

Virtual Meeting Track 2: Contracting with Providers

Maternity Multi-Stakeholder Action Collaborative

July 28, 2017
1:00-2:00pm ET

Highlights and Key Takeaways

MAC members participated in the virtual meeting for Track 2: Contracting with Providers. Below are highlights and key takeaways from the interactive meeting, which included live interviews with Lili Brillstein, Director of Episodes of Care and Market Innovation with Horizon Blue Cross Blue Shield of New Jersey, and Dr. Bill Golden, Medical Director with Arkansas Medicaid. Participants explored the steps in contracting with providers, which may vary based on whether the payer is implementing maternity episode payment as a standard approach across all providers, or whether the episodes are implemented with a select base of providers. Participants engaged in discussion with Lili Brillstein and Dr. Golden, who each represent the varying approaches, and who reviewed the implications of their organization’s decisions to pursue their respective models.

Selecting Providers Amenable to Contracting for Maternity Episodes

There are two different approaches to contracting with providers depending on if the payer is a state agency or a commercial/Medicaid health plan.

For **state agencies**, there are a variety of ways to advance value-based payment. Although the three examples below specifically mention state agencies, they can be generalized and applied to other payers as well.

- ***Example 1:*** Mandate this payment method for any Medicaid provider that has met a certain volume threshold for episodes. This is the approach Arkansas followed, however, Arkansas does not have managed care organizations (MCO) and instead contracted directly with providers.
- ***Example 2:*** If your state agency is contracting with MCOs, require your MCOs to implement a state designed episode. As we have heard in past MAC sessions, this is the model both Tennessee and Ohio are currently using.
- ***Example 3:*** Create compelling incentives for MCOs to contract with providers using a state designed approach, but do not make it mandatory. New York has shared how this approach has been incorporated into their model during prior MAC sessions.

There are many other ways, in addition to the three examples above, to approach value-based payment contracting either directly with providers or through MCOs.

For **commercial or Medicaid health plans**, there is broad discretion in terms of which provider to contract with, particularly if you’re not going to implement this approach uniformly across all providers. Many health plans have implemented their episode models with select providers and then expanded the models application as necessary. If your organization is planning to use the method of contracting with a few high-volume maternity providers to start out, consider the following matters:

- Do you have a good relationship with these providers which is built on trust?
- Do you want to attract providers with higher quality or lower quality performance? Both options are viable, however, building a model which attracts providers with lower quality performance offers more opportunity for improvement.
- What is the variation in episode costs, or cost benchmarks? Consider episode costs and whether they vary among or within the providers, or if they vary compared to cost benchmarks for the market.

- How strong is the leadership within the organization for which you are planning to contract? Implementing a maternity episode is intended to drive some improvement in streamlining clinical care delivery. It is important to know prior to implementation if the providers’ internal qualifications – leadership and strong internal management – are aligned with meeting the care delivery goals.
- Does the provider have experience with episode-based payment? Research shows that past experience is somewhat predictive of future performance. So, a provider that has some experience with episodes, even if not specifically with maternity care episodes, is probably better positioned to succeed.

Engaging Providers

After identifying the method of contracting with providers – either mandatory participation for all or choosing a select few to begin with – the next step is to engage with those providers and offer general education on payment models, how they work, and what providers need to do to succeed. Share information on cost and quality to identify where opportunities may exist to generate savings and improve quality performance, and explain how the financial model is built and what the providers must do to achieve gains or avoid losses.

Options for Identifying the Contracting Entity

There are a variety of providers with whom payers may choose to contract, such as:

- Maternity Care Providers, which may include obstetricians, certified nurse midwives, and family physicians.
- Birth locations, including hospitals and birth centers. Payers may choose to contract with birth locations individually, or enter into a more complex contracting model between both hospitals and birth centers together with the payer. Although the latter is more difficult, it is a viable option.
- Accountable Care Organizations, Independent Practice Association, or state-created entities, all of which are comprised of a larger aggregation of providers.

