NEW YORK STATE | Department of Health | Medicaid Redesign Team

Maternity Care Bundle

Clinical Advisory Group

Meeting Date: July 21, 2015

Source: Fee-for-Service and Managed Care encounter records for mothers with deliveries and neonates born in CY2012-2013. Source: HCI3

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Part I

A. Introduction to Value Based Payment

Brief background and context

NYS Medicaid in 2010: the crisis

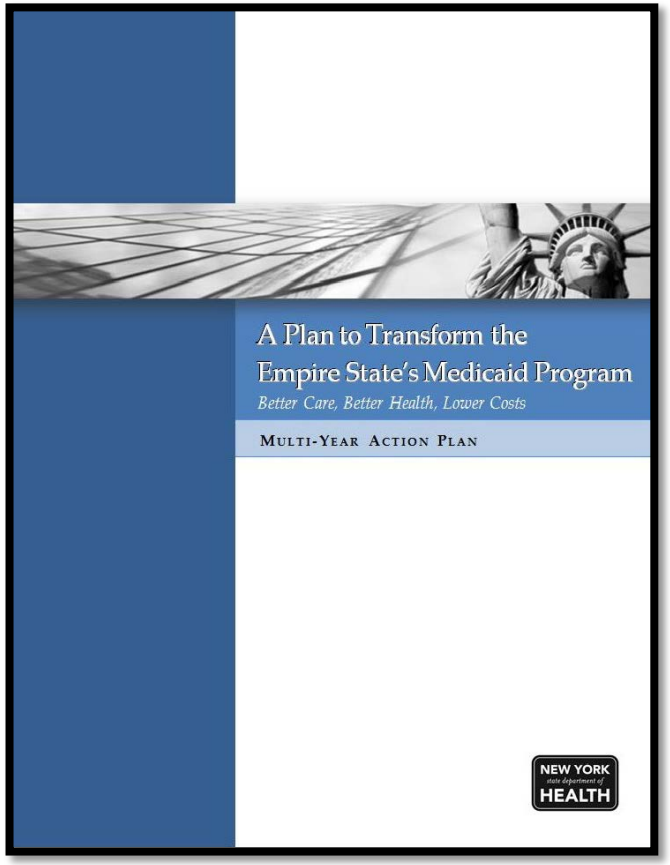
- > 10% growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per member were double the national average
  - NY ranked 50th in country for avoidable hospital use
  - 21st for overall Health System Quality

2009 Commonwealth State Scorecard on Health System Performance

CARE MEASURE	*NATIONAL RANKING*
Avoidable Hospital Use and Cost	**50th**
✓ Percent home health patients with a hospital admission	49th
✓ Percent nursing home residents with a hospital admission	34th
✓ Hospital admissions for pediatric asthma	35th
✓ Medicare ambulatory sensitive condition admissions	40th
✓ Medicare hospital length of stay	50th

Creation of Medicaid Redesign Team – A Major Step Forward

- In 2011, Governor Cuomo created the *Medicaid Redesign Team (MRT)*.
  - Made up of 27 stakeholders representing every sector of healthcare delivery system
  - Developed a series of recommendations to lower immediate spending and propose reforms
  - Closely tied to implementation of ACA in NYS
  - The MRT developed a multi-year action plan. We are still implementing that plan today

