

Brice Overcash: Hello, everyone, and thank you for attending today's Maternal and Infant Health Initiative Webinar, Perinatal Payment Strategies.

Before we begin we wanted to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets you can use. Materials for this event can be found in the Resource List widget that looks like a green folder at the bottom of your screen. If you have any questions during the webcast, you can click on the Q&A widget at the bottom and submit your question there. We will try to answer these during the webcast, but if a fuller answer is needed or we run out of time, it will be answered later via email. We do capture all questions.

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An on-demand version of the webcast will be available approximately one day after the webcast, and can be accessed using the same audience link that was sent to you earlier.

Now I'd like to turn it over to your moderator for today's presentation, Judy Ann Bigby from Mathematica Policy Research. Judy, you now have the floor.

Judy Ann Bigby (JAB): Thank you very much, Brice, and I'd like to welcome everyone in the audience and thank our presenters ahead of time as we're going to have a very exciting webinar this afternoon. This is the third in a series of Maternal and Infant Health Initiative webinars. The Maternal and Infant Health Initiative is sponsored by the Center for Medicaid and CHIP Services and is focused on improving the health of women and their infants through several initiatives.

I'm very pleased today to be able to welcome Lekisha Daniel-Robinson, who is the coordinator of the initiative, Harold Miller from the Center for Healthcare Quality and Payment Reform, and we have representatives from two state Medicaid programs, Mary Applegate from Ohio and Rebekah Gee from Louisiana.

Next

During our webinar today, you'll get an update on the Maternal and Infant Health Initiative. We will have a presentation on perinatal payment strategies, which is a topic that has become increasingly important as state Medicaid programs look at ways to improve maternity care but also increase the value of that care. And we'll hear from our two state representatives on their perspectives. We'll end with a closing from Lekisha Daniel-Robinson again, who will talk about next steps.

Lekisha

Lekisha Daniel-Robinson (LDR): Thank you. So before we move into what I expect to be a very fruitful discussion about potential approaches to align payment with improving maternal perinatal outcomes and hearing about some of the state experiences, I want to share a few updates related to the CMCS Maternal and Infant Health Initiative.

First, I just wanted to let everyone know that in November we launched an action learning series with 11 states that is focused on increasing postpartum visit rates by using a variety of strategies, such as partnering with community organizations, leveraging managed care contracting, focusing on disparities within certain populations, improving access to contraception care, etc. As part of that activity, we have identified some resources that could help states improve their postpartum visit rates, so we have posted a

resource on our Maternal and Infant Health page, the link of which is at the bottom of this particular slide, that shows a number of strategies that may be employed to improve postpartum care visits and rates.

I'd like to also let you know that we announced a developmental contraception measure back in the fall. And this coming July we plan to post an update to the specifications for that particular measure. Additionally, I know that many of you have inquired about the funding opportunity announcement that we thought would have been released at this point, however, just wanted to let you know that it has not yet been released. That is pending, but we look forward to that occurring sometime in the very near future, so please stay tuned and look out for that notice when it is finally released.

And finally, I just wanted to share that we conducted an environmental scan of state Medicaid payment strategies to address the initiative goals, which, as you may recall, are to increase the postpartum visit rates within Medicaid and CHIP populations as well as increase the use of effective contraception. This environmental scan will be posted on our web page, again the one noted below, within the next two weeks. And the scan resulted from publicly-available resources, discussions with Medicaid officials, health plans, and during a meeting convened to focus on contraception use specifically.

So with that I will turn it back to Judy.

JAB: Thank you, Lekisha. That update was really helpful.

Next slide.

I'd like to introduce now Harold Miller. Harold is the President and CEO of the Center for Healthcare Quality and Payment Reform. He is a nationally-recognized expert on healthcare payment and delivery reform. He has authored numerous monographs, journal articles, technical resource guides, and other materials on reform, and he has been a key participant for many organizations who need help with understanding the basics and the complexities of payment reform. And so we're very fortunate to have him today to talk to us about how we can use payment reforms to improve care for mothers and babies.

I want to thank Harold for taking time out of his busy schedule to join us today and will now turn it over to him.

Harold Miller (HM): Thank you, Judy. I don't think there's anything more important to talk about than how to improve maternity care, and payment reform is a pretty complex thing, so I will see what I can do to try to help explain it to everybody and try to show the path forward. So, hello, everybody. It's nice to be with you.

I'll start with what is the challenge that everybody is facing, both the federal government and the states and private purchasers, which is high and growing cost of healthcare spending. And the opportunity, really, is to be able to try to identify the unnecessary or avoidable spending that exists in every aspect of healthcare and to be able to reduce that avoidable spending as a way of both increasing the desirable spending and still achieving savings for the payers. And there are many opportunities to be able to do that in maternity care. Reducing unplanned pregnancies, reducing severe infections, reducing early elective deliveries, having more deliveries in birth centers, reducing complications at birth, reducing pre-term and low birth weight babies, all of those things would be better for mothers and babies and would also end up saving money for payers, so the challenge is how to put that in place.

A big barrier, though, is the current payment system. And this is a barrier for almost every aspect of healthcare, not just maternity care. The barriers – and many people talk about this as though somehow we have to create different incentives. I think the biggest issue is the barriers, and there's really two big barriers that exist in the current payment system. One is that in many cases there is no payment or inadequate payment for what are really high-value services for patients. So services that don't get delivered in a face-to-face visit with a clinician typically is not paid for. Services that are delivered by non-clinicians, nurses, community health workers, don't get paid for. Lots of non-medical services don't get

paid for. And in many cases, services that are in theory covered by some kind of a bundled payment, the payment is inadequate so the patients that have the higher intensity needs can't get what they really need from that payment.

So the second barrier is that that avoidable spending ends up being revenue in many cases for the providers themselves so that when you don't deliver the avoidable services you reduce that revenue. But the costs don't go down quite as rapidly as the revenue does. And what that does is then leaves providers in the bind of they're actually losing money if they were making any money before, and they may be losing more money than they were losing before if they were having a problem making ends meet before.

So the challenge is being able to fix those. And lots of people are making payment changes, but I wouldn't call it really reform unless it actually removes the barriers that are impeding high-quality care.

Now what I'm going to focus on today primarily is how do you pay for the high-value services, and if those are interested, I can go in more detail about how you solve the problem of the loss of revenue for providers separately, although I'll touch on that briefly today.

What you see around the country typically, though, is that payment reform proposals are problematic. And if you've ever seen the book *Men Are From Mars, Women Are From Venus*, sometimes you find the same approach with providers versus payers, that they approach payment reform in two very different ways that don't always meet in the middle. The provider approach tends to be what I call the Trust Us approach that says that there are studies that say this will save money, so please just pay for it and the savings will come. And I think most people really should recognize that no matter how many studies have been done saying that in the past a demonstration project (inaudible) a service saves money, it's not a guarantee that savings are going to be achieved, particularly when the service is implemented by all providers for all patients.

So payers are understandably nervous about that approach. The tendency is to say, well, gee, how do I know that there's going to be a reduction in spending if you're not actually taking accountability for reducing that spending. And even if I believe that there may be some reduction in the avoidable spending through the new services, how do I know that you're not going to be delivering more of those now newly-paid services than are really necessary such that it actually ends up the costs exceed the savings.

