Learning Community

Using Maternity Alternative Payment Models (APMs) to Drive Needed Maternity Care System Transformation

April 19, 2021

Agenda

a. Welcome, introductions, and updates

b. Spotlight presentations:

- **Carol Sakala**: Using Maternity APMs to Drive Needed Maternity Care System Transformation
- **Judy Zerzan and Beth Tinker**: The Path Towards Maternal Health Payment Reform in WA State

c. Discussion

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Welcome!

- Name
- Personal/professional affiliation
- What brings you here

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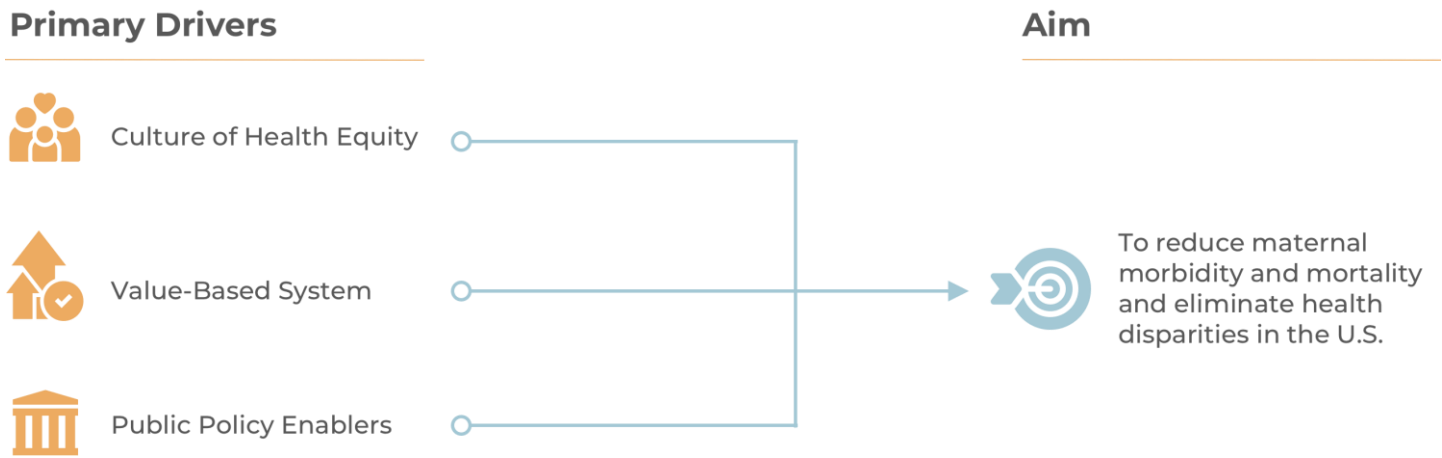
Learning Community Purpose

The ***Maternal Health Hub Learning Community*** is a forum to share learnings and best practices, payment reform evidence, and implementation resources to accelerate the identification and dissemination of effective value-based care delivery and payment strategies for maternity care that advance health equity.



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Learning community agenda & objectives

Trimesters	Topic	Objective
Oct – Dec 2020	***Building a business case for investing in community-based, equity-centered care***	Develop components of a business case for payers and purchasers to invest in community-based, equity-centered care, including addressing benefit and network design, state and federal regulatory barriers, and how to measure quality and value.
Jan – March 2021	***High-value & equitable maternity care in the time of COVID***	Share experiences with maternity care delivery during COVID and identify best practices, payment reform opportunities, and policy recommendations to address disparities in access to and experience with equitable virtual care.
April – June 2021	***Advancing alternative payment models for maternity care***	Develop strategies to advance the implementation of effective alternative payment models for maternity care delivery and develop recommendations for payers and policymakers to incorporate a focus on improved health equity and addressing social determinants of care into value-based payment for maternity care.

