Virtual Meeting Track 2: Setting the Patient Population

Maternity Multi-Stakeholder Action Collaborative

May 4, 2017

1:00-2:00pm ET

Highlights and Key Takeaways

MAC members participated in the virtual meeting for Track 2: Setting the Patient Population. Below are highlights and key takeaways from the interactive meeting, which included a live interview with Karen Love, Executive Vice President and Chief Operating Officer for Community Health Choice in Texas. She discussed the factors used to determine the patient population for Community Health Choice's maternity episode model, and what those decisions meant for the model's implementation and operationalization.

Considerations for Setting the Patient Population

When setting the patient population for an episode, there may be tension in the discussion between payers and providers when determining how broad to define the population. Providers are often uncomfortable including individual subpopulations of patients where they feel they do not have as much control over the patient's care and clinical outcomes. By limiting the population and including mostly lower risk women, however, there is less opportunity to generate savings and improve quality. Prior to setting the patient population, payers and providers should discuss strategies to mitigate risk for certain subpopulations, such as excluding patients with gaps in their insurance coverage, prorating the prenatal budget for the time period when prenatal care was delivered, or using a risk adjuster to modify budgets for clinical severity. For additional information, including examples of exclusions from current maternity episode models, please refer to the virtual meeting presentation and pre-read materials.

Although the discussion during this virtual meeting does not include much detail on budgets, how the episode's patient population is set will impact the episode budget. For example, a narrower, low-risk patient population will result in a smaller budget. When organizations are beginning the process of setting their patient population for a maternity episode, a good exercise is to start by assuming all women and all expected services for women are included, and evaluate the impact. Then consider excluding only those subpopulations of women for whom your organization feels an accurate budget could not be set. There will be a more in depth discussion on episode budgets during the June 15th MAC virtual event.

Considerations for Including the Baby in the Episode

Healthy newborns are one of the desired outcomes of a maternity episode, therefore it makes sense to include the cost of some newborn services. This requires an organization to complete preliminary data analysis to consider how to:

- Link the mother and the newborn using claims data
- Determine appropriate accountable entities for the episode. For example, will the OB/hospital be the sole accountable entity for the entire episode, or will the Pediatrician be included as well.

Do not include the newborn in the episode until your organization has determined how to accurately link the mother with the newborn. For additional resources on developing a matching program, refer to the Center for Outcomes Research and Education's (CORE) methodology which has successfully linked 89% of mothers and newborns in a sample of 17,000 births with a high degree of confidence in the match.

Subpopulation Data Analysis

As your organization decides how broad or narrow to define the patient population, and whether to include the newborn, it is worthwhile to analyze the variation in cost within subpopulations. For example, do pregnant women with behavioral health diagnoses have higher overall costs, and if so, would your organization find more value in developing a separate episode budget for that subpopulation or employing a clinical risk adjustor to account for the variation? If there is noticeable variation within subpopulations, does this suggest inadequate care is being provided, or is the variation in price effecting differences in cost? It is helpful to complete preliminary data analysis to determine where there are potential problems, opportunities for improvement, and to begin to inform how broad or narrow your organization may set the patient population.

Interview: Setting the Patient Population in Texas (Community Health Choice)

Karen Love, Executive Vice President and Chief Operating Officer of Community Health Choice in Houston, Texas, discussed the implementation of her organization's maternity bundle. Community Health Choice implemented a 2-year pilot in Houston with two of their largest Medicaid Managed Care Plan maternity care providers. The maternity episode includes prenatal care, labor and delivery, postpartum care, and care for the baby between birth and 30-days post-discharge.