The payer response then tends to be, well, okay, if we're about there's not going to be enough savings, we'll end up paying for less than what's needed. So if we really needed home visits to be able to help the patient, it turns into just office visits, or even just phone calls with the patient, and the problem with that is if we don't pay enough for what we really need, we end up paying too little and not being able to achieve the savings that were possible if we had actually provided the adequate services.

There's another problem, which is that if you just pay fee-for-service codes in the typical fashion, not all patients are alike, and so paying one amount for one code may end up being in some sense too much for some patients and not enough for other patients. The lower-risk patients that have smaller amounts of avoidable spending may not need all those services and the high-risk patients may need even more. But one fee-for-service code doesn't solve that, and so you end up with a situation in which there isn't enough savings to be able to cover the additional services for the low-risk patients and there's not enough services to achieve the potential savings for the high-risk patients. And the result ends up being that that can lead to simply having more total spending even though there was a win-win opportunity in there. What you really need to have in any payment approach is sufficient flexibility to be able to target the services based on the patient need and to be able to match where those improvement opportunities are. And if you do that, then you can find ways to reduce spending in a way that matches the amount that you're paying up front.

Now that's the provider approach. The payer approach tends to come at it from exactly the opposite direction, which is we as payers are about outcomes, and so you go first, you save us money, and if you save us money, then we'll pay you some more next year maybe. And the problem with that, obviously, is

that from the provider perspective that it means where does the up-front cost of those additional services come from. If you have already strapped providers trying to find a way to make ends meet, they don't have any money to put into that, and it may be that whatever small amount of pay-for-performance or shared savings money they could pay may end up coming either as too little or as too late to be able to cover those costs.

The other approach, which can actually work better in some ways if it's designed properly, is to create more of a budget for overall services rather than simply having individual fee codes. And if you do that and give the provider the flexibility to provide different services within the budget, then basically you have the flexibility to say if I can save money on something, then I can spend money on something else to be able to achieve that.

Now patients often have a lot of concern about that because how do I know that that global budget is not going to result in stinting on care and that it's not the avoidable spending that's going to go down but it's actually the desirable spending that goes down.

Now what all that leads to is that if you're really going to design a successful payment approach, what I call an accountable payment model, to make it successful it has to have four elements. First of all it has to have flexibility in care delivery. That it can't be too narrowly defined because that's the problem with the current system, it's too narrowly defined in some cases. You have to have the flexibility to deliver care in ways that will achieve high quality and to adjust that to the unique needs of individual patients.

But, with that flexibility has to come accountability for spending. That it actually has to assure the purchasers and payers that spending is going to decrease or grow more slowly than it would otherwise. But it has to be accountability that the providers can actually manage. It can't be total costs, it has to be the services and costs that they can actually control or influence.

There also has to be appropriate accountability for quality to make sure that this change in care doesn't just save money but actually maintains or improves quality to the patients. And, again, the accountability has to be about the aspects of quality that providers can legitimately control or influence.

And the fourth element is really adequacy. That the payments have to be big enough to be able to cover the costs of actually delivering high-quality care for the kinds of patients that providers are actually seeing, and with the levels of the costs or efficiencies that are feasible for them to achieve. And you can have a theoretically well-designed model that has flexibility and accountability, but if the payment amounts aren't big enough, then it's very hard to be able to achieve the right results.

The final problem I'll mention is that it often takes time to generate savings. And this is a problem particularly for state Medicaid programs with annual budgets is that investing in a new service this year might well reduce spending in the future, but not immediately. And one potential solution to that is to look for ways to combine both short-term and long-term savings initiatives is that there may be a service we can put in place this year that will reduce spending now and then be able to provide some savings to cover the investment in an additional service that will then reduce spending even more in the following year. And those kind of what I would call investment portfolios of services are a really important thing to think about.

So those are kind of the conceptual notions. The numbers matter, and so let me give you a hypothetical but realistic example, very simplified for the purpose of today. And if any of you have math phobia, take a few deep breaths. This will go quickly. And I will go through this quickly, but I'll make the slides available to anybody who wants them afterwards so that you can look at them more carefully. But I'm going to take a hypothetical example of 100 pregnant women on Medicaid. And their babies are delivered in the hospital by a physician. And the physician, I'm going to assume, is getting paid \$1,500.00 for each delivery and the hospital is getting paid \$3,500.00 for each delivery. Now, again, that's going to be a conservative number because, as we know, there are lots of other costs associated with the baby. If the baby ends up in the NICU, you could have a lot more expenses than that. So I'm going to take basically the very simplest, conservative numbers for this. And I'm going to assume that among my population of

100 women, that 30% of them have a subsequent unplanned pregnancy. So those 100 women turn into 130 births today, and those 100 women's 130 births ends up costing \$650,000.00.

Now you might say well, what we want to do is we want to pay more for postpartum care after the initial pregnancy to be able to focus on trying to reduce the number of those second pregnancies if they're unplanned or unwanted. And the challenge with that is that – and I'm using a very generous number here in saying we need to pay adequately if we're going to do that service well. Let's assume that we're going to provide a service for \$350.00 for each of those women. The challenge with that from the payer's perspective is if you pay for that but you don't have any impact on the second pregnancies then what that really does is simply increases overall spending by five percent. That \$350.00 is fairly small compared to the overall \$650,000.00 spending, but nonetheless it increases spending at a time that we can't afford to do that.

But if you could actually successfully reduce the number of second pregnancies, so here I illustrate that if I could reduce that 30% second pregnancy rate to 15%, in other words cut it in half, that would be a win-win because now I'm paying for the postpartum care I'm reducing the second pregnancies, and I'm actually reducing overall spending for the payer by six percent.

And what you have to figure out is what's the break-even point. So under this particular, again, hypothetical scenario, you have to reduce those second pregnancies by about a quarter, 23%, to be able to break even. So anything better than that is net savings, anything smaller than that is net cost.

Now the payer might look at that and say, well, okay, that's a nice idea, well how do I know, then, if I pay for this, that you're actually going to succeed in reducing repeat pregnancies? Well, one approach to that is to say, well, rather than simply paying a flat amount for postpartum care for each woman, how about if I turn this into a performance-based payment, and I'll pay, instead of \$350.00 up front, I'll pay \$250.00 up front per woman, but if you are successful in reducing the number of unplanned pregnancies, I'll pay you a bonus, and a significant bonus, \$1,000.00 for each of those avoided pregnancies because they are expensive if they occur. Now if I did that and you were successful in reducing the number of unplanned pregnancies by ten, you would actually have, again, a win-win in the sense that this would be a net increase in funding for the provider and net decrease in spending for the payer. And if you actually can reduce even more, so if I could cut the number of second pregnancies in half, an even bigger payment for the provider, even bigger savings for the payer.

But the payer wonders well, okay, yes you could get a higher payment if, in fact, you do better, but how do I know you're even going to try because you'll still get that \$250.00 up front even if you don't do anything.

So that leads to, when you talk about accountability, the issue is really that accountability really isn't just a bonus for success, there's also a penalty for failure. And this is what everybody is talking about today in terms of whether you just have upside – a so-called upside risk of shared savings, or whether you have two-sided risk, meaning that there is some penalty for failure.

So my hypothetical example here is I pay that \$250.00 up front, and I set a target of a 23% reduction in the pregnancy rate. And I'll pay a \$2,000.00 bonus for every pregnancy I prevent beyond that, but if there are fewer prevented than that, then there is a penalty, and it's a pretty significant penalty of \$3,500.00. If I do that, and, again, this is just a hypothetical example, then that means that if there is no impact on pregnancies, the payer breaks even and the provider basically gets nothing. So it's where we're starting today.