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Updates from the Department of Health and Human Services (HHS)

- **Extended postpartum coverage:** Illinois is the first state to provide extended eligibility for a woman during the entire first year after delivery
  - Effective April 12, 2021, through December 31, 2025
- **Notice of Funding Opportunity:** HHS announced $12 million over four years for the Rural Maternity and Obstetrics Management Strategies program
  - The funds will allow awardees to test models to address unmet needs for their target population
  - Applicants are required to focus on populations that have historically suffered from poorer health outcomes, health disparities, and other inequities

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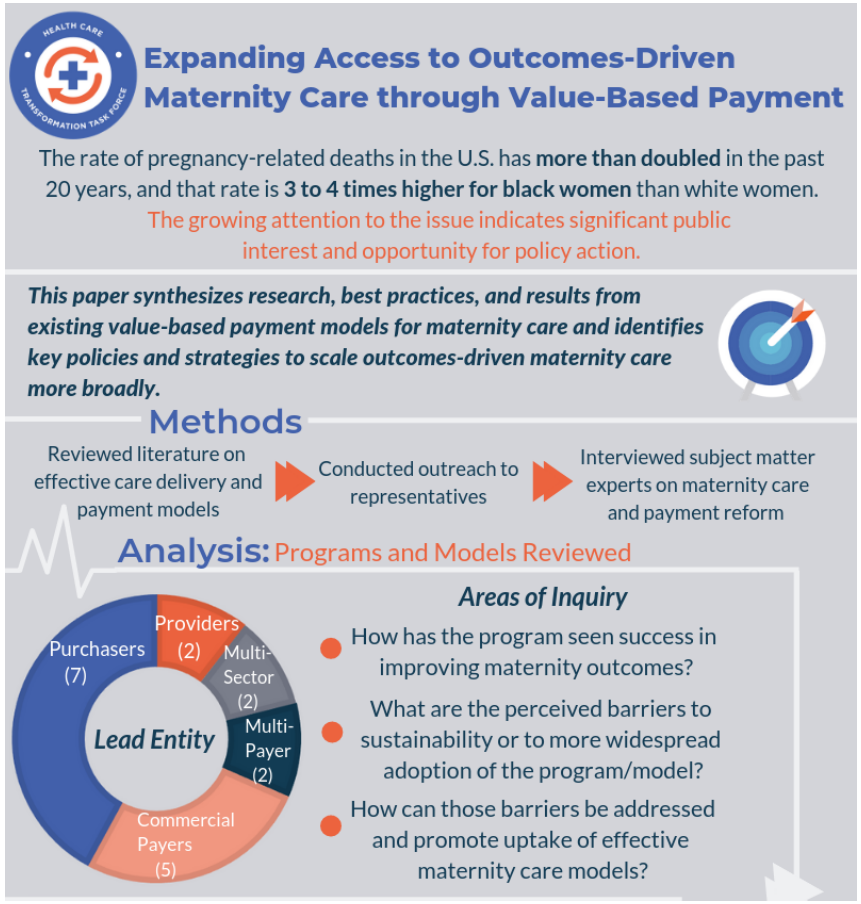
HCTTF White Paper: Expanding Access to Outcomes-Driven Maternity Care through Value-Based Payment

- This paper, published in July 2020, synthesizes research, best practices, and results from existing value-based payment models for maternity care and identifies key policies and strategies to scale outcomes-driven maternity care more broadly.

https://hcttf.org/outcomes-driven-maternity-care-vbp/



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HCTTF Urges CMS to Test an Alternative Payment Model for Maternity Care, July 2020

- Alternative Payment Models (APMs) for maternity care should address the following objectives:
  - Improved prenatal care utilization
  - Reducing the rate of unnecessary Cesarean section (C-section) deliveries
  - Improved healthy birth weight rate
  - Healthy postpartum recovery for mother & baby.
  - Reduced racial disparities in morbidity and mortality
  - Improved screening and treatment for perinatal mood and anxiety disorders (PMADs)

https://hcttf.org/cms-maternity-care-apm-recommendation/

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New Maternal Health Hub Resource

Maternity Care Delivery and Payment Changes During COVID-19: Assessing Equity and Sustaining Innovation

- Resource highlights successful stakeholder strategies developed in response to the COVID-19 pandemic. Strategies included virtual doula support services, telehealth for perinatal care services, and training birthing persons in self-advocacy to promote high-value, equitable maternity care during the.
- The resource includes three case studies exploring blended virtual and in-person prenatal care visits, virtual doula and support services, and patient self-advocacy to improve maternal health outcomes.
- In planning for the post-pandemic maternity care system, it is critical to evaluate the impact of all care delivery models with a health equity lens to determine whether birthing persons of color are benefited or harmed by pandemic related innovations.