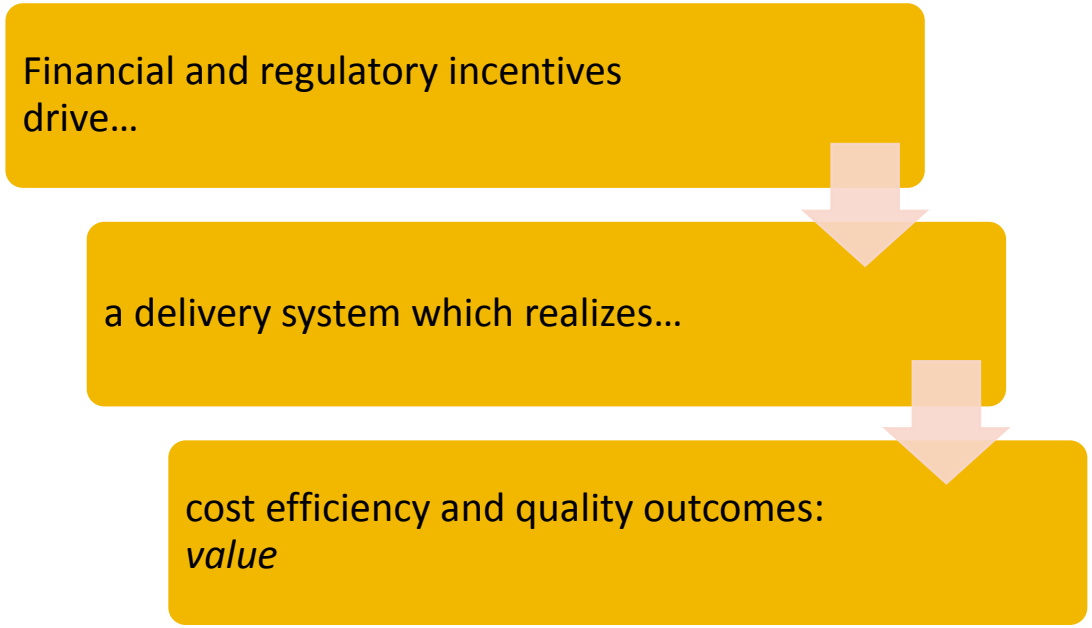


The 2014 MRT Waiver Amendment Continues to further New York State's Goals

- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system
- In April 2014, New York State and CMS finalized agreement Waiver Amendment
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
  - $6.4 billion is designated for **Delivery System Reform Incentive Payment Program** (DSRIP)
- The waiver will:
  - Transform the State's Health Care System
  - Bend the Medicaid Cost Curve
  - Assure Access to Quality Care for all Medicaid Members
  - Create a financial sustainable Safety Net infrastructure

Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
  - FFS pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination, or integration

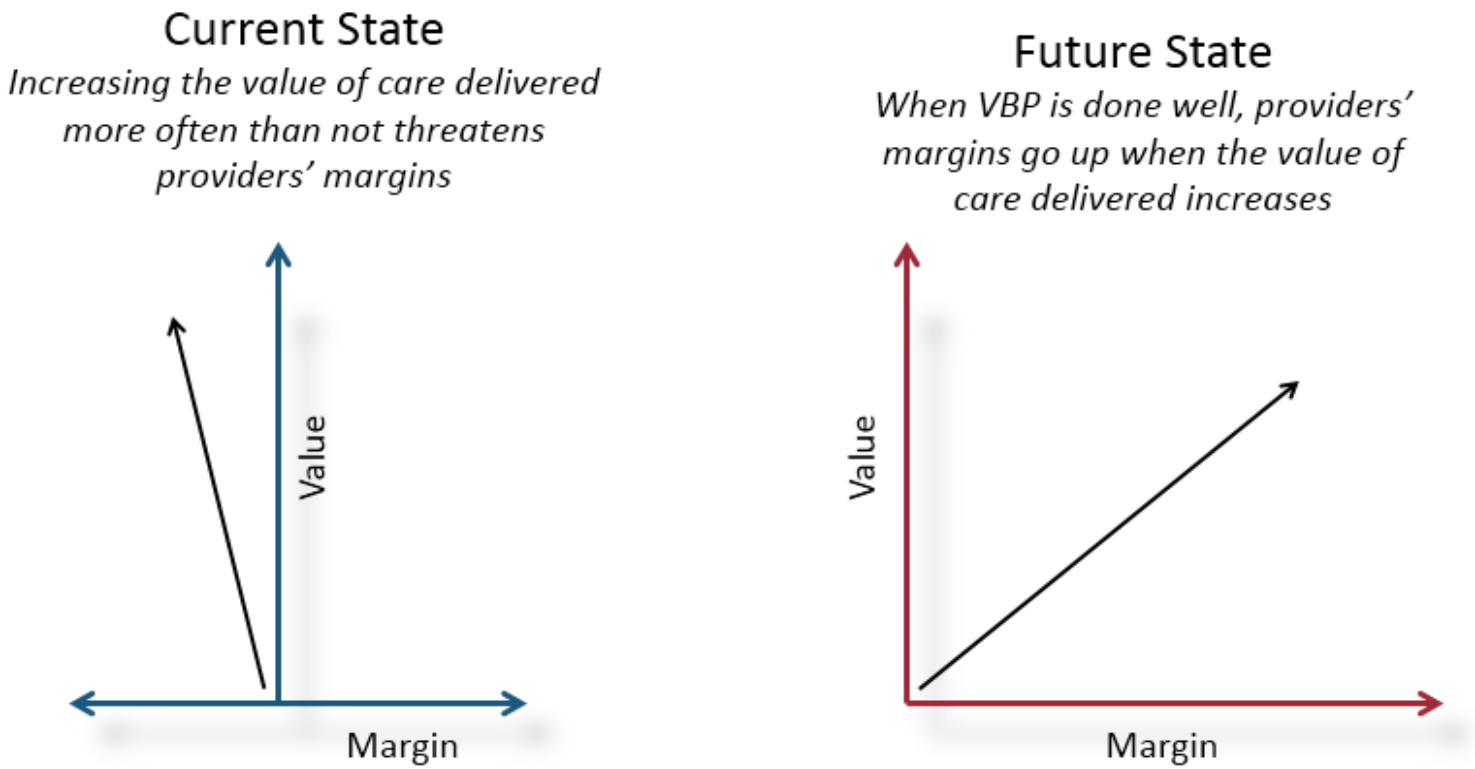


Payment Reform: Moving Towards Value Based Payments

- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver)
- The State and CMS have thus committed itself to the Roadmap
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap
- If Roadmap goals are *not* met, overall DSRIP dollars from CMS to NYS will be significantly reduced

