Virtual Convening Session Track 1: Making the Business Case

Maternity Multi-Stakeholder Action Collaborative

February 8, 2017

2:00-3:00pm ET

Highlights and Key Takeaways

MAC members participated in the first virtual convening session of Track 1: Making the Business Case. Below are highlights and key takeaways from the interactive meeting, which included a live interview with Brooks Daverman, Director of Strategic Planning and Innovation from the Tennessee Division of Health Care Finance and Administration (TennCare). Brooks shared his experience related to the decision to pursue episode-based payment and the cost of designing and implementing episodes. MAC participants were also able to share their initial feedback during this session on the draft Making the Business Case brief. These session highlights are intended to serve as a recap and reference for MAC participants and support shared learning with those not able to participate in this session.

Interview: Making the Business Case in Tennessee

- **Brooks Daverman, Director of Strategic Planning and Innovation, Tennessee Division of Health Care Finance and Administration**
    - **Question 1:** When did your organization first operationalize episode-based payments?
        - We began by bringing together multiple stakeholders, including the hospital association, the medical association, TennCare (the Medicaid agency), and policy officials at the Governor's office. They all came together to have a conversation about the possibilities for improving care and reigning in costs, using value-based payment. It was decided that Tennessee would implement episodes and Patient-Centered Medical Homes (PCMH) as two initial strategies. These strategies met our criteria of being able to be implemented relatively quickly and applying to all types of providers in all areas of Tennessee (including rural and urban). ACOs are an example of a strategy that did not meet either of those criteria.
        - Design work started in 2013, and by June of 2014, we had preview reports out for all TennCare providers and some commercial providers.
        - TennCare began its maternity episode in January 2015. However, because maternity episodes are long, and because this performance period looks at episodes that ended in the 2015 calendar year, a lot of the services included in the first performance period actually happened in calendar year 2014.
        - TennCare now has complete data for calendar year 2015, showing 21,000 maternity episodes in that performance period. The maternity episode is starting for the commercial population this year (2017), affecting consumers covered under Blue Cross Blue Shield, Cigna, and UnitedHealthcare.
        - There are currently 19 episodes, including maternity, in a performance period. There are additional episode designs in the works which will take us up to the mid-30's, and Tennessee would ultimately like to have 70-75 episodes in place in the next couple of years.

- **Question 2:** Why did your organization make the decision to pursue episode-based payment as a general business strategy (not specific to maternity care), especially in light of the fact that there was not substantial evidence of the efficacy of an episode-based payment strategy.
    - In 2012-2013, we began having conversations with the Governor about the need for a new payment model that would address most areas of health care, and reduce costs. At the time there was not a lot of evidence pointing to the success of episodes, or of other APM options.
    - There are not many APMs when it comes down to it. We considered an ACO model, but we felt that this model would work best in urban areas, and thus would not serve the needs of Tennesseans state-wide. In trying to find an approach that could be used across both public and private payers, and would target both preventive/primary care and acute care, we settled on the approach of partnering retrospective episodes together with a Patient Centered Medical Home (PCMH) model. This achieved two things: establishing alignment across payers and providers, and allowing statewide implementation of a model that covers every aspect of a patient's care: primary and preventive care, as well as acute exacerbation and specialist care.
    - To pitch the concept to the Governor, their main message was that in the traditional FFS model, the burden is on providers to work together and coordinate amongst providers, facilities, rehabs, and labs. All of this time spent is not reimbursed. Thus there is the potential for significant value in creating a payment model that rewards the providers who can successfully serve as the coordinator – or quarterback – among different providers with the end-goal being improved outcomes at an efficient price.
    - It takes several years to move from an idea to seeing results with episodes. You will typically spend 6 months designing the episode, 6 months implementing, 6 months in a preview period, and 1 year in the performance period with a 6-month wait for claims data (on which to evaluate the results) due to the claims data collection lag. This message needs to be clearly articulated as well.
- **Question 3:** Looking back, what messaging worked to sell the general episode-based payment business case, what didn't work, and what would you do differently now?
    - In addition to providers, it is important to have a core group of well-informed stakeholders who are willing to talk to providers to explain what is involved in episodes, and ease any general concerns. Having people on the ground level to engage providers in conversations about how to be successful under this model is very important.
    - When discussing with stakeholders, have honest conversations about fairness, in the context of risk adjustment and exclusions of atypical episodes.
    - Understand from the beginning that providers will be accountable for influence and not control. Accountability for influence includes what the patient does even if they are not following the provider's directions, and what all other providers involved in the episode are doing that may impact the episode. Engaging in conversations with all involved is very important.
    - For Tennessee, aligning episode requirements and measurements between TennCare and commercial plans worked well.
    - Brooks encouraged the MAC participants to use available results to help make the pitch, including Tennessee's results as well as other states such as Arkansas and Ohio.
- **Question 4:** Why did you decide to make maternity care one of your areas for episode development and implementation?