https://maternalhealthhub.org/resource/maternity-care-delivery-and-payment-changes-during-covid-19-assessing-equity-and-sustaining-innovation/

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national partnership for women & families

Using Maternity APMs to Drive Needed Maternity Care System Transformation

Health Care Transformation Task Force

Maternal Health Hub

Carol Sakala, PhD, MSPH

April 19, 2021

About the National Partnership

- Works for a just and equitable society in which all women and families can live with dignity, respect and security
- Health Justice and Economic Justice policy teams
- Celebrating 50 years of advancing key policies for women and families

About the presenter

Carol Sakala

Director for Maternal Health

National Partnership for Women & Families

I have no conflicts of interest to disclose

Maternity care needs help

For far too many, this care is not:

- Equitable
- Accessible
- Safe
- Respectful
- Effective
- Affordable

Quality warning signs

- Rising maternal mortality
- Rising severe maternal morbidity
- Rising rates of preterm birth and low birthweight
- Flat cesarean rate for 10+ years despite "too high" consensus
- Widespread overuse of unneeded care, underuse of beneficial care (unwarranted practice variation)
- Broad inequities and unacceptable outcomes in best case
- Social needs have major impact, are largely out of view
- Compare unfavorably to peer nations (incl. baby outcomes)

https://www.nationalpartnership.org/our-work/resources/health-care/maternity-care-in-the-united.pdf

Cost (and quality) warning signs

- We likely have world's most costly maternity care system
- 4/5 of all dollars paid on behalf of woman and newborn across episode cover just the brief hospital phase of care
- High prices, procedure-intensive intrapartum care for all
- 1/3 cesareans @ 50% greater payments than vaginal birth
- 85% with history of cesarean have another one
- NICU and neonatologist supply-induced demand with healthier and healthier babies spending time in NICUs

https://healthcostinstitute.org/images/pdfs/iFHP_Report_2017_191212.pdf
https://www.nationalpartnership.org/our-work/resources/health-care/maternity/archive/the-cost-of-having-a-baby-in-the-us.pdf
https://www.dartmouthatlas.org/Neonatal_Atlas_090419.pdf

Underfunding

- Prenatal care
- Postpartum care
- Social needs, care coordination and navigation
- Midwifery care
- Birth center care
- Doula support
- Services of community-led perinatal health worker groups
- Medicaid services

Inspirational success: PBGH

- 3-hospital payment reform pilot to ↓ low-risk cesarean birth
- APM limited to mother's care and hospital phase of care
- Blended case rate payment plus technical assistance
- Over 5 quarters, hospitals reduced NTSV rate by >20%
- While not a program focus, VBAC rates rose
- With averted future cesareans, about $4M savings

Versus flat national rate since 2014 ACOG-SMFM statement

https://www.pbgh.org/wp-content/uploads/2020/12/TMC_Case_Study_Oct_2015.pdf
https://www.acog.org/-/media/project/acog/acogorg/clinical/files/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery.pdf

Vision for APMs and maternity care

Over time

- Growing accountability for measures that matter
- Continuous use of QI improves practice
- Reduced unwarranted practice variation
- Increasing ability to work as team toward shared goals
- Increasing reliance on high-value forms of care for success
- Improved and more equitable maternal-infant care, experiences, outcomes
- Wise use of resources
- Clinical culture change and delivery system reform

Prioritize APMs with greatest potential for impact

- Episode payment (bundled, pregnancy-postpartum/infant)
- Maternity care home (aka pregnancy medical home, obstetric medical home, etc. – prefer to center birthing person)

- Can be implemented together
- Can incorporate additional payment reforms

We must recognize the long culture change/delivery system reform trajectory, the enormous potential benefit, and start on the journey wherever we can

Conventional maternity payment

Despite global fees, solidly aligned with FFS

- No accountability (for equity, outcomes, experiences, effectiveness, costs, …)
- Separate provider (mom, baby), facility (mom, baby), lab, imaging, pharmacy payments
- No incentives, and often no resource allocation, to reliably provide beneficial underused care
- No effective brakes on procedure-intensive overuse
- No effective brakes on high facility prices