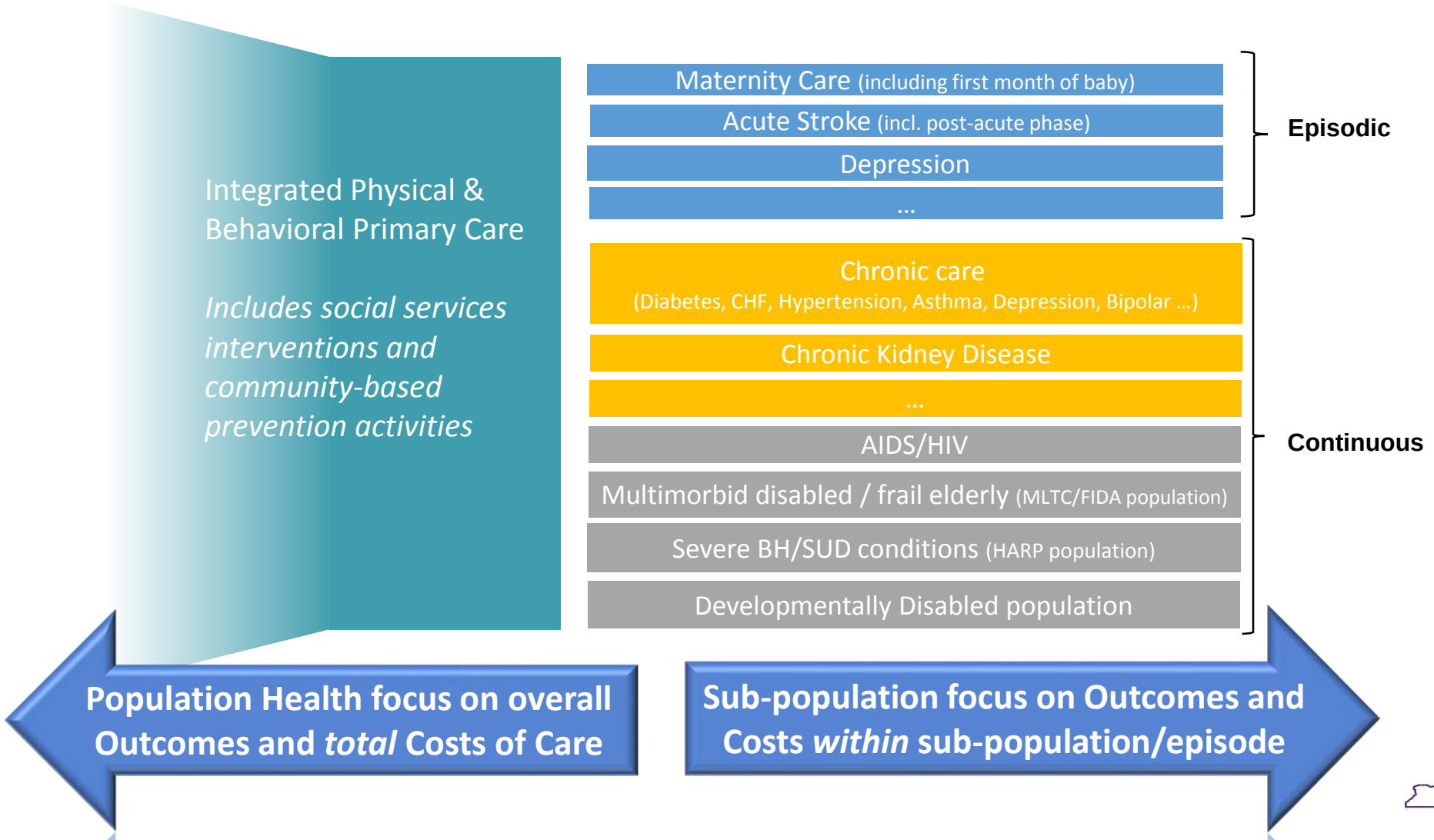
Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins* ***by realizing value***



Goal – Reward Value not Volume

The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

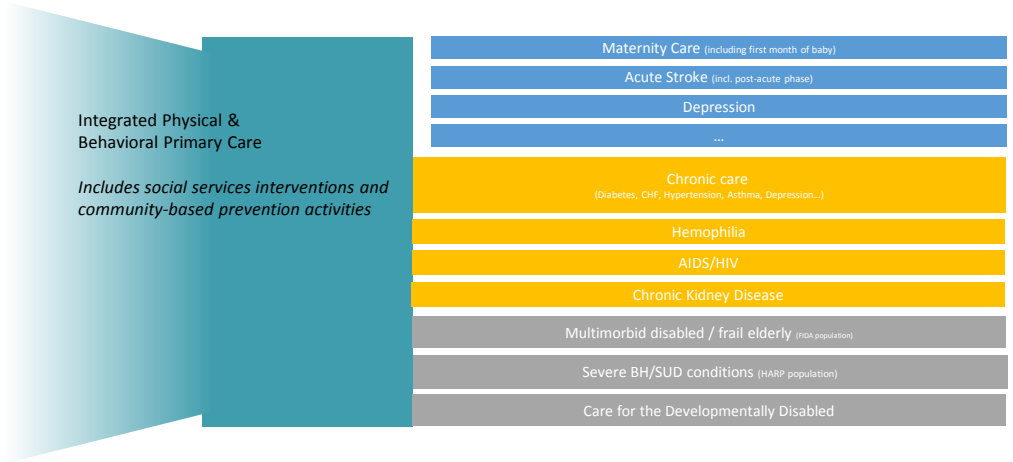


The Path Towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from.