But, now, if I can actually hit that target rate and I can reduce the rate of pregnancies by 23%, then both the provider and the payer and the patient win because you've been able to reduce these second pregnancies and increase payments to the provider and reduce spending for the payer. And this kind of virtuous cycle continues because now if you actually are more successful in reducing the second pregnancies, there's even more resources available for the provider and even more savings for the payer resulting from that.

Now it isn't necessarily the case, obviously, that every patient has exactly the same risk of a second pregnancy. So you'd want to risk adjust and you'd really want to target your resources on the patients who have the higher probability. So, again, just to carry through the example again, I'll assume that there is a second group of 100 patients where the chance of a second pregnancy is 70%. In this particular population I might want to invest more in the postpartum care, \$1,000.00 a patient, but I would need to have a higher performance standard to be able to do that. I'd need to achieve a 40% reduction in second pregnancies in order to be able to make the numbers work. And under that scenario, if I actually do that, if I can successfully reduce second pregnancies by that level, then everybody wins. The patient is better off with having fewer second pregnancies that were really unplanned and unwanted, the provider is coming out ahead in terms of payment, and the payer is winning.

Now this all sounds kind of theoretically like it works, but there's challenges because if you're trying to do this with a fee-for-service, pay-for-performance model, first of all you face the challenge of I've got to figure out exactly what that right up-front payment is in advance and turn it into a fee code, and I'm not exactly sure up front exactly what the right amount is for that. If I'm going to stratify the population based on risk, then I've got to stratify the payment amount, and now I have an even more complex coding and billing system that has actually a greater likelihood of mismatches between the payment amounts and the resources needed. I have to figure out exactly what these target performance rates are going to be, and I may have to do that before I know exactly what I can accomplish. There is likely to be random variation in the patient characteristics that can cause windfall bonuses and penalties and lack of predictability on both sides. And all the complexity and the problematic issues associated with fee-for-service are still in place because this is still a fee-for-service structure.

And I have to say to all of you who are listening in that simply paying more for postpartum care I think is a problematic proposition because there really isn't any evidence that simply providing postpartum care services for all patients is cost effective. It can certainly help for some patients, but if you have a payment that ends up being either too small or is not effectively targeted, that could end up failing to achieve the desired result, could end up increasing net spending, and then cause the failure of the overall initiative.

The goal, really, is about achieving the outcome, not simply paying for specific services. And the strategy should be to target the right kinds of resources on the patients who will benefit from them.

So what's a better way to do this? Well, one way is to think about what you could call a condition-based payment based on what the patient's issues are, not based on specific services. So, again, same exact example that I gave before. The 100 women on Medicaid. Thirty percent have a subsequent unplanned pregnancy. Same payment amounts all around. But rather than thinking about adding services and new fee codes, what I want to start with is looking and saying what I'm basically spending today for each of these women is \$6,500.00 per person, both for their initial pregnancy and for their second pregnancy. And if a provider feels that they can do a better job in terms of managing the overall care for those patients, then say, well, let me say I think I can do that for two percent less, \$6,400.00 per person, so give me the money and then give me the flexibility to figure out how to spend that money. How much needs to go to hospital care, how much needs to go to physician care, and let me decide what is the right way to allocate that budget to services to patients. Not by having fee codes that I bill for, but my own internal management system to figure out how I need to be able to allocate that to the kinds of services the women need. And if postpartum care is what is appropriate and necessary, then pay for that, but you might say, well, it's not really just postpartum care, I need to do some better prenatal care, so I'll actually spend some more resources during the prenatal period to be able to do counseling and pregnancy prevention planning and then follow up after the pregnancy rather than simply waiting until after the first delivery to be able to do that. So you have the flexibility under this model to be able to do that.

And you end up still with a win-win-win because, if you're successful, because you know that you can do this in advance, that you have this potential for improving care, that the patient comes out ahead, they have fewer unplanned pregnancies, the provider gets paid better, and the payer ends up spending less. And, again, now within this flexible payment model, if, in fact, you achieve better performance, you do better for the patients, and the provider wins even more because they have the ability then to retain any of those savings because they're operating within that overall budget.

So that's just one example of what, as I mentioned, I would call an accountable payment model that provides flexibility and accountability. So that's the notion of a condition-based payment. There are other models, bundled payments, warranted payments, that are appropriate for different kinds of circumstances. And the reason why these kinds of payment models as opposed to just fee-for-service and pay-for-performance are important is because they really allow these win, win, win approaches, that physicians and hospitals and patients can benefit by having better payment for the kinds of services that are really necessary, and the payers can also benefit by being able to get good quality services at a lower cost.

So the reason why you might say, well so, boy, that sounds really complicated, is it's not in the sense that it actually opens up a lot of other opportunities because there are many other opportunities in maternity care that you want to be thinking about, not just some individual service changes. So, for example, we know that there are right today we pay for everything separately. We pay for the OB/GYN or the nurse-midwife separately from the hospital. We pay differently for C-sections and vaginal deliveries. We could have bundles, which are being used in a variety of different settings now in healthcare, to say if, in fact, we can reduce the costs in the hospital, then we can deliver better care at a lower cost. We could, if we can reduce complications after birth through a warranted approach to things, then that's better care for the patient but done in a way that doesn't penalize the provider and still saves money for the payer. We could use this condition-based payment concept that I talked about to actually say rather than paying for C-sections or vaginal deliveries, let's pay for delivery and let's then, if we have an opportunity to reduce C-sections, we can actually do that in a way that doesn't hurt the hospital and obviously is better for the mother and the baby. We can, even if we do that condition-based payment, start to think about how we can do more deliveries in birth centers, again at a lower overall cost but in a way that doesn't necessarily then hurt either the physician or the hospital in terms of their operating margin.

We can even go a little bit upstream and say if we have an appropriate risk-adjusted payment, now we can make sure that we're not encouraging pre-term elective inductions, that we're discouraging them through an appropriately-structured payment system. And we can even go even further upstream and think about how to turn this all into a more population-based payment, or a maternity ACO or CCO where we're starting at the preconception level and talking about how we can actually now encourage, provide the resources to be able to reduce high-risk pregnancies to lower-risk pregnancies and avoid pregnancies in the first place rather than waiting until the first pregnancy occurs.

So all these payment models, the advantage of them is they give the opportunity as building blocks to be able to create these broader payment structures and take more and more advantage of the variety of different opportunities for savings and quality improvement.

So, how do you get there?

Well, if you want to develop win-win solutions, you have to follow really four steps. And the first step is not to change payment. There are too many situations today where people are inventing payment models and then somehow the providers are supposed to figure out how to make that work. Where it starts, really, is to say, what's the change in care delivery? How do we think we're going to redesign care in a way that will improve quality and reduce costs? That's where it starts, because this is really about the care for the patient.

Then the second step is to say now we need to look at the costs and savings associated with that. What do we expect there to be less of, how much does that save? What's there going to be more of, because if we need to provide some additional or different services to be able to achieve those savings, that's going to have a cost. And are the savings going to offset those costs on average? In many cases they will. In some cases they won't, which means we have to go back to the drawing board and redesign all of that.

