCOs had the option to use provider P4P funds for MCO design programs or for a chronic care regional rollout, which was a Commonwealth initiative. We were allowing the MCOs to use provider P4P funds to support. As a result of these vague descriptions, each MCO implemented a different program with completely different measures.

As a result, we defined standardized quality measures similar to the MCO P4P, which included as I mentioned HEDIS and PA performance measures. We included also a dentist-specific measure in 2017. You're probably thinking, A dentist-specific measure, how does this fit into MIH? During the same time that we designed this initiative was when the CMS Oral Health Initiative was going on, and as we were analyzing our dental data, we observed that our children 6 months to 5 years of age were low in receiving preventative visits. In addition, we knew early preventative dental care offers an opportunity to educate the parent and guardian regarding good dental care. Also, if caries was identified early on, dentists would be able to fix the caries prior to it becoming more extensive, which would result in tooth/teeth extraction.

Our dentist P4P program focuses on children ages 6 months to 5 years and 6 years to 20 years of age. Early on, in the 6 months to 5 years, we capture the early child. The 6–20, if we had a teen pregnancy obviously dental care would be important. Then with annual dental visits, those women older than 20 years of age, we would be able to capture a dental visit along with that, with maternity if they were pregnant.

What are our greatest accomplishments to date? I would say overall our performance has improved, providing an increased quality of care to our HealthChoice beneficiaries. In addition, the P4P focuses on

ensuring care from the time of conception throughout adolescence, which is one of our focuses here at the department.

Here are some of our outcomes to date: Increased performance by PH-MCOs [physical health managed care organizations] and on process measures equals positive outcomes. On the right is a graph of our rates from 2016 to 2018. Prenatal care in the first trimester has been pretty flat. Our postpartum care increased about 5.3% from over the 2 years. Our well-child visits in the first 15 months of life has increased about 0.4 percentage points, and then the frequency of prenatal care, we had a statistically significant increase of about 34.7%, which was equivalent to 24.47 percentage points.

Lessons learned: Over the years, lessons we learned are—

- Keep it simple.
- Provide guidance to the MCOs while at the same time allowing them flexibility.
- Include MCOs in the selection of measures and development.
- Allow for feedback from MCOs and stakeholders. By doing all this, the MCOs feel that they're part of the process. They feel valued, and you'll obtain gain-in sooner than later.
- Monitor ongoing process to ensure acceptance and value of the program.

Lastly where are we going with our P4P program? This year we are bundling payments. We have two different bundles. A perinatal and infant bundle includes prenatal care in the first trimester, postpartum care, frequency of prenatal care, and well-child visits in the first 15 months of life. We also have a child and adolescent well care bundle, which focuses on well-child visits in the 3rd, 4th, 5th, and 6th years of life and adolescent well care. We're raising the benchmark for payouts, and we are expanding to include additional quality measures.

Facilitated Q&A Panelist Discussion

NICOLE HARLAAR: Thank you, Michele, and thank you all so much. In this section of the webinar, we are going to move into the panelists' discussion, and we hope to touch on a number of topics relevant to selecting, designing, and implementing a VBP approach for MIH.

In the interest of time, we'll be combining external questions with the panel discussion. Feel free to submit your questions using the Q&A feature on WebEx.

We'll start with the question, why did you decide to develop a VBP approach for MIH in your state? Christy, maybe I can start with you for Mississippi.

CHRISTY LYLE: Referring back to the number of significant pregnant beneficiaries that receive prenatal care later in their pregnancies here in the state of Mississippi, the notification of pregnancy [NOP] form would give us increased access to care and receipt of earlier care for our beneficiaries. It also aligns with some work we're doing with a March of Dimes grant. We implemented work with the March of Dimes in April 2018 where we incentivized the beneficiaries in Clay County. Clay County had one of the highest preterm birthrates across the state of Mississippi, and we will give them a $25 gift card if they [beneficiaries] are early to care, as well as a $25 gift card for making their postpartum visit. So aligning with that was another reason that we looked at this approach for Mississippi.