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

- For the total care for the total attributed population of the PPS (or part thereof) – ACO model
- Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
- For integrated Advanced Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities



MCOs and PPSs may choose to make shared savings arrangements for the latter types of services between MCOs and groups of providers within the PPS rather than between MCO and PPS

MCOs and PPSs can choose different levels of Value Based Payments

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

Key Defining Factors of the New York VBP Approach

1. Addressing all of the Medicaid program in a holistic, all-encompassing approach rather than a pilot or piecemeal plan
2. Leveraging the Managed Care Organizations (MCO) to deliver the payment reforms
3. Addressing the need to change provider business models through positive financial incentives
4. Allowing for maximum flexibility in the implementation for stakeholders while maintaining a robust, standardized framework
5. Maximum focus on transparency of costs and outcomes of care

VBP Transformation Overall Goals

Goal of VBP reform within the NYS Medicaid system:

To improve population and individual health outcomes by creating a system of sustainable delivery of integrated through care coordination and rewarding of high value care delivery.

By end of 5-year DSRIP plan, the State aims to have…

1. 80-90% of total MCO-PPS/provider payments (in terms of total dollars) as value based payments.
2. ≥ 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

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B. Clinical Advisory Group (CAG) Roles & Responsibilities

Roles and Responsibilities Overview

CAG Composition

Comprehensive Stakeholder Engagement

- Comprehensive stakeholder engagement has been a key component to the development of the Value Based Payment Roadmap.

- We will continue engaging stakeholders as we develop and define opportunities for value based payment arrangements.

Composition of the Clinical Advisory Group includes:

- Clinical experience and knowledge focused on the specific care or condition being discussed (maternity)
- Industry knowledge and experience
- Geographic diversity
- Total care spectrum as it relates to the specific care or condition being discussed

CAG Objectives

- Understand the State's visions for the Roadmap to Value Based Payment
- Understand the HCI3 grouper and underlying logic of the bundles
- Review clinical bundles that are relevant to NYS Medicaid
- Make recommendations to the State on:
  - quality measures
  - data and other support required for providers to be successful
  - other implementation details related to each bundle

❖ *The CAGs will be working with national standard bundles and are not asked to tailor definitions at this point, but focus on quality measures and NYS implementation details. Working experience with bundles can lead to new insights and definition enhancements as with any reimbursement methodology.*

❖ *Definitions are standard, but financial arrangements between plans and providers around the bundles are not set by the State.*

Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will consist of the following:

Meeting 1

- Introduction to Value Based Payment
- Clinical Advisory Group- Roles and Responsibilities
- Understanding the Approach: HCI3 Overview
- Maternity Bundle High Level Overview

Meeting 2

- Maternity Bundle - Definition
- Maternity Bundle - Current Analysis
- Quality Measures Considerations– Meeting 3 Preparation

Meeting 3

- Maternity Bundle Quality Measures

C. HCI3 101

Understanding the Grouper & Development of Care Bundles

HCI3 Overview

Health Care Incentives Improvement Institute, Inc. (HCI3)

- a non-profit and independent organization
- supported by volunteer clinical experts and healthcare leaders helping to develop episode care definitions
- widely recognized as national leader

What are Episodes?

- Episodes are a grouping of all clinically related services for a condition or procedure which covers the entire continuum of care for that condition or procedure.
  - For examples, for a given condition this could include: surgery, procedures, management, ancillary, lab, pharmacy services

Evidence Informed Case Rates (ECRs) are the HCI3 episode definitions

- ECRs are patient centered, time-limited, episodes of treatment
- Definitions are publically available (not proprietary)

Source: HCI3 Presentation: http://216.70.89.98/onlinecourses/Module201prt1.htm

Evidence Informed Case Rates (ECRs)

Evidence Informed Case Rates (ECRs) are the HCI3 episode definitions

- ECRs are patient centered, time-limited, episodes of treatment
- Include all covered services related to the specific condition
- Distinguish between “typical” services from “potentially avoidable” complications
- Are associated to one another based on clinical logic
- Clinically vetted and developed based on evidence-informed practice guidelines or expert opinions