And if you want to learn more about this, there's a free publication called Making the Business Case for Payment and Delivery Reform that walks through a ten-step process with examples of how to actually go through the analysis process of saying what's the change in care, how much is it going to cost, is it going

to work within the current payment model, and how do you change the current payment model to be able to adapt that.

One of the biggest barriers that people face, though, is data. And the providers need to know what's the current utilization and costs for their patients in order to know whether this kind of condition-based, or bundled or warranted payment amount will really cover the costs of delivering effective care to the patients. And the people who are paying need to know the same thing because they need to know whether the payment is going to be a better deal than what they have today. And both of the sets of data have to match because – and oftentimes they don't – so that people are actually speaking the same language. So you really need to have shared trusted data to be able to do this.

And then, and really only then, you design the payment model that actually supports the change. It has to have the flexibility to change the way care is delivered, the accountability for costs and quality. It has to have adequate payment, and it needs to have appropriate protection for the provider against unmanageable risk.

And as I said earlier, four key elements of a successful payment reform. Flexibility to be able to actually change the way care needs to be changed for different kinds of patients. It has to have appropriate accountability for spending, things that providers can actually be accountable for, appropriate accountability for quality, and adequacy of payment. And then there has to be protection against unmanageable risk. And I don't have time to go into all this today, but there's a number of different important elements of any kind of a payment arrangement that needs to be there, risk adjustment, outlier payments, risk orders, adjustments for external price changes that are outside the control of the provider, and excluding certain services that the provider can't control. All of those elements are really critical to be able to make a payment model work for providers, and actually for payers, too.

And then there have to be quality measures. And increasingly as we move to these new payment models, what we really need are quality measures that are focused on protecting against underuse. Today we have lots of process measures trying to define exactly what should be done, but a lot of those process measures are really constraining innovation and don't have strong evidence of necessity associated with them, so we need to move away from a lot of those process measures. And we also need measures about overuse because the payment model will inherently incentivize reducing the overuse of services. What we've got to emphasize are the measures that protect against underuse so that preventive services that have longer-term benefits. And in some cases extensive services where there's really strong evidence of benefit and serious impacts from failure to use them so that there is not an inappropriate choice by some providers to not deliver those expensive services simply to save money.

Now I think one of the best ways to be able to do this is if appropriate use criteria can be developed. They're administered by the providers but help them avoid the unnecessary services and also then ensure patients that they're getting the necessary services.

And then finally, and I would say in many ways this is the most critical thing of all, is trust. Nobody trusts anybody in healthcare today, and it's one of the big barriers that we have because in order for payment reform and delivery reform to really be able to work, the providers and the payers and the hospitals and the doctors and the patients all need to trust each other. And there has to be a recognition that only win-win solutions are sustainable. There has been much too much of an approach that's focused on a win-lose model to things, and those things simply aren't sustainable. And there has to be a commitment to transparency because if people don't share with each other accurate information about what things actually cost, then it's very difficult to develop these win-win-win approaches.

And there has to be a commitment to come back to the table to be able to adjust the payment system as necessary because I guarantee you that none of these changes, no matter whether they are small or large, will work exactly the way everybody expected initially because we don't have good data, we don't know exactly what will work, and what you want is to have everybody be able to come back to the table and be able to say, okay, didn't work exactly the way we thought, but we did make some progress. Let's



fix the things that aren't working. Let's make sure that nobody is losing through this process inappropriately. And then be able to achieve bigger and bigger wins over time.

And I think that if we can do that, then we will get genuinely better maternity care. We will have better care for patients because we will have providers that have the flexibility to design the care that matches the patient needs. We will have lower spending for payers because the providers will be able to use the best combination of services for patients without worrying about which services generate more profits. And a critical thing that nobody talks about is that we will have financially viable healthcare providers, which is physicians, and hospitals, and hospice agencies, and nursing homes, and other providers, all of whom, across the whole spectrum of care that are paid adequately to be able to deliver high-quality care.

And I'd encourage you to learn as much as you can about all of these different payment models and the approaches to them. There's lots of free publications available on our website. And if you'd like a copy of at least this set of slides from today's presentation, you can download them there and I think they're going to be made available through the webinar to everyone. And if you have questions I'll be happy to answer them now, and also here's the contact information for me if you want to get in touch after the webinar.

And with that, Judy, I'll turn it back to you to see if we have questions.

JAB: Thank you very much, Harold. There's a lot of information in your presentation, a lot of it very practical, and we have questions from the audience that I'd like to begin with.

The first question that I'd like to pose to you is the idea of winners and losers. You spoke to that issue briefly when you talked about how somebody's savings is lost revenue on another party's part. But the question is really about hospitals lose money and a different set of providers gain in this process that you describe where you're improving care to prevent unplanned pregnancies. Can you talk a little more about how systems could resolve that inherent conflict in this new payment structure?

HM: Sure. So the issue is – I'll focus on hospitals because the question is really what does it mean for a hospital to win in the future. And a hospital, really what matters to the hospital – matters to any provider, but obviously the hospital – is their margin. They have to have a positive margin to be able to stay afloat, to be able to have revenues to be able to reinvest in terms of capital improvements, etc. The problem is the way we pay hospitals today is we pay the same amount for every procedure regardless of the number that are performed. So a hospital ends up the only way it can improve its margin is to do more things. And if it does fewer things, it actually loses dramatically because it loses 100% of the revenue for every procedure that it doesn't do, but its costs don't go away. And hospitals, particularly, we expect – they're big, fixed-cost institutions, we expect them to make the investment to be there when we need them. We expect the emergency room, the labor and delivery suite, the cardiac cath lab to be there 24/7, whenever we need them, but we don't pay for that. We pay them to be able to treat emergencies and to do deliveries and to be able to do short (inaudible) balloon time for heart attacks.

So the solution is to say, well, you can actually adjust the way the hospital is paid so that it doesn't lose 100% of the money whenever it does fewer procedures so that it – because the hospital does have variable costs. It can save on the variable costs. It just doesn't lose 100% of the costs. And I could show you, and if anybody goes to my website you'll see various examples that I've shown there about how the hospital can actually come out ahead in various examples like this, including for labor and delivery. But it requires actually understanding the cost structure and being able to say what's that right balance in terms of how much money does the hospital need to be able to cover its costs, and how much can it legitimately save by doing fewer things.

The other thing that's important to understand in terms of hospitals is that we have essentially as communities, as a society, encouraged them to build to the level that they have built. And so they have a lot of fixed costs now that they probably don't need under a better healthcare system, but those costs don't exactly disappear instantaneously. And so it will take a little bit of time to be able to get there, and the hospital has to have a pretty clear signal from the community about what it's intending to accomplish in terms of the demand on the hospital. So you don't suddenly say to the hospital, gee, we don't want as

many people using the emergency room, close down half of your emergency room, and then the hospital suddenly discovers that there are patients, you know, still coming to the emergency room with no space for them. Or the people are sitting in the halls waiting for a bed. Or that mothers can't get in to a delivery room who need to be there.

So that's why it really has to be a collaborative process in the community for everybody to say what are we trying to accomplish, where do we think that there's going to be fewer patients, what's the hospital going to need to be able to transition to that in a way that keeps the hospital afloat but saves money overall.

JAB: Okay. Thank you, Harold. I think that what you're speaking to is that there are multiple actors in this process and it isn't just between providers and payers but community values also play a part, consumers probably do as well, and policy makers also.