Maternity Care Episode Payment

Optimal features, may not be possible at first

- Include both birthing person and infant (interim maybe mom)
- From pnc entry through postpartum and newborn periods
- Include vast majority of women, babies, at various risk levels
- Small number of very high-cost exclusions to limit provider risk
- Also limit provider risk with risk adjustment and stop-loss
- Single payment for whole episode (interim maybe 3 payments)
- Willing person coordinates

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

Maternity Care Episode Payment

Optimal features, continued

- Use population-impacting performance measures; adjust targets annually
- Both upside (gainsharing) and downside risk
- Succeed with high-performing forms of care (e.g., midwifery)
- Integrate into practice (e.g., data collection, payment mgmt)
- Meaningfully engage birthing people and families
- Quality improvement and continuing education
- Build equity into design

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

Proposed episode performance measures

Nationally endorsed by NQF – strongly preferred

- Cesarean birth (aka NTSV)
- Unexpected complications in the term newborn
- Exclusive breast milk feeding
- Contraceptive care – postpartum

Other priorities, no current nationally endorsement

- Person-reported experience of maternal-newborn care
- Person-reported outcomes of maternity care

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

Building equity into APM design

Approaches include

- Adjusting payments for social risk
- Equity-focused performance measures, including stratification by race-ethnicity and other key demographic variables
- Increased reward for reaching equity benchmarks
- Increased payments to safety net providers for infrastructure, social needs
- Relevant service enhancements, e.g., telehealth, support from community-based organizations

https://www.healthaffairs.org/do/10.1377/hblog20201119.836369/full/
http://ldi.upenn.edu/sites/default/files/pdf/PennLDI-Future-of-Value-Based-Payment-WhitePaper.pdf

Maternity Care Home

Optimal features, may not be possible at first

- Payment mechanism (e.g., per member per month)
- Personnel: prepared, tasked, resourced, held accountable
- Performance indicators (e.g., care planning) and targets
- Program incentives (e.g., infrastructure support, recognition program)
- Dual focus: community and social supports, care navigation

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

Maternity Care Home

Optimal features, continued

- Meeting individualized needs of all vs. premature segmentation
- Provide support from pregnancy through postpartum period
- Integration into practice (e.g., work flow, relationships with community services, communication across care team)
- Build equity into design

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

Win with high-performing care models

- Midwifery-led care
- Community birth, birth centers and home
- Doula support, birth doula and extended model
- Community-based and –led perinatal health worker groups

https://www.nationalpartnership.org/improvingmaternitycare

Win with high-performing care models

These models share a set of attributes

- Appropriate practices minimizing both overuse of unneeded unneeded care and underuse of beneficial services
- Mission driven; meet birthing families where they are
- Individualized, relationship-based care and support that are dignifying, trusted and often culturally congruent
- Attend to physical, emotional and social needs; build resilience
- Skills and knowledge for physiologic childbearing
- Remarkable outcomes, e.g., ptb, cesarean, breastfeeding
- In surveys, highly valued by childbearing, esp. BIPOC, people

https://www.nationalpartnership.org/improvingmaternitycare

Hypothesis: Prioritize quality, wise spending will follow

- Give priority to dire, in many cases worsening, situation
- Design APMs for equity and improvement
- Savings will accrue: e.g., ↓ preterm birth, ↓ cesareans and repeats, ↓ NICU stays, ↑ breastfeeding
- Need to sort out appropriate and now-imbalanced allocation of resources by type of payer and phase of care

Evolving maternity care APMs

- From national health plans, including Anthem, Cigna, Humana, UnitedHealthcare
- From state and local health plans, including Community Health Choice, Horizon Blue Cross Blue Shield of New Jersey
- From Medicaid agencies, including AR, TN, NC, OH, WA, WI
- From other entities and collaborations, including 32BJ SEIU, Metro-Nashville Public Schools, Qualcomm, Unified Women's Healthcare

Bottom line

- Alternative payment models can drive delivery system reform
- Achieving goals is long-term project requiring persistence
- This requires new ways of working together, new priorities, new accountability
- We can change culture and practice
- We can achieve improved and more equitable outcomes
- We can spend more wisely
- There is so much to gain, and nothing to lose

Questions for ongoing APM discussion

- How have planned maternity care episode initiatives of national health plans played out during the pandemic?
- Did moving to maternity episode payments offer resilience during pandemic economic dislocation (as many others have reported)?
- What are prospects for maternity care APMs in Biden-Harris administration? Policy signal and encouragement from CMMI?