- **Question 1:** Based on your Year 1 results, Community Health Choice found that one practice was more successful in lowering their cesarean rate than the other participating practice. What changes in care delivery were made to accomplish this?
    - To determine the budgets for each participating provider group in Year 1, a blended cesarean rate was set using historical data for each provider. Results showed that one provider group had a better than historical blended rate and the other group had a worse than historical blended rate. Neither provider made changes in their practice patterns during Year 1, so it is unlikely these results were caused by specific actions taken be either provider group. Both providers felt they were performing well and would analyze their data at the end the period of performance.
    - Year 1 ended in February 2016, and because the episode uses retrospective reconciliation, full final performance data was not available until July 2016. To allow the providers to better assess their first year of performance and make informed decisions about interventions or changes in care delivery, we delayed the start date of Year 2, which will now run from October 2016 through September 2017. We spent time with each provider group discussing ways they could produce savings, with reducing cesarean rates being one of many opportunities.
- **Question 2:** Why did your organization make the decision to include all pregnant women?
    - The two participating provider groups are both tertiary referral groups with only a small percentage of their business including higher risk cases. We analyzed their historical data and showed the providers their percentages of higher risk cases remained consistent over the past four years. Recognizing that, the providers agreed there was no need to exclude certain populations if we are comparing their results to their own provider-specific historical performance.
    - We do use risk factors to adjust the patient specific budgets, so risk factors for outlier cases or higher-risk women are incorporated. Moving into Year 2, neither provider indicated a desire to exclude specific patient populations, so this design continues to work with our model.
- **Question 3:** Why did your organization make the decision to include newborns in the episode?

  - Community Health Choice finances about 22,000 births in our 20-county service delivery area every year, and we have a strong position in the Medicaid market for pregnant women. We noticed variability in the quality and cost of care across our hundreds of participating obstetricians, and the greatest variability appeared to be in the percentage of newborns who needed neonatal intensive care, and their lengths of stay in the NICU. Both participating provider groups are multi-specialty groups that have obstetricians, pediatricians, and neonatologists, all as part of the same group so it does not just fall on the obstetricians to produce savings.
  - Including the newborn in the bundle emphasizes that our payers, providers and patients all value the outcome of a healthy newborn and a healthy mother. Including the newborn also expands the number of opportunities in which providers may produce savings.

- **Question 4**: How do you link the mothers with the newborns?
  - Upon notification from the hospital about the birth, our health plan's eligibility team creates an internal proxy number for that newborn that is used by the hospital and the Utilization Management Department to authorize the newborn's stay. When the eligibility file from the state that includes that newborn is received, we merge the proxy number with the unique Medicaid ID number that is assigned to the newborn.
  - In about 10% of these cases, we may not have the opportunity to assign a proxy number so we use a process similar to CORE's methodology, matching mothers with newborns using phone numbers, dates of birth, and dates of delivery. If we are unable to match a mother with a newborn, then that case is excluded from the episode.
- **Discussion between MAC participant Lili Brillstein from Horizon Blue Cross Blue Shield of New Jersey and Karen Love**:
  - **LB:** I was not aware that your two participating provider groups included obstetricians and pediatricians. Who is the accountable group, or is everything billed under one Tax ID for both the obstetricians and pediatricians?
  - **KL:** They are all under the same Tax ID, but from my experience, the obstetricians are the most engaged physician leaders.
  - **LB:** At Horizon, we are contemplating launching an episode that includes newborns this year. The concept is that there may be costs of care and decisions made by the obstetrician while the mother is pregnant that may increase cost on the prenatal side of the episode, but which may ultimately improve the quality and cost of care for the mother and newborn together in a combined episode. This is one reason why our obstetricians are extremely interested in including the newborn in the episodes, but our pediatricians would not be billed under one Tax ID with the obstetricians.
  - **KL:** We have been approached by a large Independent Practice Association, with multiple obstetricians, who is interested in participating in our maternity bundled program, so we have begun thinking about this. The discussion to include providers with more than one Tax ID starts with conversations about who are the pediatricians and neonatologists primarily being referred to, and which hospitals are primarily being used for delivery. This also requires working collectively to determine how to distribute savings.

  - **LB:** In many states, there are regulatory concerns around other providers taking on risk, such as if an obstetrician was the accountable entity for an episode that included care provided by a pediatrician as well. In some instances, the obstetrician might not be able to take on risk, distribute payments, or have downstream agreements. Having obstetricians and pediatricians under one Tax ID does make the process less complicated.

- **Question 5:** Have you encountered any issues with clinical risk adjustors being able to adjust for certain populations (e.g., opioid dependent pregnant woman)?
  - I do not recall any conversations with our participating providers raising the issue of risk adjustment within certain subpopulations of women during Year 1. As we move into Year 2 and there is downside risk for the providers, this may be a topic that we will need to address.
  - One change we did make from Year 1 was concerning exclusions for some of newborns. Initially, we excluded newborns who required the highest level of NICU care but we discovered this was not the best predictor of high cost newborns. A newborn with significant developmental deformities or other complications at birth may still be high-cost even if the newborn was not admitted to the highest level of NICU care and excluded from the episode. To avoid creating an incentive for providers to move a baby into higher NICU care simply to exclude the newborn from the episode, we added a stoploss level in Year 2. Essentially we are mitigating risk in two ways – clinical risk adjustment and truncating claims for high cost newborns. Currently, we do not have stoploss in place for high cost mothers.