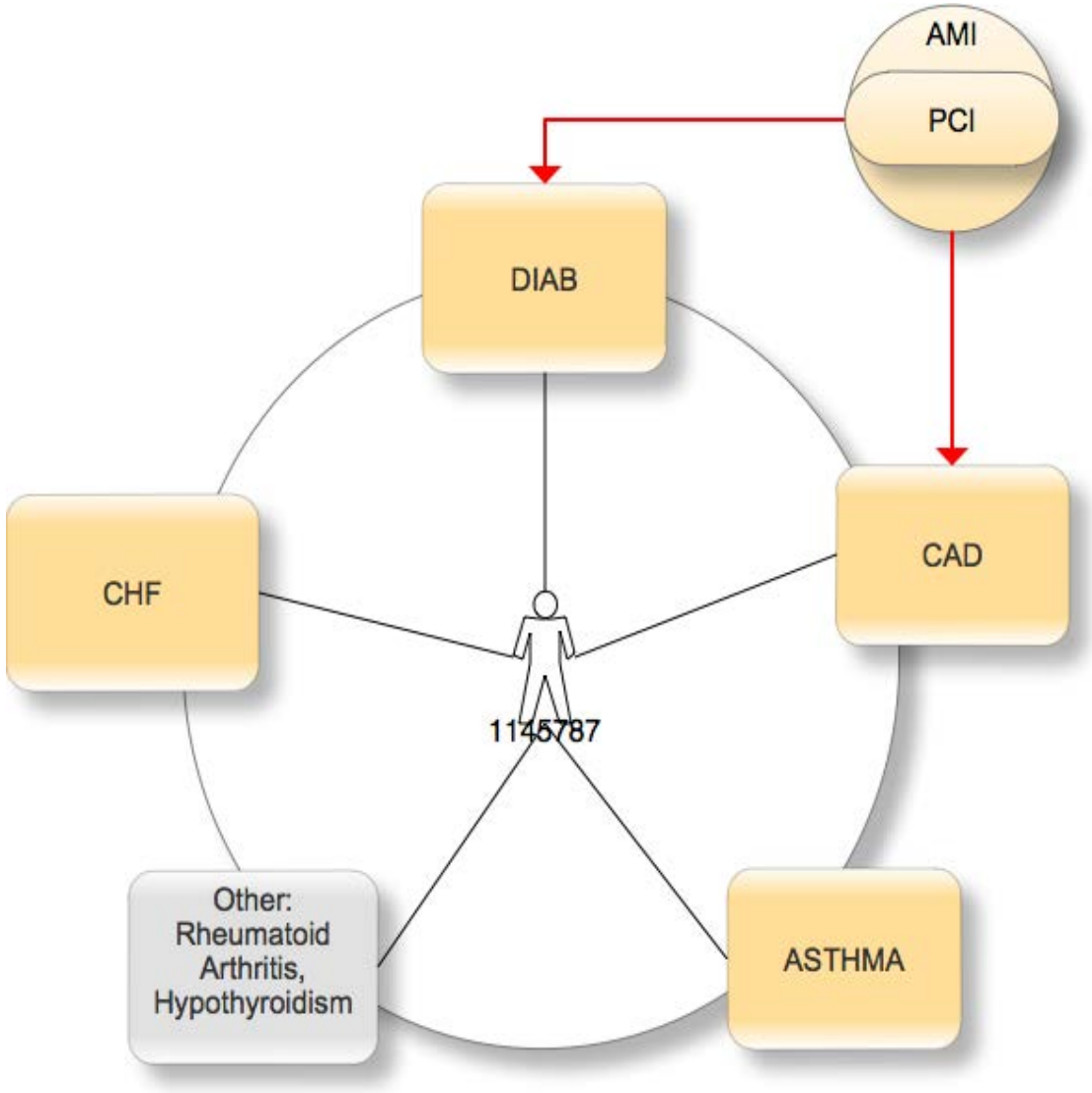
All patient services related to a single illness

Sum of group services (based on encounter data the State receives from MCOs).

Source: HCI3 Presentation: http://216.70.89.98/onlinecourses/Module201prt1.htm

Overarching Clinical Logic

Logic	Example (See Right)
Individuals can have: • Concurrent episodes • Multiple episodes	This individual has multiple, concurrent episodes: diabetes, coronary artery disease (CAD), asthma, (CHF), etc.
Episodes can be classified as: • Typical • Complication	The acute myocardial infarction (AMI) episode may be associated to CAD or diabetes episode
Episodes are related to one another through defined clinical associations	The angioplasty (PCI) is a separate procedural episode but is 'grouped' into the AMI episode when it occurs directly after



Episode Components : PACs

- Costs are separated by "typical" care from costs associated with Potentially Avoidable Complications (PACs)
  - PACs for chronic conditions and some acute conditions have been endorsed by the NQF as comprehensive outcome measures[1]
  - Expected costs of PACs can be built in as an incentive towards a shared savings
- PACs are generally considered to be controllable by the physicians and hospitals that manage and co-manage the patient
  - Can stem from medical error, ineffective treatment or lack of best practices
  - Examples: ambulatory-care sensitive admissions, hospital acquired conditions and inpatient-based patient safety features

Example Maternity PACs

Obstetrical Trauma	Urinary Tract Infection
Failed Induction	Disruption Wound (C-Section)
Sepsis	Fetal Distress

Alignment with NQF

Many PAC measures are based on established NQF measures. Four unique PAC measures have been endorsed by the National Quality Forum (NQF) with 7 more submitted this year

1 http://www.hci3.org/content/hci3s-measures-improve-quality-and-outcome-care-patients-endorsed-nqf

