Establishing Maternity Episode Payment Models: **Experiences from Ohio and Tennessee**

Health Care Payment Learning & Action Network

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Contents

Overview

The Health Care Payment Learning & Action Network (LAN) was created to drive alignment in payment approaches across the public and private sectors of the U.S. health care system. The CMS Alliance to Modernize Healthcare (CAMH), the federally funded research and development center (FFRDC) operated by the MITRE corporation, was asked by the Centers for Medicare & Medicaid Services (CMS) to convene this large national initiative.

From 2015 to 2016, The LAN's Clinical Episode Payment (CEP) Work Group was charged with developing recommendations to accelerate adoption of aligned clinical episode payment models. The CEP Work Group developed recommendations for designing person-centered maternity episode payment models, published in the LAN's 2016 Clinical Episode Payment Models White Paper. Later that year, the LAN began a 10 month effort – the Maternity Multi-Stakeholder Action Collaborative (MAC). The MAC was designed to support payer and provider organizations seeking to accelerate the adoption of maternity care alternative payment models (APMs) that both improve outcomes and care experience for mothers and babies, and reduce the cost of care. The white paper and all materials related to the MAC are available on the LAN's MAC Online Resource Bank.

This document highlights the ways in which two state Medicaid agencies – Ohio and Tennessee – established their maternity episode payment models. Both states received funding from the CMS State Innovation Model initiative (SIM), which was used to design and launch their episode models. This report also includes information about the considerations that underlay various high-level decision points. **Table 1** gives an overview of the two states' episode models.

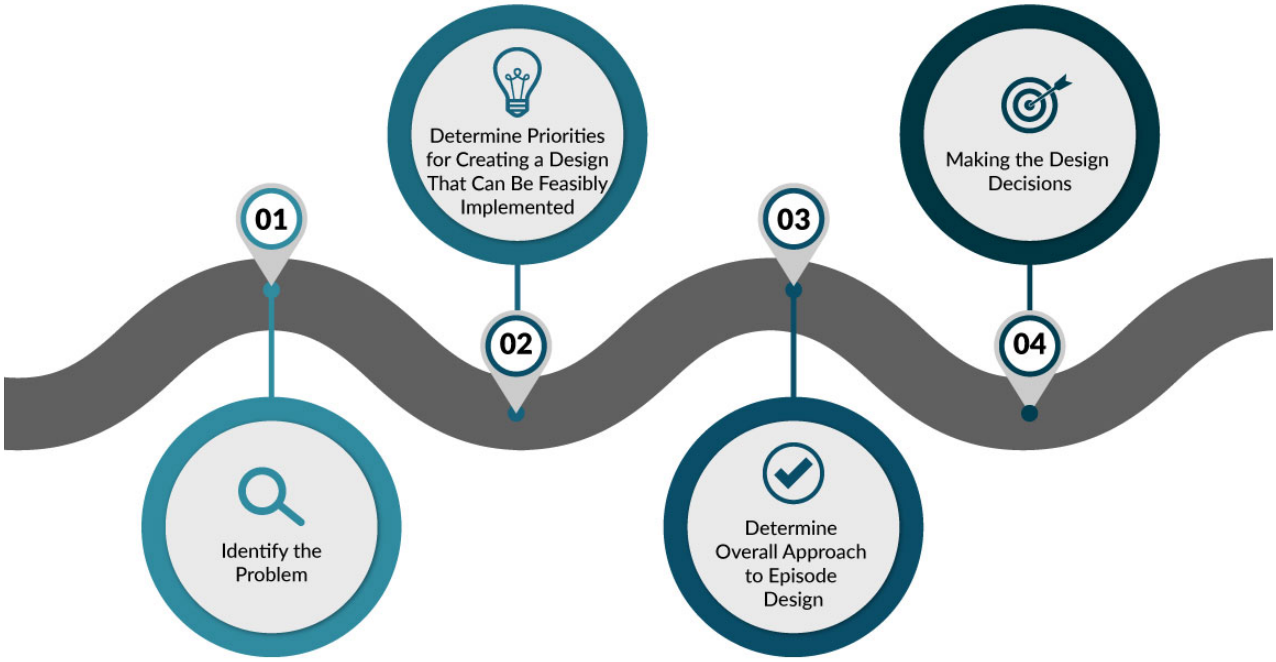
Table 1. Summary of Ohio and Tennessee Maternity Episode Payment Models