Contact Info

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NationalPartnership.org

ChildbirthConnection.org

national partnership for women & families

Washington State Health Care Authority

The Path Towards Maternal Health Payment Reform in WA State

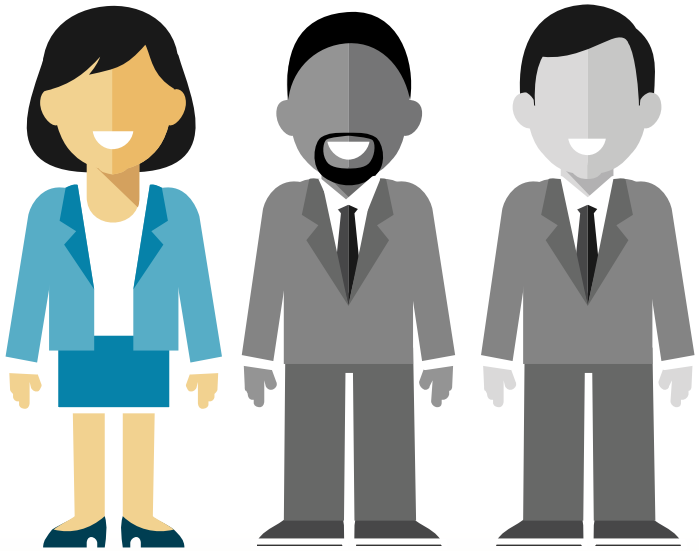
Beth Tinker PhD, MPH, RN
Nursing Consultation Advisor
Clinical Quality and Care Transformation Division
April 19th, 2021

Objectives for Today

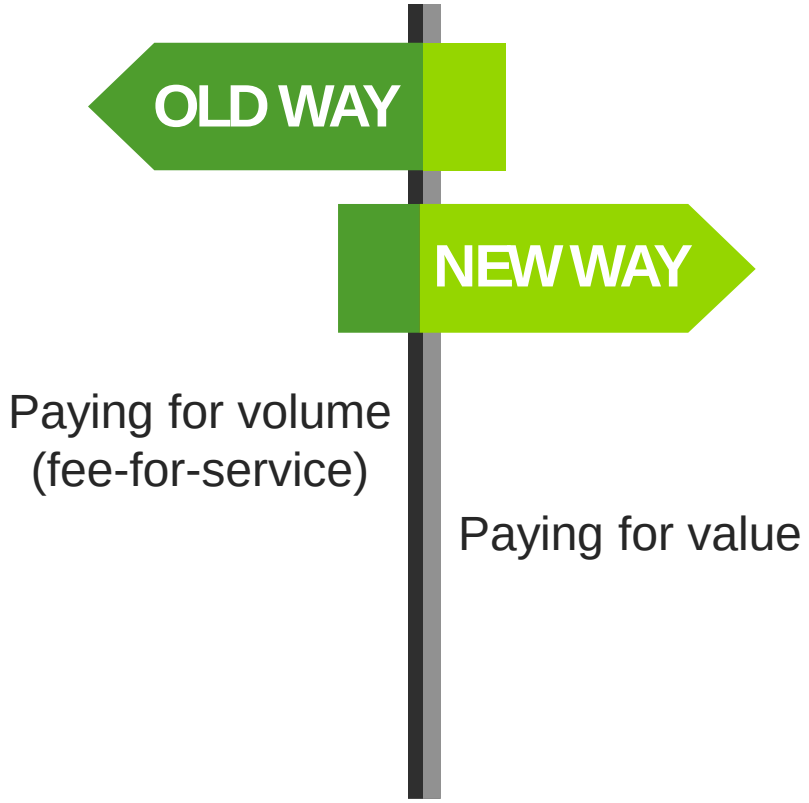
- Big picture roadmap for WA Health Care Authority (HCA) to value-based purchasing
- Medicaid maternal health in WA
- What we have accomplished in terms of maternity care and VBP and what lies ahead
- Q&A

Who is the HCA?
WA state's largest health care purchaser

We purchase care for 1 in 3 non-Medicare Washington residents.