And then also an earlier referral for peer management programs through both our MCOs and our perinatal high-risk management service that we have through our Mississippi State Department of Health.

NICOLE HARLAAR: Thank you, Christy. Second question, can you describe your process for setting and refining your goals and what data resources did you use? Michele, I might pass this one on to you to respond for Pennsylvania.

MICHELE ROBISON: Sure, in Pennsylvania we utilize our HEDIS rates, our MCO weighted averages, and NCQA benchmarks when studying and refining our goals as all of these rates are validated. We use these data sources to set our benchmark performance payout piece. Within our MCO pay-for-performance [P4P] piece, we have a benchmark payout and an incremental improvement payout, so we use these data sources for the benchmark piece of it. The incremental piece is a year-over-year performance improvement payout.

NICOLE HARLAAR: Great, thanks Michele. Here is another question that has just come in. Did you partner with any additional organizations such as care provider organizations or other state agencies in selecting and designing your VBP approach? Maryann and the Maine team, perhaps I can ask you to address this question?

MARYANN HARAKALL: Absolutely, this is an interesting question, Nicole. We started out with one group of people. and then as we kind of got into the project, we recognized pretty quickly that we needed to pull in other folks. An example of that is, although I do the maternal and child health as part of Maine CDC, within the division I work in we also have our Tobacco and Substance Use Prevention and Control team. As we started to define our goals, it became very clear that they needed to be part of our group as well.

The other thing that happened to us throughout the project is that we had to adapt to leadership changes. We got a new governor and leadership all the way down to our Maine CDC Director but also the Office of MaineCare Director changed as well. As that happened, we pulled in other folks as well. So yes, we definitely did.

NICOLE HARLAAR: Great, thank you Maryann. Christy, do you want to discuss Mississippi's experience partnering with organizations?

CHRISTY LYLE: When we first started out initially, we didn't bring in our MCOs, initially looking at how we're going to approach this. That significantly grew with both our internal partners and externals. We brought in our managed care organizations [MCOs]. We worked with the March of Dimes, our other state partners, the state Department of Health. We also brought in a provider group from our Clay County area who have been strong advocates and lent the Division of Medicaid lots of resources for this project and having conversations with the Blue Cross Blue Shield [BCBS] private partner here and ACOG [American College of Obstetricians and Gynecologists], the ACOG chapter here in Mississippi.

NICOLE HARLAAR: Thanks, Christy. Okay, the next question is, in selecting and designing your VBP approach, did your states leverage existing state VBP initiatives? Michele, I think I'll pass this one over to you.

MICHELE ROBISON: In Pennsylvania, our MCO P4P program has been in effect for almost 14 years, and choosing the quality measures, we chose to include measures that based on past data indicated a need

for improvement across our program, as well as the potential to improve health care for our broad base of population. In addition, we included measures where the overall performance rates were good. However, continued improvement was necessary as they were important to our overall population. I think that's it.

NICOLE HARLAAR: Thanks, Michele. Here is another good question, have you encountered any barriers in establishing your VBP approach, and how have you dealt with those challenges? Maryann or Maya or Linda do you want to take this one for Maine?

MAYA CATES-CARNEY: Maryann might be able to speak to this better but definitely getting providers to bill the code so that we knew we could see the small numbers of screenings that were happening. We had some anecdotal data that providers that served privately insured women and didn't want to accidentally charge women if this code was billed for them, even if it was going to be covered by MaineCare because they didn't want to change their practices for differently insured clients. And while there has been plenty of outreach for that, as Maryann said, the survey was done about why providers weren't using the code. That was definitely a barrier. Maryann do you have anything else to say?

LINDA RIDDELL: This is Linda, I would chime in to say that's one obstacle that would be resolved if screening for illicit drug use became a United States Preventive [Services task force approved preventive service], right?