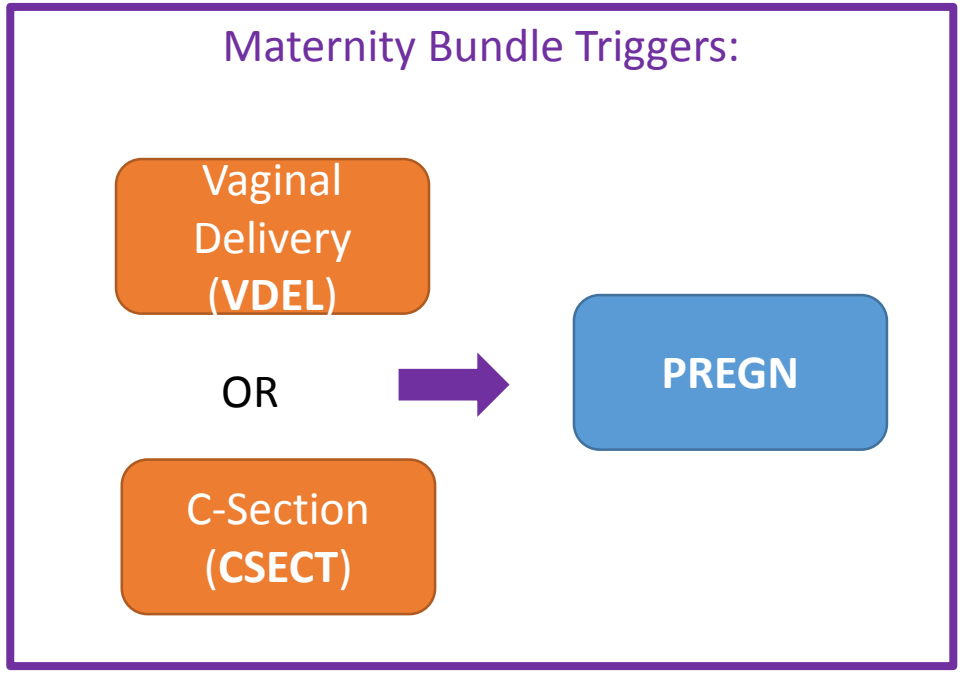
Episode Component: Triggers

- A trigger signals the opening of an episode

- 4 types of triggers:
  - Inpatient Facility Claim
  - Outpatient Facility Claim
  - Professional Claim
  - Episode

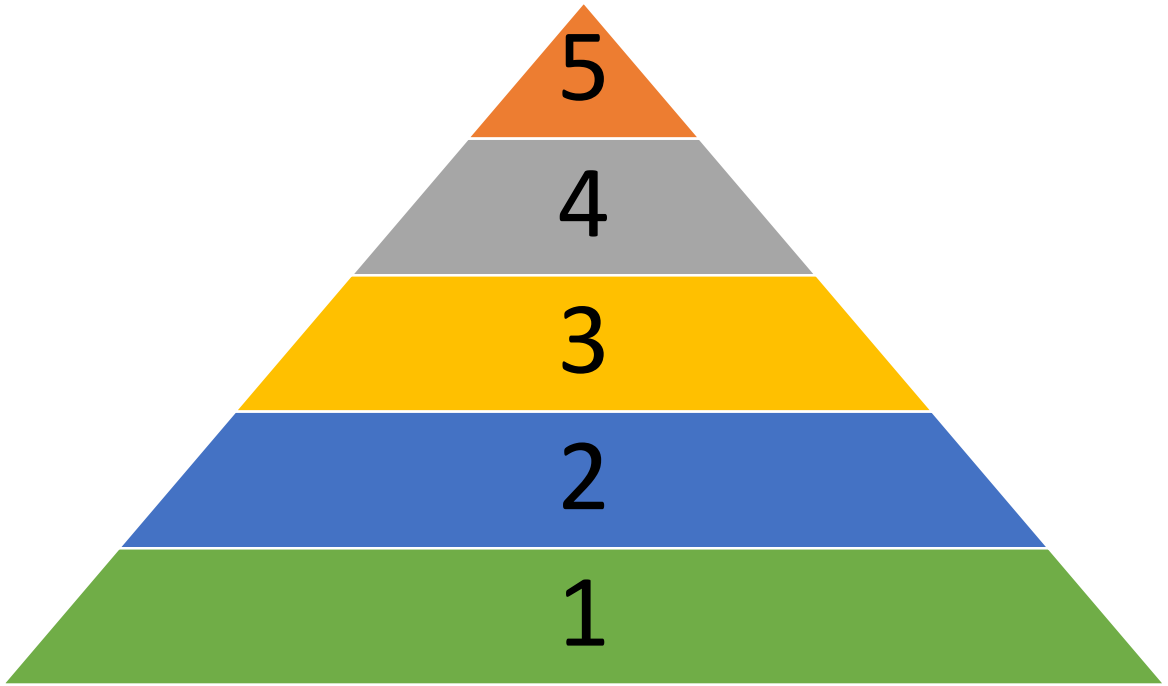
- More than one trigger can be used for an episode
  - Often a confirming claim is used to reduce false positives