What to Include in a Contract

There are four priority components of a provider contract:

1. **Define the episode** and include specifics such as when it begins and ends, what is included or excluded, and member eligibility.
2. **Payment terms** need to be defined in significant detail so that there is a thorough understanding of what will transpire after the contract starts. You may need to include an appeal mechanism as well, especially in a contract where the episode experience is new for both the provider and the payer.
3. Clearly state the **provider responsibility**. Providers should understand the volume and type of information they will be submitting, and if required, how to notify the payer of episode commencement.
4. **Payer responsibility** should be defined as well, specifically the volume, type, and frequency of reports payers will supply to providers to assist with managing an episode. It may be difficult for a provider to appropriately manage an episode if they are not receiving the information they feel they need from a payer.

Please also note that, while it is not listed above, it is the payer’s responsibility to conduct the financial reconciliations, make appropriate payments, and be transparent in all calculations and reports for the provider.

Conducting a Readiness Assessment

Conducting a readiness assessment may be easier when contracting with a smaller number of providers and may not be practical if an entire network of maternity providers is participating in the episode model. Readiness assessments are not always completed prior to contracting with providers for episode-based payment arrangements, however, completing an assessment allows the payer to take some level of confidence that the provider is ready to enter into the new arrangement and is positioned to succeed.

Strategies for Contracting Success

Listed below are a few strategies for contracting success based on a number of payers and providers who shared their experiences:

1. Create an environment of openness and flexibility with providers. However, a payer's flexibility may depend on if they are contracting with a limited number of providers, or their entire network. Regardless of the scale, payers should be open to gathering and incorporating providers' input.
2. Consider delivering consultative assistance to help the providers succeed, especially when they are new to episode models. It is in the best interest of both the payer and the provider for the episode model to be successful, so if it's possible for the payer to facilitate the provider's work, and the provider is open to it, then this is an optional strategy to consider.
3. Complete the whole contracting process in a timely fashion. One potential maternity episode initiative, which was in development and ultimately never implemented, shared their experience and attributed their inability to implement the episode to the conversations dragging on for so long that the momentum ran out and the work stopped. While contracting can be challenging, it is important to maintain a sense of momentum and excitement for all involved.

Interview: Experience Contracting with Providers (Horizon Blue Cross Blue Shield of New Jersey and Arkansas Medicaid)

During past sessions, we have referenced the episode-based payment models in both Arkansas and Horizon on multiple occasions. Today we will learn more about Arkansas' model from Dr. Bill Golden, and Horizon's model from Lili Brillstein. Arkansas uses a statewide, mandatory payment model for any provider or provider group who has five or more deliveries in a 12-month period. Eligible providers are able to share in savings if they meet certain quality and efficiency performance thresholds, or may share in risk if their costs are high. In contrast in New Jersey, Horizon Blue Cross Blue Shield is a voluntary model. Contracted providers and provider groups are eligible for shared savings under Horizon's maternity model.

- **Question 1:** Explain the decision-making process for Arkansas to mandate the use of episode-based payment instead of offering a voluntary participation option.
 - [Bill] In 2011 when Arkansas started work on an episode-based payment model, the notion was to try to work toward a transformation of the health care system with a focus on changing how the patient journey is approached instead of focusing just on money, profit margins, and marginal cost of care. The patient journey should be viewed as the collective impact of what the experience was for the patient and the overall cost to deal with the condition as a whole.
 - [Bill] Arkansas was charged by the Governor to do this work, and leading up to the implementation of episode-based payment models, we spent several months setting the stage, engaging stakeholders, discussing sustainability, and promoting stewardship. We worked with Blue Cross Blue Shield (BCBS) of Arkansas to align activities between a major commercial payer and a public payer, knowing that we would have greater impact changing payment for a large percentage of business – both Medicaid and commercials - for a particular service. Together, we worked to design a fair system that would reward better performers who showed better quality metrics and better economic output. Clinical leaders felt they could be successful in this framework. Through public town halls and feedback received through learning systems, both Arkansas Medicaid and BCBS provided information about the program to help increase the comfort level of developing and participating in episode-based models.
- **Question 2:** Elaborate on Arkansas' public town halls, were these more used to provide education on episodes, or to share data with the health care community in order to show the variations in maternity costs or quality across the state?