Yes, absolutely.

The next question comes from someone in the audience who observes that it's his experience that providers and payers are not prepared to take on new payment systems or models. And can you speak to that challenge?

HM: Well, I think that is, again, a transitional issue. There are costs to a payer to be able to put a payment system in place. And no clear basis today for covering that investment unless there's going to be compensating savings. For many on the commercial side, for self-insured employers, many of the savings will go back to employers rather than go back to the health plan. Same thing in terms of providers is that if you have invested a lot of money in terms of being able to code and bill under the current system, then one has to make some new investments to be able to move to a different system.

The good news is that a lot of these payment models can actually be based while one continues to use the current billing and payment system. I referred to the notion of a condition-based payment, but you can actually treat it as a budget, so in a sense one continues to bill as one does today, one can authorize some new codes within that if one wants to, but there is not the same kind of constraint that one feels in terms of which codes to authorize, or how many codes, or how much the payment is because you know that it's all going to be within that overall budget.

And particularly if you can do that over a multi-year period of time, then it actually makes sense for people to think about now we know what the future is going to look like, we understand how this is going to move forward, and we can put those systems in place.

And for payers, it's really – it can be done as a retrospective reconciliation in terms of the budget, activating some new codes. From the provider's perspective exactly the same thing. And there are a number of payers around the country that are already doing that, that are paying based on those virtual budgets and authorizing new payments within that. And it's a much more feasible approach than thinking that somehow one has to convert to prospective bundles out of the box because those are much more challenging to do.

JAB: Thank you. The next question has to do with evidence, Harold. And are you aware of any hard evidence that shows that payment reform achieves the results that are intended in any states where they've been able to implement any type of payment reforms, whether on a small scale or a large scale?

HM: I would say that that's the wrong question. Payment reform is not a pill. It is not something that you simply say here's a payment reform model and all of a sudden does it work and does it work everywhere in the same way. Because it has to be driven – that's why I said the first thing is what's the change in care delivery. And the question is does the change in care delivery work for the population it's being applied to, and then does the payment system support that.

And in many cases what you have are payment systems that might look superficially like they do something but they may not be adequate in terms of payment amount. They may not be applied in the right way in the right particular communities, that it's a delivery issue as opposed to a payment issue. And I think that it is a mistake for people to say we can't do payment reform until somebody has proven that it works. Most of the major payment changes in the country in Medicare and in Medicaid were not based on some study that was done that proved that it works. The DRG payment system in Medicare that has been in place for hospitals since 1983 was implemented with no evidence that it was going to work. It was implemented 15 months after Congress enacted it into law. What has happened is that every year it gets adjusted to be able to make sure it's working. But it was generally believed that it was going to be a system that was more supportive of the right kinds of resources and incentives for hospitals. The physician RBRVS system was put in place with no prior evidence. The Hospital Outpatient Prospective Payment System was put in place with no prior evidence. And I don't think that we, frankly, have time as a country to go off and try to wait for multi-year evaluations of small payment demonstrations to be able to figure out what to do because the truth is even if we evaluate small payment demonstrations, it will not tell us anything about what's going to happen more broadly with it. What we really have to have is providers who are figuring out how to be able to improve care and then payment systems that will support their ability to do that. And if you have the right kind of accountability built into the payment system, then you are – by definition have a structure that is going to achieve what you want it to achieve because you designed it that way.

JAB: Thanks, Harold. I think that your answer speaks to a point that you made in your presentation, but it's a real big, practical issue for states or other purchasers who are trying to improve care and also contain their costs, and that is that redesigning the delivery system to provide the type of care that providers and consumers and others feel should be delivered, and at the same time developing a payment system that supports that delivery of care can be really tough to do simultaneously or in parallel. Can you give examples of approaches that have been tried and speak to the practical information that some members of our audience are looking for to address that issue?

HM: Sure. I mean, you're absolutely right. It's a bit of the chicken-and-the-egg problem, is that you can't fix the delivery system if you don't fix the payment system, and you can't change the payment system if you don't fix the delivery system. And the two have to go together. And they have to co-evolve, in a sense. And it's important to think about that. So it's not just as sequential completely as I described. You know, you sort of say how do we want to change the delivery system, what would the payment be to be able to support that, and then let's move forward. And how can we evolve over time. We're not going to jump immediately into the deep end of the pool and try to change everything. What are some of the incremental changes that we can make.

But it's important, I think, to have a clear sense of where you're going. You know, where do you want to be. It's not that nothing can happen for ten years and then all of a sudden magic happens. But it also doesn't mean that we'll do one small thing this year and then we'll figure out later what we're going to do next. I think one of the challenges a lot of providers and payers today face is that there's not clarity about what's coming next.

So what I think has happened in a number of settings, and particularly if you have a long enough term point of view, is that you can start doing some things and then evolve from there. I think that, for example, what Massachusetts Blue Cross Blue Shield has done in Massachusetts with the alternative quality contract is an excellent example of that because they said this is a five-year contract, and really the accountability that's built into it is going to increase slowly over time because what we're asking you to do is not save money in the first year. What we're asking you to do is to be able to control the growth in costs over time. And if you look at what people under that contract have done is that they have done some things that had impact initially, but they also then made some investments in things that were going to have some longer-term impact or that took some longer periods of time to do. And so some of that, I mean in that particular case, was that some of the initial work was to say let's move patients from higher, more expensive providers to lower expensive providers or hospitals, and then beyond that we'll start to then figure out how to actually reduce utilization. And it's why I gave the example early on in the presentation that you may want to combine initiatives together to say let's find some things that we can do

that will save some money in the short run so that we have some early successes and give everybody confidence that this is really going in the right direction, but let's also make sure that we're investing early on in the things that will take a little bit longer to put in place so that we then have those additional successes down the road. And I think that maternity care is a perfect example of that because there are some low-hanging fruit, and maybe somewhat higher fruit, and even harder-to-grab fruit. But if you say look at all of that as opportunities and what we want to do is build to that over time, I think that it will work better for everybody than to simply take one initiative and then not have a sense of where we wanted to go beyond that.

JAB: Okay. Thanks, Harold. I'd like to change the stream from what we've been on to a slightly different issue that has been raised by a number of people in the audience. And that is in your presentation you talked about newly-paid-for services, and you mentioned home visits, emails, that sort of thing. But among the Medicaid population, and I think states have the notion that there may be other types of providers who can enhance access and help providers improve the quality of care, such as (inaudible), community health workers, navigators, those types of personnel. And historically certified nurse midwives have been underutilized within the system, and the way they are paid suggests that they're not as valued in the system. I wonder if you could speak to what states may need to do to push forward the idea that looking at those two groups of providers might help to increase value.