- The criteria Tennessee used to select clinical areas were 1) volume; 2) cost per patient; and 3) explained and/or unexplained variation in care, treatment, or outcomes that we think could be improved. In the perinatal episode, there is variation in cesarean deliveries that can be improved
- Medicaid pays for about half of all births in the state, so perinatal care amounted to about 4% of Medicaid medical costs, which made it the episode with the most dollars associated with it. For comparison, perinatal makes up approximately 1.5% of medical costs for state employees, which places it behind breast cancer, respiratory infections, lung cancer, colon cancer and arthritis.
- By reimbursing for maternity care via an episode model, providers are motivated to increase the use of underutilized services, such as early and frequent prenatal care, and avoid over-utilized services such as avoidable emergency room use or unnecessary imaging studies.

o **Question 5:** How did you set benchmarks for when providers are meeting value and outcome goals for episodes in general and for maternity episodes?

- Providers have to pass all of the quality thresholds that are tied to gainsharing in order to be eligible for any kind of reward, so we started out by setting the thresholds for gainsharing at a level where about half of the providers can reach that and receive a reward. In order for us to achieve that, some quality measures needed to have relatively lenient thresholds to start. For example, we required providers to have a cesarean section rate of 40% or below.
- For some measures, claims-based data is ideal, but we are going to start using more non-claims based quality measures to better measure the patient experience and quality of care where claims data doesn't get at what we want to measure.
- Generally, about 10% of providers face a financial penalty based on how they perform on the quality measures. Approximately 25-50% of providers receive a gainsharing reward (percentage varies on the episode and health plan). Finally, approximately 40%-65% of providers land in the middle of the range, with no financial losses or gains.

o **Question 6:** What are the upfront infrastructure costs to create this model and what are the ongoing infrastructure costs?

- We spent approximately $250,000 per episode (through a contract with McKinsey) for analytics, design work, and development of the detailed business requirements. This does not include the cost of loading the data and it is in the context of a larger contract with to build many episodes, so I would expect designing a single custom episode would be more expensive.
- Tennessee has the Detailed Business Requirements posted online for others to use and using that may help save on some of that cost, but other payers would need to develop their own risk adjustment analysis.
- We estimate needing an additional $200,000-300,000 (per each new episode) once you have your data all in place to implement and run an episode initially. For a single episode the method of coding does not need to be as rigorous and extensible. If a system is running a lot of episodes it quickly needs to have an architecture that allows the system to be flexible, because different episodes are going to have different design elements.
- Other needs may include – but are not limited to – a data warehouse, analytics team, analytics tools, communications team, report engine, and a provider portal or alternative method for sending performance reports. Note that these can all be much more expensive than the design and implementation amounts.

- **Question 7:** As a part of your provider outreach, what was the most common assistance need that providers had in adapting from traditional FFS payment to an episode?
    - It is important to make sure when you are sending any communication to an insurance company (e.g. contract amendments, letters, emails, reports) that the person receiving the information understands what it is and gets it to the decision maker in the organization.
    - The most frequent need was to schedule time with providers to explain the information and reports they would be receiving, how to read and use their specific reports, and how they can find opportunities within this model to succeed.
- **Question 8:** Now that you have had substantial experience with maternity episodes, can you share with us the results you have observed?
    - Tennessee's top line analytics indicate a savings. The average cost of an episode dropped by $224 between 2014 and 2015, which is a 3.4% reduction and that is significant since we have such a high volume of maternity patients, and Medicaid covers half of the births in the state. This episode is so important that it is practically creating enough return on investment by itself for all the work involved in the initial program and the design and implementation of the first three episodes.
    - To providers, there were more rewards paid than penalties imposed. There were about $500,000 in rewards and about $250,000 in penalties in the last performance period. Even with paying about $250,000 more in rewards than penalties received for Medicaid, with an overall estimated savings of $4.7 million, we still have about $4.5 million cost reduction. Factoring in the medical inflation that would have otherwise been present our estimate for savings is $11 million.
    - In terms of quality improvement, there was not much change either up or down. Overall, the level of quality that was in place prior to the episode was maintained. There is hope that providers who were eligible for a reward but didn't meet the quality threshold in the 2015 performance period will try to achieve better quality scores so they receive a reward in the 2016 performance period.