- **Question 6:** How has insurance eligibility impacted your episode (e.g., gaps in enrollment, enrollment changes, or loss in eligibility)?
  - With our Medicaid population, we do not have significant problems with changes in eligibility or coverage. Our most common issue is with women who have employer sponsored coverage, but transition to Medicaid for their pregnancy and return to their employer sponsored coverage after delivery. Transitions like this, or other extenuating circumstances, may cause a woman to delay prenatal care until their second or third trimester. To account for this, the prenatal component of the episode budget is prorated based on the month the woman enters prenatal care.
  - We did complete data analysis to determine the percentage of births for each participating provider group in which they provided no prenatal care whatsoever, and found that was less than 4% in each case.

- **Question 7:** Can you share some lessons learned from your maternity episode pilot program?
  - Be patient and be open to change along the way. Providers want to know that the payers aren't capriciously putting them at risk. Community Health Choice addressed our outlier criteria and refined how our quality metrics were captured mid-year. As a result of those changes in how we are calculating and quantifying the metrics, our quality scorecard will compare the last two quarters of Year 1 to Year 2.
  - Be supportive. Our providers saw our willingness to support their efforts and reach the ultimate goal of a healthy mother and a healthy newborn, together.
  - Share your learnings within and outside of your community. Karen is happy to take questions by email if MAC participants would like to ask any further questions or continue the discussion from this virtual meeting.

Tools to Utilize to Begin Data Analysis

The Health Care Incentives Improvement Institute (HCI3) offers public episode of care definitions on their website, including definitions for maternity care. The definition will provide you with a group of codes to use, such as trigger codes and diagnosis codes, to begin your own data analysis. A suggested place to start is to use the trigger codes provided by HCI3 to analyze volume and variation in spending in your claims data. To do this, determine your volume of cesarean births and volume of vaginal births, then determine hospital costs, professional costs, volume in total, and volume by provider for each type of birth to determine how much variation is present.

If you would like to run further analysis, you could begin looking at how excluding certain populations may impact volume and cost. HCI3 offers more sophisticated analysis, which we will discuss during the June 15, 2017 MAC virtual meeting on the topic of *Setting the Episode Budget*. Until that virtual event, we encourage MAC participants to begin thinking about how your organization may identify the maternity patient population.

Appendix: Interactive Poll Results

Setting the Patient Population Poll Questions

Setting the Patient Population Poll Question	Participant Response	Total Percent
Is Your Organization Considering a Maternity APM That Includes the Following: *	Low-risk pregnancies	64%
	High-risk pregnancies	7%
	The newborn baby	21%
	N/A	29%
	Other Responses from Chat Box • *MBGH is working on a maternity improvement project that will explore a pilot with 2 employers and 2 health plans using maternity payment bundles.*	7%
What Do You Perceive to be the Greatest Challenges to Including a Broad (i.e. high-risk) Patient Population? *	Setting an episode budget	40%
	Changes in patient risk profile	33%
	Including conditions/complications	33%
	Excluding conditions/complications	33%
	Risk adjustment	40%
	Creating risk mitigation strategies	47%
	Provider engagement/buy-in	47%
	Other	0%
What Do You Perceive to be the Greatest Challenges to Including the Newborn? *	Linking data for two patients	57%
	Selecting the accountable entity	36%
	Choosing newborn service inclusions	21%
	Risk adjustment	36%
	Creating risk mitigation strategies	14%
	Other • *No "other" responses were typed into the chat box.*	7%

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

Feedback on the Value of this Meeting

Question	Answer	Total Percent
Please let us know how you would rate the value of this meeting?	Very Valuable	54%
	Valuable	31%
	Somewhat Valuable	15%
	Not Valuable	0%
How can the next meeting be more valuable? *	Allow for more Q&A time	60%
	Restructure guest presentation	0%
	More aligned reporting focus	20%
	Provide meeting agenda sooner	0%
	Other Responses from Chat Box • *No "other" responses were typed into the chat box.*	40%

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