Background	
Ohio	**Tennessee**
• Ohio designed its model in 2013, and launched it in 2014. In 2016 the state began linking payment to performance. • It covers pregnancies resulting in a live birth, starting 280 days prior to delivery, and extending through 60 days post-delivery. • The episode price covers only the mother, and excludes various comorbidities, maternal death, any indication of leaving against medical advice (AMA), related medical claims, related medication, or emergency department claims. • The episode covers relevant prenatal care and complications, delivery care, and relevant care and complications through the postpartum period, including readmissions relevant to the episode. • The accountable entity is the physician or group practice that delivers the baby. Payment is through traditional fee-for-service (FFS) with retrospective reconciliation.	• Tennessee designed its model in 2013, and launched it in 2014 by sending preview reports to providers. In 2015 the state began linking payment to episode performance. • It covers low-risk pregnancies with live birth, starting 280 days prior to delivery, and extending through 60 days post-delivery or discharge. • The episode price covers only the mother, and excludes various comorbidities, maternal death, any indication of leaving against medical advice (AMA), related medical claims, related medication, or emergency department claims. • The episode covers relevant prenatal care, including medication and emergency department claims; all delivery claims; Post-partum days 1-30 covers claims for non-inpatient admissions, ED claims not resulting in readmission and other pharmacy, professional, or facility claims; Postpartum days 31 – 60 covers all related medical claims and medications. • The accountable entity is the physician or midwife who delivers the baby. Payment is through traditional fee-for-service (FFS) with retrospective reconciliation.

Steps to Design and Launch an Episode Payment Model

Both states followed similar steps in creating and launching their models. The steps are outlined in Figure 1 and discussed in further detail below.

Figure 1. Episode Development Process



1. Identify the Problem

Both states were seeking to improve quality by transforming delivery through value-based payment, not just for maternity care, but for non-maternity-related conditions and procedures as well. When it came to their perinatal (maternity) episodes, both recognized that the spend on maternity for their populations was extremely high; in Ohio, maternity claims are the single largest Medicaid claim type.

Tennessee

In Tennessee, more is spent by Medicaid on maternity care than on the next seven conditions in their value-based payment episode portfolio combined.

Ohio

In Ohio, the focus was more specifically on transparency in key quality measures, such as cesarean section rates, which reflect variation from best practice.

2. Determine Priorities for Creating a Design That Can Be Feasibly Implemented

Both states developed their perinatal episodes as part of a broader movement toward value-based payment.

Ohio

Ohio, through the Governor's Office of Health Transformation, created a "Pay for Value" initiative that encompassed the development of episode payment models for a broad set of conditions and procedures.

Tennessee

Similarly, Tennessee launched the Health Care Innovation Initiative, which included a focus on Episodes of Care for a range of conditions and procedures, including perinatal care.

3. Determine Overall Approach to Episode Design

Ohio and Tennessee both went into the perinatal episode design process with the goal of creating a payment model that could be launched based on existing systems and infrastructure to not delay implementation. Both states also viewed perinatal care as the "classic" episode, due to the very specific start and end points, as well as the episode trigger (live birth) point. In addition, each state had its own set of foundational guiding principles that led to their design decisions.

Ohio

Ohio began the process of designing its perinatal episode by bringing together a group of providers, including OB-GYNs and nurse midwives. Some of the questions asked included: What would it look like for a patient to have an optimal maternity care journey? What services would that encompass? When would the care start and end? What types of providers would interact with the patient, and how would the system determine whether the patient was receiving high value, high quality care? Each of these factors were considered to determine a patient's optimal perinatal care journey, as well as where there were opportunities to improve value within that journey in Ohio.