MARYANN HARAKALL: This is Maryann. I think Maya you hit on it exactly. From the Maine CDC side we've been trying to do some outreach to providers to find out how we can improve the use of the screening code and get more of our pregnant women into treatment. We have been trying to get the SnuggleME guides out. Some of our partners in the local and larger hospital systems have been doing some eat, sleep, and console trainings, and they've been pushing the SnuggleME guides out to the folks that they're presenting to as well. So, we're not giving up on that issue. We're still just digging for a way to resolve it. That's something we'll be continuing even after this project ends.

NICOLE HARLAAR: Great, thank you. Christy, do you want to summarize any barriers you've encountered in Mississippi and how you've dealt with those challenges?

CHRISTY LYLE: Absolutely, I really want to point out that having the infrastructure available and staff continuity is key. This has been a 2-year project and as I stated before our work is not nearly done, but one of the barriers we've had throughout is that we have had staff that has been a part of the project and then leaves the agency or turnover is there. Having a dedicated champion and enough resources to devote to the project for us has been key. Also looking at what other priorities your agency has in place. We're in the stages of implementing a new physical agent and looking at anything that we're doing right now is going to have to be repeated again with our new physical agent. Just looking at what those priorities are is key for anyone looking at a project like this in the future.

NICOLE HARLAAR: Thanks, Christy. We are getting quite a few questions related to monitoring and assessing the performance of VBP approaches. Firstly, which measures do you plan to track to assess the performance of your VBP approach? Christy, maybe I can direct this one to you again.

CHRISTY LYLE: Sure. We've still got some technology issues before us that we have to overcome. We're looking at setting up electronic transmissions. That's going to determine a lot for us and what our next steps are. Then the data that we pull from that will be key and our collaboration with Blue Cross Blue Shield [BCBS] in rolling this out at the same time. [Those are] some of our next steps that are ahead of us.

NICOLE HARLAAR: Thanks, Christy. Michele, we've got quite a few questions for Pennsylvania. Firstly, do your OBs [obstetricians] report to each prenatal office visit in claims, or did you have to get access to the medical record in order to do the HEDIS prenatal care measure?

MICHELE ROBISON: In a simple answer, both. There is a claim, but there also is medical record review. In addition, we have implemented an OB needs assessment form that providers are able to utilize for the frequency. They submit that to the plan every time for a visit for updates. I hope I answered whoever's question that was.

NICOLE HARLAAR: Thanks. What was your rationale for expanding the number of measures?

MICHELE ROBISON: When you say expanding the number of measures, are you referring from prenatal to well child 15 or expanding the number of measures overall?

NICOLE HARLAAR: Maybe the person who submitted that question could clarify. Shall we move on to another question and come back to that one?

MICHELE ROBISON: That's fine.

NICOLE HARLAAR: Due to the fact you have both urban and rural areas in Pennsylvania, how are quality measures determined based on the unique trends of urban and rural areas?

MICHELE ROBISON: This is a good question. This is something we're looking into right now. However, initially when we selected rates, it was based on the overall population and areas that we identified that we wanted to improve care on and/or sustain care for. This is something we are looking into based on our ruralness and urbanness of the Commonwealth.

NICOLE HARLAAR: What is one piece of advice your state would provide other states seeking to implement a VBP approach to improve MIH outcomes? It would be great if all the states could answer that. Maryann, do you want to start?

MARYANN HARAKALL: I think one of the things—and I mentioned it earlier—is that building your relationships with different partners and having patience with that. We went through that whole storming, norming—whatever that thing is called—as we started building relationships here in the Maine CDC world with the MaineCare folks. We hadn't really had those relationships before, and we really had to work through that. But I think on the other end of it as we all just kept trying to get on the same page with each other, we got there. I think we built a really good relationship that we use in other arenas, not just for this project.

I think the other thing that we figured out pretty quickly—and I'll give Linda some kudos here—is we figured out pretty quickly that we needed a good data person on board with us, and so she [Linda Riddell] was pulled into the project. But that's where it points out that you need to make sure that everybody that's on your team has a very specific set of skills because not everybody's going to have every skill

needed to do a project like this, but as a team we each bring something to the table. So, I think that was really important for us.