- We purchase health care for more than 2.7 million Washington residents through:
  - Apple Health (Medicaid)
  - The Public Employees Benefits Board (PEBB) Program
  - The School Employees Benefits Board (SEBB) Program



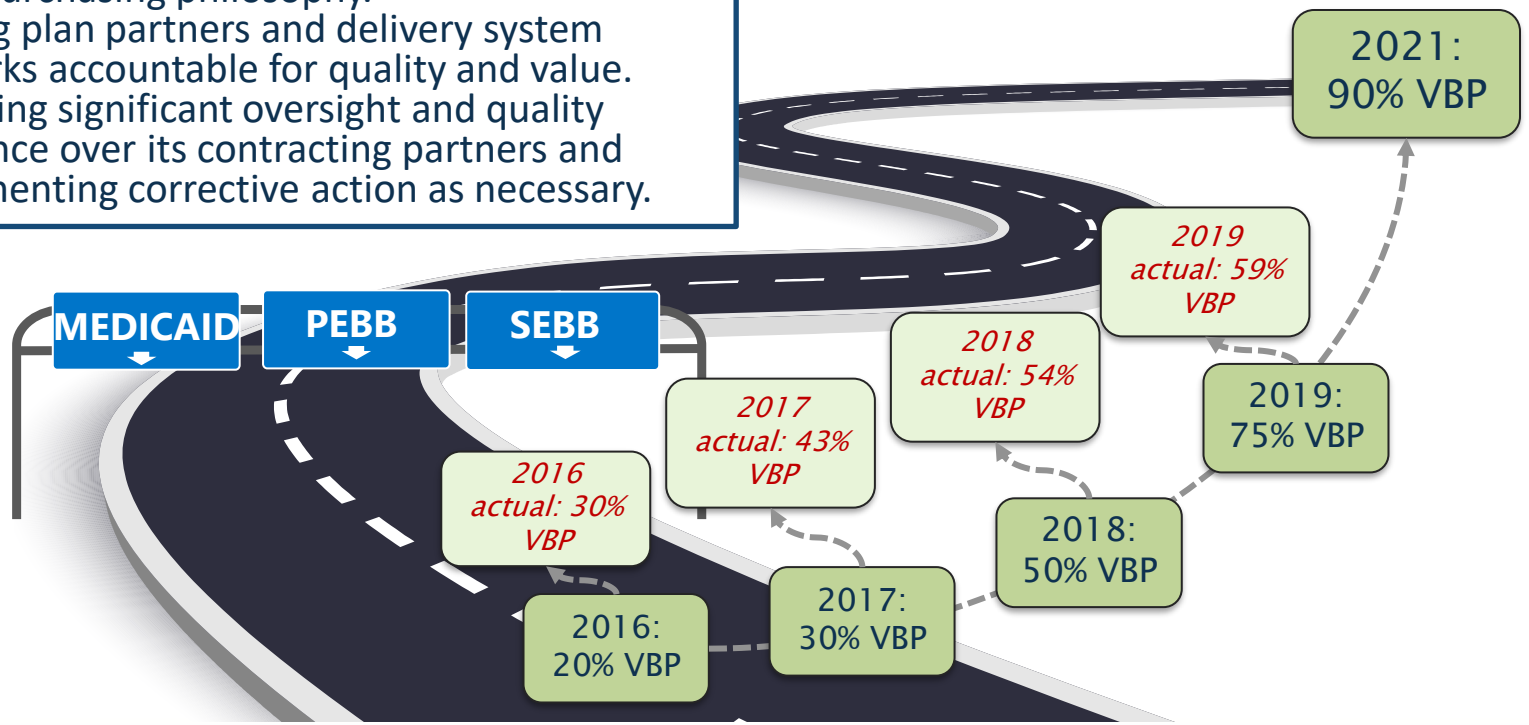
Our approach to health care purchasing

- Transforming care: better health and better care at a lower cost
- Whole-person care: integrating physical and behavioral health services
- Using data-informed evidence to make purchasing decisions

VBP roadmap

HCA's vision is to achieve a healthier Washington by:

- Aligning all HCA programs according to a "One-HCA" purchasing philosophy.
- Holding plan partners and delivery system networks accountable for quality and value.
- Exercising significant oversight and quality assurance over its contracting partners and implementing corrective action as necessary.