Tennessee

Tennessee was in the process of developing a Patient Centered Medical Home model (another pillar of its Health Care Innovation Initiative), and thus viewed the perinatal episode within that context. Design decisions were made based on the idea that maternity care should be broad and reflect a medical home model in terms of providing patients with coordinated care across the spectrum of their care needs. Tennessee also wanted to ensure that the model would be implementable state-wide, and would not only be operational in urban regions of the state.

Finally, since both states are Medicaid Managed Care states, they knew that the design decisions had to reflect the infrastructure that came from providers contracting with multiple payers in their delivery of care to Medicaid patients.

4. Making the Design Decisions

The LAN's Clinical Episode Payment Models White Paper identified ten design elements that go into the development of an episode payment model. Furthermore, the paper provides the design recommendations for maternity care episodes that are outlined in Figure 2.

Many of these elements are considered together when designing an episode, and fall into the following categories, which are discussed in greater detail below: working with payers; working with providers; and setting the episode budget.

Figure 2. Design Recommendations for Maternity Care Episodes

1. Episode Definition	2. Episode Timing	3. Patient Population	4. Services	5. Patient Engagement
Episode includes maternity and newborn care for the majority of pregnancies that are lower risk, as well as for women with elevated risk conditions for which there are defined and predictable care trajectories.	Episode begins 40 weeks before the birth and ends 60 days postpartum for the woman, and 30 days post-birth for the baby.	The population is women and newborns who are lower-risk, as well as women who may be at elevated risk due to conditions with defined and predictable care trajectories.	All services provided during pregnancy, labor and birth, and the postpartum period (for women); and newborn care for the baby. Pediatric services are not included. Other exclusions should be limited.	Engage women and their families in all three phases of the episode (prenatal, labor and birth, and postpartum/newborn).
6. Accountable Entity	**7. Payment Flow**	**8. Episode Price**	**9. Type and Level of Risk**	**10. Quality Metrics**
Accountable entity chosen based on readiness to both re-engineer change in the way care is delivered to the patient, and to accept risk. Shared accountability may be required, given that a patient may be cared for by multiple practitioners across multiple settings.	Payment flow – either retrospective reconciliation or prospective payment – depends on the unique characteristics of the model's players.	The episode price should balance single and multiple providers and regional utilization history. It should reflect the cost of services needed to achieve the goals of the episode payment model.	Ultimate goal is both upside reward and downside risk, with strategies in place to mitigate risk, encourage provider participation, and support inclusion of a broad patient population..	Prioritize use of metrics that support the episode goals, including measures of clinical outcomes and patient reported outcomes, for use in payment, accountability, quality scorecards, and other tools to communicate with and engage patients and other stakeholders.

Accelerating and Aligning Clinical Episode Payment Models, August 1, 2016, HCP-LAN; https://hcp-lan.org/groups/cep/clinical-episode-payment/

Working with Payers

As noted above, both Ohio and Tennessee are Medicaid Managed Care states. Ohio has five Medicaid managed care payers, in addition to Medicaid FFS. Tennessee has four plans that contract with TennCare. Both states designed the payment flow as a traditional FFS reimbursement, with a retrospective reconciliation period that occurs at the end of the episode. In both states, the reasoning behind this approach tied back to step 3 above, "Determine Overall Approach to Episode Design," and to the principle that the episode must be feasible to implement. In order to create a reimbursement process using a prospective payment reconciliation model, the state would have to develop a new data sharing infrastructure, which was not feasible within the design timespan.