And I think the other thing that was super important was just communicating with each other and making sure that we were very consistent and very transparent with each other over what our agendas were, and that sort of opened the door for Linda and Maya, if either of you have anything else I didn't think of that you'd want to add.

MAYA CATES-CARNEY: I think you captured it.

LINDA: Indeed, and thank you for the kudos.

NICOLE HARLAAR: Thank you. Christy do you want to describe your advice or key takeaways that you have for other states?

CHRISTY LYLE: I think aligning pretty much the same. Team members having a defined role and having that dedicated champion and the staff continuity is key and making sure that it aligns with agency objectives at the time. For us, those change frequently, and making sure that you have a strong champion to be able to keep progress going for that project is key.

NICOLE HARLAAR: Thank you, and Michele, any key takeaways?

MICHELE ROBISON: What my one piece of advice would be, and I touched on this earlier, is provide guidance to your MCOs while at the same time allowing some flexibility and including your MCOs in the process. This allows them to feel that they are part of the process, they are valued, and will allow buy-in sooner.

NICOLE HARLAAR: Thank you. Just wanted to circle back to a question we received for Pennsylvania about the quality measures. This question was in relation to your last slide where you indicated that you were going to expand the number of quality measures. Why did you decide to do that?

MICHELE ROBISON: We are looking at expanding because of areas that we feel we would like improvements in either quality of care and/or sustaining the quality of care. That was the main reason was areas we've noted of high importance to us as a department that we feel the measures, the rates the MCOs are currently at could be improved, and we'd like them to improve. This is our way of bringing more attention to them.

NICOLE HARLAAR: Wonderful, okay, that's all the questions we have time for today. Thank you all so much for participating in this.

Key Takeaways

Okay, I want to wrap up the webinar just with a few key takeaways from what we've learned through this technical support opportunity and also what we've learnt through our discussions with Pennsylvania.

First, leverage existing care delivery models to integrate VBP approaches compatible with the amount of risk providers are willing to assume. I think this has been shown very nicely in the case of Pennsylvania, which has been working very closely with its MCOs to develop and refine its P4P program. We know that VBP approaches are much better suited than fee for service to support patient-centered, high-quality,

cost-effective maternal and infant care. But participation involves financial risk for providers, and not all assess the capacity to successfully operate in these payment models. States should balance the potential for delivery state system transformation against the risk of physicians taking on greater financial and insurance risk than they can manage.

A second takeaway is that it's very valuable to conduct small-scale pilot testing with selected care delivery sites and refining VBP approaches before expanding. Ideally there'd be some kind of continuous feedback loop where states are able to provide information to and receive comments from key stakeholders, so their approach can be refined and adapted in a timely manner.

The third point is closely related to the first. Assess provider capacity, community needs, and the existing care delivery system context when transitioning to more complex VBP approaches. Collaborate with key stakeholders (e.g., payers, clinicians, patients) to foster strong commitments to shifting towards VBP. The effectiveness of stakeholder engagement and collaboration is particularly clear for Maine's work on this technical support opportunity. By collaborating with the Maine CDC, the Office of MaineCare Services was able to roll out a screening code in conjunction with the SnuggleME guidelines, so providers have both evidence-based resources at their fingertips.

I am now going to turn it over to Bill.

WILLIAM OLESIUK: Thank you, Nicole. Just to summarize what was discussed earlier, there are a number of resources available on the IAP MIHI VBP section of the Medicaid.gov website. Those [resources] cover topics of interest to states looking to implement value-based payment [VBP]. We hope that you check those out as you are able. This presentation, slide deck, and recording will be posted there in the weeks and months ahead, as well as a resource list and guide for important research and information available for states looking to implement value-based payment [VBP] to serve their populations of interest. Nicole?

NICOLE HARLAAR: That brings us to the end of today's webinar. We would like to extend a special thank you to all our speakers and state teams that participated in the MIHI VBP technical support opportunity. We would also like to thank you all for joining today's webinar. If you have time, please fill out the evaluation form that will appear on your screen when you log out of this webinar. This meeting will now stop being recorded. Thank you.

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