HM: Sure. I mentioned the issue of the community health workers in one of the early slides, and even on one of the maternity later slides I talked about certified nurse midwives because I think that one should be not necessarily having specific V codes for specific types of people but again thinking about what the outcomes are. And so if you move to a condition-based payment, for example, and you say I'm paying for the set of services to be able to deal with this mother's or baby's needs, then you naturally then have both the flexibility, and the accountability, and the incentive to say, well, who's the best person to be able to deliver that. You don't say, well, gee, we can't do that because the only person who can bill for that is this person, or that this person can bill for more than that. You say, we have a budget, and we're trying to achieve this outcome, who's the best person for that? Is the best person for that a physician? Is it a nurse? Is it a nurse midwife? Is it a (inaudible)? Is it a community health worker? And so it actually supports the team concept better because people are no longer fighting over who gets to bill the code as opposed to what's the right combination of people to be able to do the service. And, in fact, I think it ends up being able to help increase capacity because we're very concerned in capacity of primary care, capacity of maternity care, for the population. And so if, in fact, you can deliver the same set of services at a lower overall cost and you free up physicians nurses, whatever, to other professionals who can do that, then they have more capacity to be able to take on more patients, and it is more affordable for Medicaid programs to do that because in effect you're able to serve more people for the same amount of money in a much more efficient and high-quality way. So that's yet another advantage of being able to move away from the narrowly-defined fee codes into paying for something that is more flexible and outcome oriented.

JAB: Thanks, Harold. One additional question. In your model you talk about helping providers change their behaviors through both incentives and penalties. Can you talk about how you avoid the potential for there to be issues between providers and patients when the providers' incentives or penalties are aligned in one way, the patient values might be going in a different direction, and how you avoid making the system respond to the provider incentives or penalties exclusively.

HM: Well I think – I mentioned in terms of the quality measures, that I think that what is very desirable to have are appropriate use criteria. And obviously those are challenging in many cases to do. But where they exist, they're very helpful. And the appropriate use criteria both help the provider to be able to focus on the things that are clearly inappropriate and to ensure that they are delivering the things that are appropriate. And I think that those appropriate use criteria should be developed, first of all, with patient consumer participation in terms of how to develop those appropriate use criteria. And then I think there needs to be an important broad-based consumer education process associated with it. It's one of the things that I like about the Choosing Wisely campaign is that not only does it identify basically sort of a small set of appropriate use criteria, but it's also something that is being – people are being educated about through consumer reports and everything else. Because it shouldn't be up to the individual

physician or nurse-midwife or nurse or whomever to be the one to say to the patient, no, you shouldn't get this, when the patient is hearing from everybody else that they should get that. It needs to be something that there's more community education involved with.

JAB: Thank you very much, Harold. We're going to move on now to the next presentation here. I would like to let people know that in your resource folder there are two resources that Harold provided that are relevant to this topic, and we hope that you'll go to that resource folder to look at those.

As we turn now to the states, we're going to hear about their approaches to improving maternity care by using different payment reform strategies. But I hope that our two presenters will also give us some of their perspective on some of the issues that were raised in Harold's presentation and also speak to the specific challenges that you have in your Medicaid programs related to these types of reforms.

Our first state presenter is Dr. Mary Applegate, who is the Medical Director of the Ohio Department of Medicaid. And she'll be talking about improving postpartum visit rates through value-based purchasing. Thank you, Dr. Applegate.

Mary Applegate (MA): Wonderful. Good afternoon, everyone. Thank you for the opportunity to let you know what's going on in Ohio.

So in front of you you can see the map. Specifically I focused on postpartum visits here to show that like the rest of the country, there is wide variation, more than twofold variation, across the state in this particular measure that has variation in how closely it may be tied to improving outcomes. It all depends on the content. So this is just whether or not you show up. It's really not about, you know, was a reproductive health plan addressed as the prior speaker suggested.

So there's been much work around this, but we are taking an entirely different and more holistic approach through value-based purchasing to move this measure along with others.

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Like the rest of the country, we have fussed around the fringes, for lack of a better term. Pay-for-performance doesn't change anything in the center, it's just the edges. And when we look at where we are in terms of maternal and infant outcomes in our state, we need a giant leap forward. We feel the urgency to not keep doing small efforts. One clinic, a safety net system, one plan, one region. We really need the entire state and all of the women in our state to better understand what good care looks like and how we might get to better infant mortality and other population health outcomes.

So what have we tried? Managed care plan contract changes, P for P, local maternal-child health efforts. We've had a big groundswell of disparity-focused types of efforts, which is still about communication and less about action, sadly. I think many of you are aware that for decades of paying for prenatal care we have not really changed infant mortality rates. So it's not just about the medical care and the health system.

After doing a lot of this, our conclusion is that we're not going to be able to take a giant leap forward unless we change how we pay. So part of the chicken and the egg. And what I'd like to go through very briefly is what our approach was.

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We took a very broad view and really looked at our population as a whole. Our system was set up to pay a claim. It was not necessarily intended to get people better. So under Fee for Service we might have all the women we want to take care of in Fee for Service, but we put them in a strainer, and a lot of the high-risk people just, you know, sift out, and actually you might have hands on them once, but that's it. And that's actually not enough to change the outcome. So first things first is we actually streamlined how one

becomes eligible for Medicaid so it's not 150 different ways where we can't let people know. Like your average person can't tell you are you eligible or not. The next piece we did is we modernized Medicaid and streamlined the entire program. Part of that was separating ourselves from some of the Health and Human Services entities which made quick decisions very difficult. And of course I realize I'm saying this at the time that Michigan and other states might be going the other direction.

Then with the Affordable Care Act we actually have insurance coverage for more women, so that is the system. So if everyone gets in the system that means we have to enroll them so that we can count them. And there has to be outreach to get that done in addition to other efforts such as presumptive eligibility. So even though it's fee for service, at least we can count them and there is some opportunity, at least with the health system, to get our hands on high-risk women.

The next piece, to Harold's earlier point – and thank you so much for teeing this up for me, is not all women are the same. It's just like all cars are not the same. If there's a car on the road that has three wheels, everyone knows and gets out of the way and tries to help harm not happen. If we have women who might be at risk for pre-term birth, for example, no one knows, including the mother sometimes, and then no one is ever treated differently. So we're never going to get there with that kind of a system, which is actually what you get with fee for service, as Harold mentioned.

The next piece is once you've established that somebody is high risk, we must do two things. One, identify if you're pregnant or not. And then in either bucket we must provide enhanced services.

And then the last piece is once we have our hands on folks, not to let go of them over the course of their life because many of our outcomes are actually cumulative in nature, so if you've had one pre-term birth baby, you know, why would we be surprised if you have a second one. So to the earlier points related to intentionality.

On the right-hand side I have this drawing that really suggests there is a foundation of data and information that needs to be shared, that in this particular case could be anchored in vital stats and Medicaid claims, that really allows us to get to that first step of transparency, which is actually what Ohio Medicaid did.

Next slide.

So instead of just continuing with fee for service, we really looked at the entire population and realized fee for service will not get us there. So our Governor and major payers – so not just Medicaid, this is the major payers in Ohio – agreed that over the next three years 80% of all healthcare payments will actually be in a value-based framework. Either episode-based for hospital-types of care, or population-based on an outpatient center, either through PCMHs, Patient Centered Medical Homes, or an ACO or (inaudible) patient sort of arrangement. And on the legend on the right, you can see that for chronic conditions, terminally ill, chronically ill patients, the population-based PCMH model works well, but for acute procedures, and your traditional inpatient type of work, the episode-based payment with clarity around definitions and measures and how the payment works, really could advance the bar quite far. So what I would like to do is walk through what Ohio's version for a perinatal episode looks like.