Goals with VBP and maternity care in WA

- Higher value care – improved patient/dyadic outcomes per dollar spent
- Data driven care reform – promoting and incentivizing care that has demonstrated better outcomes
- Intentionally addressing health disparities that are large and persistent
- Investing in dyadic care/family well-being

Characteristics of the pregnant and post-partum population covered by HCA (2019)

- Just under 50% of the births in WA are covered by Medicaid (approx. 40k annual births) – eligibility up to 198% of FPL
- 81% enrolled in 1 of 5 MCOs
- 67% had a prenatal visit in the first trimester

(36% for Hawaiian/PI, 58% AI/AN, 59% AA, 69% White)

(For non-Medicaid, 81% had 1st trimester PNC -2019)

- About 70% had a postpartum visit (MCOs)

Snapshot metrics – maternal health

- Report smoking during pg
  - 9.7% of Medicaid population vs 1.3% of non-Medicaid (2019)
- Cesarean sections (NTSV)
  - 23.8% statewide rate (total population) (2019)
- Breastfeeding
  - 89.2% at birth (2017 – WIC data)
  - 50.7% breastfeeding at 6mo of age

Snapshot metrics – maternal health

- Access to contraceptive care PP
  - 42% accessed most or moderately effective BCM by 60d PP
  - 16% accessed LARC by 60d PP (both for 7/18-6/19)
- Maternal mortality
  - 1/3 of pregnancy-related deaths occur 43-365d PP. Leading cause is behavioral health – suicide and accidental overdose
  - AI/AN people 6 to 7 times more likely to die, AA and multiracial more than 2X

    (2014-2016, Maternal mortality review, WA DOH)

The goal in WA State – improve population outcomes, intentionally address disparities

- Center the patient/family AND health equity
- Leverage HCA's purchasing power to drive higher quality care
- Follow the evidence (e.g., midwifery-led care, doulas, alternative models of care, addressing psychosocial needs/MH/BH)

What action has taken place?

- Bree Maternity Bundle – approved by Bree Collaborative 1/28/21.
- Bree Collaborative – est. by the WA St Legislature in 2011 so public and private stakeholders collaborate to improve health care quality, outcomes, and cost.
- The bundle promotes and incentivizes quality care by: specifying required evidence-based clinical components, quality tracking, and performance metrics (with thresholds tied to incentive or penalty).
- Allows for more personalized, tailored care and opportunity to receive incentive payments for better outcomes

Next steps

- Bree maternity bundle – grappling with difficult questions around the specifications of the episode (e.g., exclusions, risk adjustments, metrics- reporting and those tied to incentive/penalty, timeframe for birth parent and infant, payment model/structure, pilot program vs. more widespread model, etc.)
- Goal is implementing a maternity episode of care – across HCA, likely starting with Medicaid

Washington State Health Care Authority

Questions?

More Information:

https://www.hca.wa.gov

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Upcoming schedule

Third Trimester: Advancing Alternative Payment Models for Maternity Care

- May 17th
- June 21st

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Resources: Virtual Doula and Perinatal Support Services

- Bree Collaborative: Perinatal Bundled Payment Model
- Integrated Healthcare Association: Transforming Maternity Care: A Bundled Payment Approach
- Health Care Payment Learning and Action Network: Clinical Episode Payment Models Maternity Care
- Health Care Payment Learning and Action Network: Establishing Maternity Episode Payment Models: Experiences from Ohio and Tennessee
- Institute for Healthcare Improvement: The Maternity Medical Home: The Chassis for a More Holistic Model of Care?
- Institute for Medicaid Innovation: Improving Maternal Health Access, Coverage, and Outcomes in Medicaid

Follow the Forum discussion and add additional resources

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