- Trigger codes are unique to each episode—no overlaps



Episode Components – Aggregating episodes into one

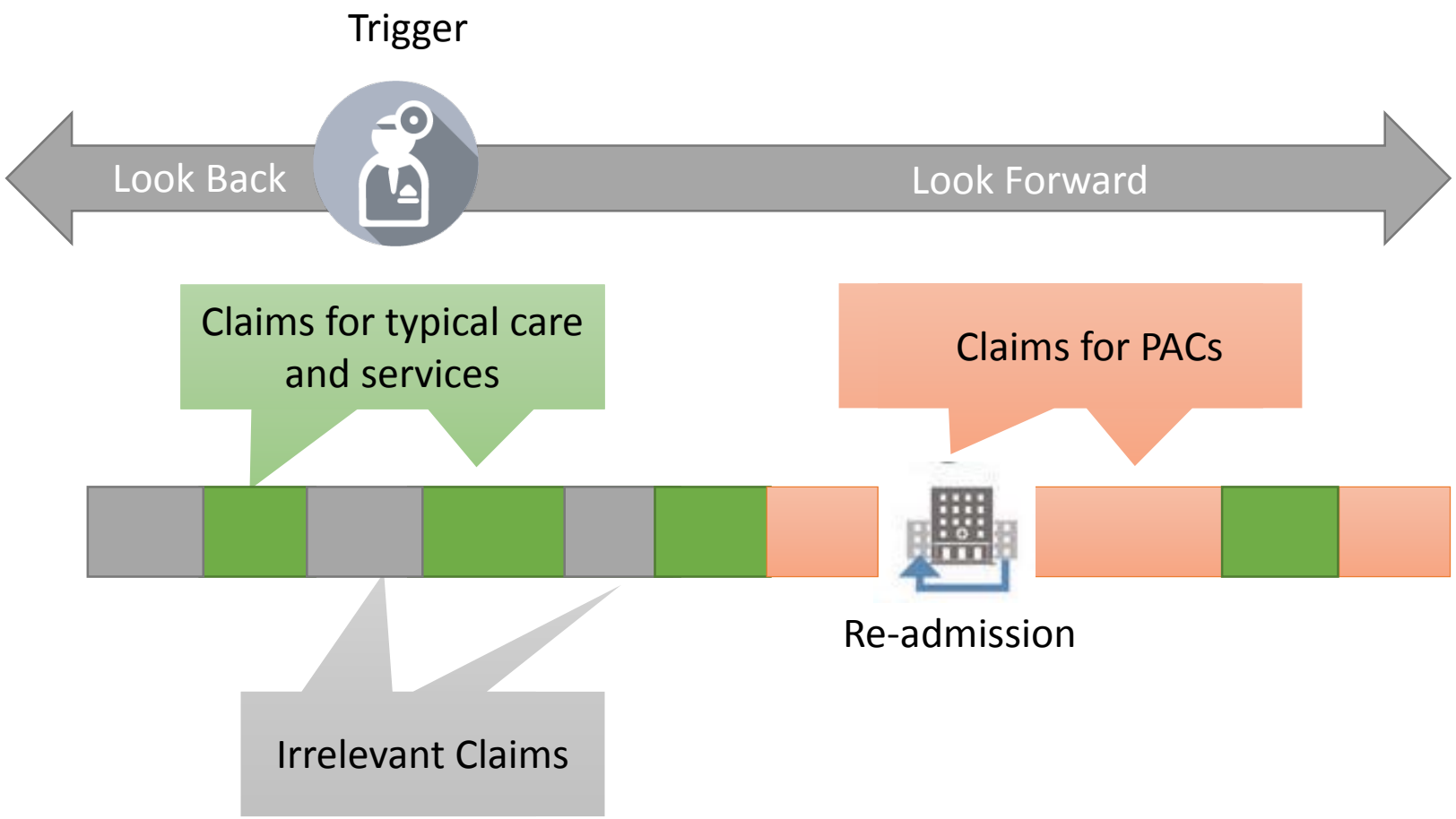
- The grouper can aggregate smaller episodes into larger wholes: individual associated episodes may get grouped together into more comprehensive bundles as you move to higher aggregation levels.



As you move up to higher aggregation levels, associated episodes get grouped together, in our example, pregnancy, delivery, and the newborn bundle are grouped into the Maternity Bundle

To start, claims are grouped into defined individual episodes, for example pregnancy, vaginal delivery, c-section delivery and newborn, exist as separate episodes at the first aggregation level.

What does a full episode look like?