In both states, the payment distribution and frequency of reconciliation was determined by the Medicaid agency, with all payers providing reimbursements on the same schedule.
One significant difference between the two states is in the way performance data is shared with providers. Ohio recently moved to consolidate data from six payers into a single report that is made available to providers via the Medicaid provider portal. Tennessee, on the other hand, does not

consolidate data across its four payers. Instead, providers receive an individual report from each payer with whom they contract.

Finally, in working with payers to implement the perinatal episode, Tennessee, while prescriptive in its approach to the episode model parameters, did not prescribe to payers how they should approach contracting with providers to implement the model. Each TennCare payer was able to utilize their existing contracting processes (e.g., amendments, stand-alone documents, contract revisions) to design the details of the new payment model with their providers. The state reviewed contract language to determine whether it was accurate and appropriate and suggested new language if needed. Again, this was in line with the foundational principle of using existing systems to the extent possible.

Working with Providers

Both states viewed providers as the key to the episode model's success. In order for the model to be successful, providers would have to a) understand the model and become well-versed in how to interpret their performance data; b) understand their role as driver for the episode; c) buy into the episode payment model as a strategy for addressing the maternity care problems that the states are seeking to address; and d) be responsible for encouraging patients' behavioral changes in order to have the goal of improving health outcomes for the mother and the baby. These factors all played a role in delivery care, and in shaping the states' decision points as related to interactions with providers.

Ohio

Ohio took numerous steps to help providers understand the episode model and their role. They involved clinicians early in the process and asked for their input and expertise throughout. The agency also developed and disseminated educational materials to train providers in how to read and interpret data reports, and how their performance and spending per patient would affect their shared savings or risk. In the design phase, Ohio held four in-person meetings with providers, giving them the opportunity to offer substantive input into the model's design. The state also worked with the Ohio chapter of the American Congress of Obstetricians and Gynecologists (ACOG) to educate providers, providing webinars to their members and leveraging their communication vehicles to spread information.

A particularly challenging issue that Ohio dealt with in working with providers was patient choice related to the use of epidurals during labor. The state recognized that reducing epidurals would elicit both financial savings (due to the high cost of having an anesthesiologist involved in a patient's labor and the birth) and could also reduce the rate of early elective deliveries which are linked to pre-term births. Weaving the threads of both the quality and cost implications of epidurals into conversations between providers and patients required sensitive cultural discussions. Providers were also encouraged to work with patients on other behavioral and cultural changes that could result in improved outcomes for infants.

Tennessee

Similarly, in the lead up to implementation of its maternal episode model, Tennessee, via the Managed Care Organizations (MCOs) as well as through the state, disseminated written educational materials to providers, as well as data analytics to support the episode's purpose. The state's Blue Cross MCO, for example, developed educational video materials, and also created operational support materials to help providers understand how to read and interpret their performance data reports.

General Concerns

A critical feature of all episode payment models is the notion that one provider will be accountable for ensuring that the patient receives the care she needs. This may often include coordinating with other clinicians, such as maternal/fetal specialists, while striving to keep the overall spend within the established episode budget.

The LAN's Clinical Episode Payment Models White Paper noted that the accountable entity should be chosen "based on readiness to re-engineer change in the way care is delivered to the patient and to accept risk." In both Ohio and Tennessee, delivering practitioners (such as obstetricians, family physicians, and midwives) were determined to be the appropriate entity for accountability, given their role in determining services, pharmaceuticals, and their role in the delivery and birth process. In both states, the education process included conversations about coordinating between OB practices and specialty practices.

Ohio

Related to coordination, Ohio leveraged the implementation of this model as an opportunity to create greater transparency in primary care provider referrals to perinatal care providers. Providers participating in the state's Patient-Centered Medical Home (PCMH) model (called Ohio Comprehensive Primary Care) have access to data about perinatal physician performance, which they can use to either make referral determinations, and/or engage in discussions with a variety of obstetrical providers seen by their patient population. The state believes this partnership with primary care clinicians will be a key driver of behavior change among OB/GYNs as the episode portfolio continues to evolve. Providers in the state are encouraged to give continuous feedback on their experience in the model. For example, obstetricians made it known that they would benefit from having more granular detail regarding the perinatal lab tests run on each patient. In response, the state now hyperlinks perinatal episode data reports to the Medicaid Management Information System (MMIS), which gives providers access to information on claims, related to their data reports from payers.