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I believe we've taken into account the four factors that Harold referenced for us. So first of all, define what an episode is. What is it that trips the switch that tells you an episode has started and so payment is kind of clustered around this? In this particular case, for maternity care, it wasn't too difficult. It's the delivery. Then, when you have decided what that trigger is, what's all included? Like when does it start and when does it end? So, again, for perinatal care this wasn't too complicated because you have nine months ahead of time, and then cleverly it doesn't stop right after the delivery, it actually continues at least a couple of months out to including postpartum visit. And without that postpartum visit you don't have an entire episode, and so you don't have the chance to financially win. So this is a game changer.

So instead of paying separately or differently, we're stepping back and taking a bigger piece of what counts, partly because we realize in order to have good outcomes it's not just about what happens in the hospital. So broadening it this way allows for different kinds of conversations. And it also allows for nontraditional partners to participate in areas where they can make the case that they're adding value to the earlier question that was posed. So there's a pre-trigger window that's time based, and then we look at the kinds of care that you need, and so there's a lot of work done around the right kind of prenatal care. The trigger window is actually when the inpatient piece starts, and so what all happens in that inpatient setting related to early elective delivery, C-section, internal hemorrhage, the kinds of screens you do with the group B strep, and there are a whole number of things that can go in there. And then when does this end and what relevant and appropriate care needs to happen. So I think what we're trying to do with a definition that's this clear is really nail down many of the details Harold talked about in terms of appropriateness with a minimum standard and not necessarily a maximum standard. Although what was interesting is as we gathered the state together, many of the clinicians wanted more quality measures, not less quality measures. So my thought was the goal was on a full term, vigorous baby as the outcome of maternity care and a happy, healthy mom, if that's where your eye is on the ball, then we shouldn't need as many process measures in between.

So the next piece has its own bucket because this might be contentious as was referenced earlier. Who actually is the accountable entity? Who are you actually going to pay? And I think you brought up earlier that, you know, hospitals and doctors don't necessarily talk to each other, and they definitely do not share financial information. So just having some of that transparency around where the costs are is absolutely a game changer. So for different episodes, this is perinatal, but for different ones, the accountable entity sometimes is the hospital and sometimes it may be the clinician. And by clinician I do mean nurse practitioners and midwives and whoever might be delivering.

So we defined it in Ohio as whoever is in the position to impact the outcome the most. So in Ohio this is actually the obstetrician, realizing that there are plenty of obstetricians who are actually employees of the hospital, in which case the hospital is still king.

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The next element of the episode design relates to quality metrics, and so, as was referenced earlier, this is actually where we make sure that you're not just doing the least amount possible for maximum financial gain. What we ended up doing related to my earlier comment about the providers wanting more measures is we only linked some to financial gain versus others we have available for reporting and continuous improvement purposes. So in the beginning you see here that HIV screening, Group B strep, C section rate, and postpartum visits, which they call here follow-up visits, those are the only four that are actually linked to financial gain, although we're going to ask everybody to help report on the gestational diabetes screening, hepatitis B, the ultrasounds, and Chlamydia screenings that were done. And so you can see the clear link here related to evidence-based practice, and then also certain items related to pre-term birth.

Next up we did a lot of work related to the data analytics that Harold mentioned because we don't necessarily want cherry picking, right? And then if somebody – if there's this uncontrolled risk, people on ventilators and all kinds of things, you have to exclude folks so that this is a manageable risk for folks to take. So we did two things. One, risk adjustment based on a regression analysis specific to Ohio, and then two, we came up with exclusion criteria which, in effect, were three standard deviations over cost, for example, and a number of other conditions that we did not think allowed us to compare apples to apples in terms of a maternal delivery. And so that's actually what I reference here.

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So how did the process work? We actually gathered what we call a clinical advisory group from around the entire state. Managed care plans were reflected. Community, clinicians, those associated with health systems, those who were employed. And we had each part of the state actually reflected, including managed care plan clinicians. We actually went through, at the clinical patient level, and drew out what

ideal care looked like. From prenatal care, which is that first box and a whole bunch of things that go in there, included what should happen when you're actually at your site of delivery, and then what should happen afterwards. And then we also delineated complications.

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Based on that, we actually called out the opportunities for added value. So the appropriate and effective mix of prenatal care. Does everybody need everything all of the time, especially if it may not be your first baby. The next piece, the source of value is the appropriate utilization of services in the hospital. And this is where birthing centers, for example, come to mind because we realize that costs are lower but we have really good outcomes with birthing centers.

The length of stay is very much tied to C section rates, but what is the appropriate length of stay. And then after the baby is born, the promotion of the desired postnatal practices. And then after that, just because of the readmissions issue, we actually did flag the reduction of unnecessary readmissions for the mothers.

So these are the things we're trying to get to by designing it this way.

So based on the prior definition, what we did was we pulled all of those claims for all of the Medicaid mothers in the prior year, and actually put them on a graph. And then we saw the range of the cost – the costs of care across the state.

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So what this next slide shows is the variation in average cost per episode that is risk adjusted and excludes the outliers. So you can see that there is a pretty big difference. So it's, you know, close to \$9,000.00 and at the other end it's around \$5,000.00. Then based on each of the quality measures, we also saw equal variation. What we did note here is that one of the drivers of cost relates to the number of ultrasounds that are done and the number of inpatient or triaging episodes connected to a delivery.

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So the proposal is this. This is retrospective, trying to answer the earlier question about how are you going to get people on board? You can't make – you can't fly the plane and fix it at the same time. In essence. I'm paraphrasing what was said earlier. So this effort in value-based purchasing is retrospective. So what happens is right now all the providers in the hospital, they bill like they normally do. And they submit their claims, they get reimbursed. But when a year goes by, we actually run all the data analytics that I just went through and we feed it back to whoever the principal accountable entity is, the provider, which in this case is the obstetrician, and we give them their purse. You know, we give them the state curve and then we put their line in red to say these are your average costs. And then we have detailed business requirements so if they want to know well, how much was pharmacy, how much was inpatient, how much related to other factors, and what are my quality marks, they actually know what that is.

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The next slide here shows what a curve might look like. And I've color-coded it so that you can see folks who cost a lot on the left side in the red, to Harold's point earlier, this is the stick part. We are actually overpaying them. But we right now are trying to figure out how are we going to manage getting them to (inaudible) whatever we think an acceptable threshold line is. On the far right side, what you see are some folks are in green and some are in blue. The folks who are in blue had low costs but they actually did not meet their quality metrics. They may not have had enough folks getting to postpartum visits, or their C section rate may have been 80%, so even though their costs are low, they actually would not be eligible for any gain sharing. And the folks in gray actually would see no change in payment. So what



this told you is that about half the folks may not actually see a change. Those on the right in green actually stand to gain, and those in red actually will have the payback.

So what we have not done yet is right now we're in conversation related to where the thresholds are set, you know, does every managed care plan do it differently? Is there a state range? What about the private payers since this is an all payers system. So that's actually what the providers would actually see and where they are, we would put them in red so they can tell where they are in this.

Then what happens, on the next slide, is they can go into our Medicaid portal, and on a quarterly basis get their own report. And I have an example of what this report looks like. So here you can actually see the number of cases that were counted because, like I said, based on exclusions and whether or not we had complete data, there could be folks they're not getting credit for, which is actually incentive to make sure that the data, you know, that every delivery counts. And then here's an example of how we highlight the line for where this particular provider actually may be. We also tell them what percent of their patients were risk adjusted, and what was interesting to us is that the folks on the right side of the curve who did really well have some very sick patients in there as well. So it's not that the lower-cost patients actually are simply sicker. So that risk adjustment definitely cuts down cherry picking and does allow for this apples-to-apples comparison.