Source: HCI3 Presentation: http://216.70.89.98/onlinecourses/Module201prt1.htm

Risk Adjustment

- Make “apples-to-apples” comparisons between providers by accounting for differences in their patient populations
- Takes the ‘probability risk’ or ‘insurance risk’ (co-morbidity, severity of condition at outset, age of mother etc) out of the equation

Method:

Using Risk Adjustment, an *expected cost* for the bundle is calculated

- Subsequently, the *actual* cost for the bundle is calculated (based on the actual claims for this bundle)
- Per case, the net difference (‘expected cost – actual cost’) is calculated per patient
- The gross savings/losses are calculated by adding all net differences together (see example coming up)

More information can be found at http://www.hci3.org/sites/default/files/files/Reliability%20of%20Prometheus%20Measures_0.pdf

Part II

A. Maternity Care
Bundle Definition & Example

The Maternity bundle includes all pregnant females and newborns that meet the identified inclusion criteria

Inclusion Criteria:

Pregnant females who have a claim under a qualifying trigger code. [1,2]
Newborns who receive care up to 30 days post-discharge

Exclusion Criteria:

Patient Exclusions:

- Non-pregnant females or males
- Those who have no claim under a qualifying trigger code (i.e.: pregnancy without delivery)
- Members who are discharged against medical advice
- Members who die in the hospital
- Those without an inpatient/outpatient stay and a relevant professional claim (an orphan episode; i.e.: delivery out of state).

Medical Exclusions:

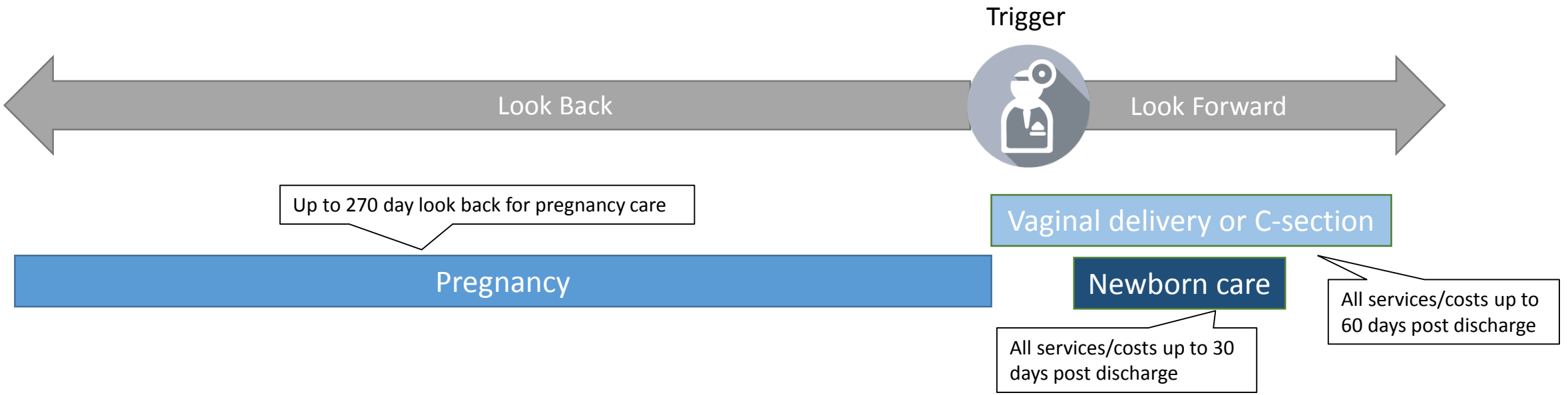
- Patients who have comorbidities of HIV, cancer, suicide, or end-stage renal disease.
- Newborns with NICU level 4 care

Notes

- Given the often short enrollment history of the pregnant individuals, risk adjustment factors that occurred pre-enrollment cannot be included.
- A mother-baby link has been implemented to combine mother and neonate claims, but may be subject to a margin of error.

1. A qualifying trigger code is a ICD-9/CPT/HCPCS code which, when implicated, will automatically create the maternity bundle. *See* Appendix 1 (regarding a list of the HCI3 PREGN, CSECT, and VAGDEL ICD-9/CPT/HCPCS qualifying trigger codes). http://www.hci3.org/ecr_descriptions/ecr_description.php?version=5.2.005&name=VAGDEL&submit=Submit
2. The HCI3 data is for the period between January 1, 2012 through December 31, 2013.

What does a full maternity episode look like?



Included in bundle:

- Both low risk and high risk pregnancies with severity markers
- **For the mother**: all related services for delivery including post discharge period (60 days post discharge) and entire pre-natal care period (270 days prior to delivery)
- **For the infant**: initial delivery stay and all services/costs up to 30 days post discharge

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Appendix

Appendix 1: Trigger codes

Trigger codes vaginal delivery		
Type of code	Group Name	Code(s)
ICD-9	Forceps, vacuum delivery	720, 721, 7221, 7229, 7231, 7239, 724
ICD-9	Abnormal Presentation	7251, 7252, 7253, 7254
ICD-9	Forceps, vacuum delivery	726, 7271, 7279, 728, 729
ICD-9	Other procedures to assist delivery - 137	7359, 738, 7391, 7392, 7393, 7394, 7399
CPT / HCPCS	Procedure - vaginal delivery	59400, 59409, 59410
CPT / HCPCS	VBAC	59610, 59612, 59614

Trigger codes c-section		
Type of code	Group Name	Code(s)
ICD-9	Cesarean section - 134	740, 741, 742, 744, 7499
CPT / HCPCS	Procedure - cesarian delivery	59510, 59514, 59515
CPT / HCPCS	C-Sect after attempted VBAC	59618, 59620
CPT / HCPCS	Procedure - cesarian - after vbac attempt	59622