- [Bill] The public town halls were used for both purposes. First, we had to sell the concept of episode-based models. We presented an episode model which was driven by data, and we were fortunate that we have a robust and useful claims data warehouse where we ran pilot data on the previous year’s fiscal year. We were able to demonstrate the existing variations, and provide examples on how the thresholds would be set using the previous fiscal year’s data. We also made it clear that this isn’t a zero-sum game which relies on having “winners” and “losers”. The episodes would have set thresholds, and we would provide data and progress reports through a portal for providers to monitor their progress. All providers who reduced costs and improved quality metrics would receive the gain-sharing bonus.
 - [Bill] Maternity providers did have some early concerns, such as cesarean rates, differences in length of stay, adverse selection, and excluding high-risk patients. We had many discussion with providers around risk mitigation and the fairness of metrics and data to help them feel more comfortable with the model.
- **Question 3:** In contrast to Arkansas’ approach, Horizon Blue Cross and Blue Shield of New Jersey chose to contract with select providers. How did you decide which providers to initially contract with for maternity episodes?
 - [Lili] The maternity episode was not the first episode at Horizon. We had past experience with our hip and knee replacement episodes of care, which were not mandatory models either. We considered many of the same matters discussed previously during the *“Selecting Providers Amenable to Contracting for Maternity Episodes”* portion of this session. Horizon looked for providers who had significant volume with us to ensure a significant portion of our members were being treated by those providers. We found there already was tremendous variation existing within practices and across the state.
 - [Lili] Although it’s the first bullet on your *“Selecting Providers Amenable to Contracting for Maternity Episodes”* slide, an existing good relationship was not necessarily the first thing we looked for because this model, and the way Horizon implemented it, builds good relationships with providers. Historically, payers and providers have an adversarial relationship, but the structure of this model has really changed the spirit of the relationship by allowing payers and providers to work together to achieve excellent outcomes for the patients. Rather than looking for an established good relationship, we looked for providers who had the propensity to think with us, those who had the willingness to engage with us in developing an episode, developing criteria, and reviewing data.
 - [Lili] Strong leadership is also an important factor in the success of value-based and episode models. There needs to be strong leadership within the provider community who understands the episodes, communicates effectively with the payer and with others across the continuum, analyzes the data with the payer, and identifies opportunities for improvement. Success happens when the provider leadership takes that information and develops clinical pathways or protocols for their organizations. It should not be the payers telling the providers how to provide care to their patients, it should be the provider leadership determining the best protocol to follow.
- **Question 4: [Participant Question]:** Who gets a piece of the savings, is it the health care system or just the clinician? How did you decide if you should contract with a hospital, Obstetric group, or both?
 - [Lili] Horizon currently has 18 episodes in multiple specialties, and for the most part, the models are physician centric, meaning the practice or physicians, the ones with whom we contract, are the “conductors”, or the most accountable party. We have our models designed this way because it is the physician who makes the clinical decisions about where, when, and how to treat the patient. Although we do have a contract with a hospital in Newark, NJ, which is a new model for us. We are also in the process of creating episode under the umbrella of accountable care organizations (ACO).