Additional Pre-Arranged Questions That Were Not Asked (for lack of time) During the Session

Question	Answer
Did you need to test the cost and clinical impact of maternity episodes to demonstrate value on a small scale at first, or did you start with a broad application? ➢ If you started with a test, what were the clinical, utilization and cost measures that you employed to assess efficacy?	We started with a broad application to all Medicaid perinatal episodes statewide. One advantage of episodes is that it can be applied to all providers relatively quickly.
For TennCare, what were your sources of funds to support the costs associated with implementation?	We used SIM funds as well as a trust fund that comes from a hospital assessment.
We have a considerable number of organizations participating in the Maternity Action Collaborative that have expressed	One way to start would be to build the case with data. If you have the capacity to run some analytics, consider running the perinatal episode design that is available at

Question	Answer
interest in maternity episode-based payment, but have not yet made the decision to pursue it. How would you recommend that they make a pitch within their organizations that maternity episode-based payment is a smart clinical and payment reform strategy that generates value for patients, providers and payers?	http://www.tn.gov/hcfa/topic/episodes-of-care and see what kind of variation you see in the quality measures and the cost of care. Based on the results, you can build the case for the need to address quality and value in perinatal care. The evidence of the effectiveness of episodes is growing stronger. This is an approach that can be operationalized relatively easily, because it is built on top of the existing volume-based payment system. Episodes are being used in several states, commercial carriers, and CMS. Once you have buy-in to the goals, there are only a few options to change payment to support those goals: pay for performance, changing the payment differential between c-section and vaginal delivery, changing payment for unnecessary early inductions, prospective bundles, and retrospective episodes (there are likely others I haven't thought of). I'd actually recommend looking at some of the simpler changes listed at the beginning if you haven't already. Depending on your appetite for change these may be low-hanging fruit. Then make a decision about your approach. Does it make sense to engage with a few large providers first or engage all providers? This is likely a decision based on the local context that you will know best. If you are planning to engage all providers then you are likely going to need to use a retrospective approach. There is too much change required to go to a prospective approach, I believe. Even if you are going with a smaller number of providers, prospective may not be the best route, but you can discuss that with your providers. Prospective is intuitively attractive, but may not be feasible once you start talking to hospitals and Ob/Gyns about how they will pay the anesthesiologist and the imaging centers, etc.

Questions asked by MAC Participants During the Session:

Question	Answer
Has TennCare worked with any of the four accredited freestanding birth centers in Tennessee?	Yes, at least some of these providers accept TennCare, and so they are included in episodes.
Do you plan to tighten the quality thresholds over time to see greater cost savings?	That is something we have talked about. We also hear from providers about additional quality measures they would like to add.
Has TennCare looked at NICU admissions and the impact this might be having on the episode, as well as neonatal outcomes, including morbidity and mortality?	We do not currently include baby services or outcomes in the episode, the episode is focused on the mother's services and outcomes, although we are interested in connecting these over

Question	Answer
	time. We are working on the underlying data issues to be able to achieve this.
How do the MCOs distinguish their performance given the uniformity of the model?	One way they can distinguish themselves is in their communication activities with providers.
Were the savings described across all of the episode bundles or just the maternity?	The savings are across the first three episodes. The total cost of care for perinatal episodes was reduced by 3.4% from 2014 to 2015.
Where were the savings identified for maternity (e.g. hospital costs, imaging, ER visits)?	We have top-line results now and are adding analytic capacity to explore the drivers of these results.
Hospital costs are generally the largest driver of costs but the doctor generally does not control hospital charges, short of cesarean rates. How does that work?	While the accountable provider does not have direct control over all services included in the episode, this provider can influence the other services. We believe that services
Is there any role for midwifery care or birth centers?	Any provider that submits a professional claim for a delivery a baby is included in the episode.
How would the prenatal enhanced services be incorporated into a bundled payment and its costs?	I'm sorry, I don't understand the question.

Comments on the Making the Business Case Brief

- Would be helpful to include more information on upfront costs, related work, and a sense of a timeframe.
- Helpful document – the challenge for the state of Louisiana in working with providers has been getting people to a point where they have enough awareness to even engage on this work.
- Having information on how other maternity APMs – such as a blended case rate – could be presented as part of a business case would be helpful, so we could compare the investment, ROI, and outcomes to episodes (to the extent possible).

Follow Up Activities: A revised "Making the Business Case" brief will be available to participants soon on the MAC webpage.