



# State Medicaid Perinatal Health Care Cost Containment Strategies

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# + Examples of State Cost Containment Strategies


- Nonpayment (multiple states)
- Broad payment and delivery system reform (Arkansas, Oregon, North Carolina)
  - Performance measurement incentives
  - Medical home



# + Medicaid Nonpayment

- State policy not reimbursing for *elective* early deliveries
  - New York (C-section or induction at less than 39 weeks)
  - South Carolina
  - Texas
- Reduced reimbursement for elective C-section
  - Washington (pays vaginal delivery rate)

# + Arkansas Health Care Payment Improvement Initiative

- Goal: improve health outcomes, care experience and reduce costs
  - Team-based care coordination (medical home, health homes)
  - Retrospective episode-based payment for specific conditions/episodes of care
    - Congestive heart failure
    - **Perinatal**
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- Principal accountable provider (PAP) or “quarterback” drives improvement, shares savings/excess costs of episodes
  - Quality metrics and cost benchmarks (“acceptable” or commendable” average cost)

# + Arkansas: Perinatal Episode of Care

- All pregnancy-related care (prenatal, labor/delivery, postpartum maternal care, labs, etc.)
  - Excludes high-risk pregnancies
- PAP is provider who performed the delivery
- Episode begins 40 weeks prior to delivery; ends 60 days after delivery
- Quality measures/targets required to share in savings
  - Prenatal screening in 80% of episodes
- Average cost



# Oregon's Coordinated Care Organizations (CCOs)

- Goal: improve health outcomes, care experience and reduce costs
- Medicaid 1115 waiver
- CCOs are:
  - Local networks of providers coordinating care together
  - Community-based, led by partnership
  - Serve as single point of accountability for quality and outcomes for members
  - Paid through a global budget
- 36 quality measures



# CCO Quality Pool and Incentive Measures

- Incentive program (quality pool) requires reporting on 17 incentive measures
  - Improving primary care
  - Integrating primary care and behavioral health
  - **Improving perinatal and maternity care**
- For most measures, CCOs qualify for incentive by meeting
  - State benchmark or
  - Individual improvement target
- First quality pool (to be paid in 2014) is 2% of payments made to CCOs



# CCOs: Timeliness of Prenatal Care

Women with a prenatal visit in the first trimester (or within 42 days of enrollment) -----

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All women with a live birth (in measurement year)

- Statewide baseline (2011): 65.3%
- 2013 state benchmark: 69.4%
- 2013 improvement target: reduce gap between CCO's baseline and state benchmark by 10%





# CCOs: Early Elective Delivery

The number of members with elective vaginal delivery or  
elective Cesarean Section with  $\geq 37$  and  $< 39$  weeks  
gestational completed

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Patients delivering newborns with  $\geq 37$  and  $< 39$  weeks of  
gestation completed

- 2013 state benchmark: 5% or below



# North Carolina's Pregnancy Medical Home Program

- Goal: improve perinatal care quality and birth outcomes, while also decreasing costs
- Medicaid State Plan Amendment
- Identify and coordinate care for high-risk pregnancies
- Administered through Community Care of North Carolina (CCNC) and operated by CCNC's 14 networks
  - OB physician champions and OB nurse coordinators
  - Care managers from local public health departments
- Quality goals:
  - Reduce low birth weight births
  - Reduce C-section rates

# + Pregnancy Medical Home Incentives

- Local health departments receive population-based per member per month payment
- Pregnancy medical homes receive enhanced reimbursement
- Pregnancy medical homes receive other incentives:
  - \$50 for high-risk pregnancy screening
  - \$150 for post-partum visit with minimum elements
  - No prior authorization for OB ultrasound
  - Rate increase for vaginal deliveries



# Takeaways

- Perinatal examples across the country
- Narrow and broad strategies
- Cost containment in conjunction with quality improvement and access (Triple Aim)