On the left-hand side you can see all the insurance plans that participate.

JAB: Thank you very much. We are going to move on to the next presenter, but this information really does show how comprehensive Ohio's approach is to this reform especially related to the goals that you have to improve maternity care. And we want to make sure that the audience has a chance to ask you questions as well.

So we're going to go over to Dr. Rebekah Gee from Louisiana, who will give us an overview of how they are just starting to look at how to think about using payment reform as a way to improve postpartum care. Dr. Gee?

Rebekah Gee (RG): Great. Thanks, Judy.

So Louisiana and Ohio have had a lot of parallel challenges over the last few years. One of them is that we continue to have significant healthcare disparities and poor birth outcomes, particularly among our African-American populations. But, of course, Louisiana has the distinct advantage of being 49<sup>th</sup> or 50<sup>th</sup> in the nation on birth outcome, meaning the highest prematurity and infant mortality rates in the nation, so we also have the biggest opportunity to improve. So I'm just going to share our story and talk a little bit about where Louisiana is.

So Louisiana started in 2010 a birth outcome initiative, which is really focused on improving the non-medically indicated elective deliveries before 39 weeks. We were at that time one of the highest rates in the nation in many of our hospitals for these hospitals, and the consequence had extremely high NICU admission rates that were short-term rates for the 37 and 38-week babies that were born as a result of those deliveries.

Our approaches, and as I'll say with the next phase of it, has always been consistent, which is that we started with a large process that engaged around 70 providers throughout the state, both providers, patients, moms, hospital administrators, the March of Dimes, our hospital association, to try to get buy-in before we implemented policy change as to what the solution would be. So we did not start at that time with payment reform. And as a result of those efforts, which were largely voluntary, we've reduced our NICU admissions by ten percent statewide and by over 85% the rate of non-medically-indicated elective deliveries.

So starting with the next phase of the birth outcomes initiative, we're very focused on issues relating to prematurity and preconception care. As Mary mentioned, all the efforts that have been substantial to

improve access to early prenatal care really haven't made a dent in prematurity and infant mortality rates, and there are complicated reasons for that but mostly due to the fact that preconception health, or the health of the mother going into the pregnancy largely determines the health of that pregnancy even though there are important interventions in pregnancy, predominantly progesterone administration, which I'll talk about, it's too late to really undo the effects of a lifetime of chronic disease, so really focusing on how do we get women into care prior to the pregnancy.

So we've had a multi-pronged approach in Louisiana to these issues. Compounding the problem is the fact that we have some of the highest prematurity rates in the nation, we also have some of the highest unintended pregnancy rate. So whereas 39% of the births nationally are due to unintended pregnancies, in our state 56% of the births are due to unintended pregnancies. So we really have a crisis on our hands in terms of access to effective contraceptive methods. So I'll start with that.

So we do know, and as you've heard previously today, that long-acting reversible contraceptions are incredibly effective, and in fact 20 times more effective than the oral contraceptive pill. And so we've done several – made several interventions and payment approaches to increase the utilization of long-acting reversible contraceptives, and so far, so good. It's early data. It was shown that if the trend continues we will have doubled just in one year due to these policies, the use of long-acting reversible contraceptives.

So what was done, number one, was we paid for long-acting reversible contraceptives in addition to the per diem so that hospitals can place both (inaudible) and IUDs right there at the time of admission for the birth. So that's been very important. We've seen a lot of movement with the use of long-acting reversible contraceptives in the hospital.

Secondly we had previously had a utilization predominantly through CVS CareMark, and that has moved to a buy-and-bill process because we've increased the prices of all of our long-acting reversible contraceptives to meet the average wholesale price so providers can now give them in their offices, stock them and not lose money, but also can order them through CVS CareMark.

In addition, in our managed care contracts, we have not allowed the managed care companies to prior authorize the use of these devices.

So, Judy, are you saying that I need to wrap up or was this for Mary, your text here?

JAB: Yep, we have about one minute left.

RG: Okay. So just quickly. I'll just – in one minute I'll say all the things we've done. We've unbundled the postpartum visit, and that will be happening soon. One of the big challenges was the fact that we couldn't measure the postpartum visit. We also could not – because it was also billed for at the time of delivery, so we've unbundled it and providers in the upcoming months will be required to bill for the postpartum visit separately from the delivery. We have four performance measures in a birth outcomes package. We have the first date to use a progesterone measure, which is our top priority, so utilization of progesterone in women who have a history of prior pre-term birth. Our plans are financially held accountable for a metric of 20% rate of administration whereas they were previously at a five percent rate. And we're engaged in a statewide quality collaborative.

In addition to progesterone they'll also be held accountable for improvements in a postpartum visit, adolescent well check, and lowering the rate of first time low risk Cesarean section births.

Finally, we have started to pay for birth centers. As was previously mentioned birth centers can cost less, have lower overhead. And we've also aggressively pursued a state plan amendment for family planning, which in a state like ours we have some of the highest rates of Chlamydia and gonorrhea in the nation and the highest congenital syphilis rate in the nation. We previously did not pay for men to get treated. We previously did not pay for women to get treated for STIs, just for testing, so unsurprisingly we had

extremely high rates. So we now have a state plan amendment that over 100,000 people are eligible for – newly eligible for. We're very excited about it. It's men and women. It's treatment and testing and a well visit similar to a South Carolina program called Healthy Checkup. So it's an expanded benefit for reproductive age individuals which we hope will move the needle on preconception health for both men and women.

So as you can see there are many policy approaches. We are new to managed care. We are just in year three of managed care. We expect to be able to do more value-based purchasing but we're still getting our sea legs in terms of our managed care companies and getting those rates actuarially sound, so our parties really focus on targeted – very targeted – interventions in the area of progesterone, preconception health, long-acting reversible contraceptives, and the postpartum visit, and we're measuring them monthly. We're aggressively sharing our findings with each of the plans so that whatever is learned can be quickly disseminated. And we're looking forward to improving our birth outcomes because we really think that there's nothing more important in the long term, for costs, than having healthy women and healthy babies. So thank you.

JAB: Thank you, Rebekah. Unfortunately we are out of time. There were some questions for you and Mary, and we will get those answers for people so that we can make sure they get the answer.

If I could turn to Lekisha who's going to wrap up for us.

LDR: So thank you for the great presentations, and obviously there are a lot of questions and discussions around this topic. And this will be helpful for CMCS as we continue to work with states on some of their payment reform initiatives.

In terms of our next steps, in collaboration with CMMI and the Innovation Accelerator Program, CMCS will explore alternate payment approaches to support the accountable costs and quality issues that Harold raised earlier.

And finally, we will release guidance related to achieving the Maternal and Infant Health Initiative goals through payment reforms.

Stay tuned for our next webinar, which will be scheduled for a June-July timeframe.

Thank you so much.

Brice Overcash: This concludes the webinar.

Thank you for your interest everyone.

(Inaudible) feedback to the presentation team using the survey that appears in your browser window when the event concludes. If you are unable to provide your feedback at this time, you can view the on-demand recording of the event and access the survey widget there. The on demand will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you earlier. Any questions can also be shared with the team using the Technical Assistance mailbox, (inaudible) [MACQualityTA@cms.hhs.gov](mailto:MACQualityTA@cms.hhs.gov). Thank you.