Tennessee

Tennessee took a similar path in terms of routinely bringing providers together to elicit their expertise and input into the model. The state felt that the financial reward of potential shared savings for practices that met performance and budget targets would help motivate accountable

providers to drive culture and behavior change. Tennessee also works closely with organizations, such as the Centering Healthcare Institute, and its *Centering Pregnancy* model, to drive culture change at the provider and patient levels.

$ *Setting the Episode Budget*

Both Ohio and Tennessee set payment thresholds, rather than episode budgets, per se. These thresholds were based on average historical Medicaid costs. Both states used multiple years of historical data to develop the threshold, and worked with stakeholders, with the technical assistance of the consulting firm McKinsey & Company, to develop the methodology for identifying the resource utilization and clinical performance quality thresholds that determine whether there is shared savings, a financial downside risk, or no change in payment from the negotiated reimbursement rate. By setting thresholds based on performance of all providers, each state can make their episode-based payment "budget neutral" (i.e. an equal number of providers are face downside risk as are rewarded). Additional detail on the states' thresholds and on each state's methodology can be found on the LAN's MAC Session 6: Episode Budget and Price page.

A critical question that drives those seeking to develop an episode model is how to address variation in spending, and how to identify that variation so it can be incorporated into the budget. Since neither Ohio nor Tennessee set a specific finite budget, but rather incorporated the full range of provider spend into their method for determining the financial implications for providers, variation was already built into the model. Related to variation in spending is the question of risk adjustment, and the potential for more high-risk patients to drive spending up, beyond the top of the average cost per episode threshold ceiling. While this is a concern for payers, Tennessee noted that perinatal care in particular is a relatively data-rich episode for the purposes of appropriate and accurate risk adjustment, based on the known length of the episode (i.e. approximately 40 weeks) and the claims data associated with each patient. This is true even though for many women who receive perinatal care via Medicaid, the pregnancy is their entry into Medicaid and there is no historical data on the patient. Tennessee maternity providers have ample opportunity to note all changes in a patient's condition, and these changes are often associated with a billing code. This results in a rich data pool from which to develop appropriate risk adjustment tools. The state does acknowledge that there are non-clinical risk factors that cannot be captured by claims data, but there are sufficient data from the clinical side to develop an accurate episode budget.

Next Steps

Both Tennessee and Ohio realize there is room for improvement in the models they have started. An area where both states are seeking to evolve the maternity care episode payment model is performance measurement. Both Ohio and Tennessee acknowledge that the measures they are currently using are not necessarily the most effective in helping them achieve their perinatal care goals. For example, Tennessee would like to incorporate a Cesarean Section measure that takes into account a history of Cesarean sections for the patient but it would require the use of non-claims data, which creates data collection challenges. In the area of quality measurement, Ohio and Tennessee are looking at ways to better incorporate electronic health records to evolve their quality measures into e-measures that would reduce data collection burden.

Tennessee notes that the design and launch of any episode is just the beginning. As with traditional FFS reimbursement, an episode model built on diagnosis and treatment codes will require upkeep to ensure that new regulations and other events are captured. For example, the new ICD-10 code for a strep test was not updated in the Tennessee model, which led to many providers receiving poor performance data in their reports until the code was added. Designs and related codes need to be adjusted to keep up with changes in the environment, which may require support from outside contractors.

Resources

Ohio

Ohio Governor's Office of Health Transformation: http://healthtransformation.ohio.gov/Current-Initiatives/Implement-Episode-Based-Payments

Tennessee

Perinatal Model Summary: http://tn.gov/assets/entities/hcfa/attachments/Perinatal.pdf

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