- [Lili] The conductor is responsible for all care rendered to the patient from their first qualifying day in the episode through their last qualifying day, no matter if they rendered the care or it was provided elsewhere. This encourages the conductor to collaborate with other providers across the continuum.
 - [Lili] With the way the contract is structured today, Horizon holds the risk and shares savings with the conductor only. To my knowledge, the obstetricians, who are predominantly the conductors, are not sharing savings with others in the continuum. With that being said, the environment we created is a no-risk, retrospective, upside only, environment. This is a learning environment for our physician partners, so when the model moves to risk-based arrangements, everyone will understand their roles and will be well positioned to succeed.
 - [Lili] I would also like to point out that Horizon has ACOs contacting us who are actively engaged in crafting these arrangements and who would bring their specialists into the episode model under the umbrella of the ACO. So rather than having providers directly contract with Horizon, the ACO may contract with Horizon and act as a support in various ways that will help the specialists succeed better than they might have alone, particularly for smaller practices who might not have the administrative, care navigation, or care coordination support.
- **Question 5:** How did Arkansas decide who the principle accountable provider (PAP) would be for maternity episodes? To what extent do birth centers or nurse midwives play a role?
 - [Bill] Arkansas had an active Pay for Performance program, almost a level 2 APM for hospitals, that was created when hospital rates were increased and there was a negotiated withhold of about five percent. For many years, we measured metrics that could transform maternity care specifically for maternity hospitals, such as early elective deliveries, low risk cesarean rates, and exclusive use of breastfeeding. When Arkansas moved towards episodes of care in 2011, we mostly targeted physicians as PAPs for active clinical management, such as pregnancy, and targeted hospitals as PAPs for acute medical conditions such as asthma, admissions for COPD, or congestive heart failure. Although maternity care does have inpatient and outpatient management over the course of the episode, it makes sense to have the physician assigned as the PAP because of their overall responsibility for clinical care decision-making for the patient. Providers were receptive to this idea and did not pushback on the decision to make them the PAP.
 - [Bill] Our reimbursement structure does not accommodate freestanding birth centers, and there are issues involving the medical board, our legislature, and a variety of other politics involved in contracting with independent midwives. We reimburse PAPs who are recognized by our legal and regulatory system as being able to bill independently and be accountable for the delivery of services.
- **Question 6: [Participant Question]:** Are maternal fetal medicine providers considered PAPs or conductors?
 - [Bill] The maternal fetal medicine providers are often the delivering provider, or their group is the delivering provider, so they would be considered as a PAP.
 - [Lili] Anyone who touches the patient in relation to pregnancy, including the maternal fetal medicine providers, are part of the episode. Currently, Horizon doesn't have any that are conducting episodes, however, it is not inconceivable that we would. We do not have any birth centers as conductors, either.
- **Question 7: [Participant Question]:** If a health plan wants to contract with a provider on a shared savings model, what is the industry standard percentage of savings that is shared with the provider in this model and others? I have heard 50% is a typical amount shared with providers, but I'm still searching for this information.
 - [Lili] I don't know that there is an industry standard because the industry around this is pretty small. The retrospective model sits on a fee for service (FFS) chassis, where everyone is paid FFS so any shared savings is on top of the FFS payment and is only earned if quality metrics are met and savings are

community was not ready, then there would have been significant political speedbumps and we would have not been able to develop and implement episode-based payment models.

- **Question 10:** If you had to start the contracting process for maternity episodes all over again, what would you do differently?
 - [Lili] I don't think I would do anything differently, the maternity episodes have been one of our largest, most successful, and most important episode models. The obstetricians love this program and they've seen tremendous success with moving the needle on certain metrics, such as cesarean rates. Although our first episodes started with the lower risk population, we quickly realized the high-risk patients should be included as well, and now close to 100% of all maternity episodes are handled by providers in the program.
 - [Bill] In this process we have learned a lot about claims data and modeling. When starting out, we were so early in the game for developing and implementing episode models that we didn't have the knowledge we have now. You don't know what you have in your data model until you run the data and then hold providers accountable, so I think if we would start over, we would start with better data modeling.

Appendix: Interactive Poll Results

Contracting with Providers Poll Questions

Data Sharing and Infrastructure Poll Question	Participant Response	Total Percent
At what stage is your organization in the process of contracting with one or more providers to implement episode-based maternity payment models?	Determining who to approach	27%
	Currently negotiating	9%
	Conducting readiness assessment	27%
	Have current, signed contracts	9%
	Not yet decided to pursue	27%
What are your concerns/challenges for the contract negotiation process?*	Defining the episode	33%
	Defining financial risk terms	78%
	Setting quality thresholds	56%
	Data sharing infrastructure	44%
	Low patient volume per provider	22%
	Other	0%
Rate the Value of this Meeting	Very Valuable	56%
	Valuable	33%
	Somewhat Valuable	11%
	Not Valuable	0%

* Participants had the option to choose more than one response for these questions, therefore results do not equal 100%