Provider Listening Session
Washington State Maternal Care Model

October 31, 2022

Washington State Health Care Authority

Introductions

- Washington State Health Care Authority (HCA)
  - Beth Tinker, Clinical Nurse Consultant
  - Mary Fliss, Deputy, Clinical Strategy and Operations
- National Opinion Research Center (NORC)
- Aurrera Health Group

Agenda

- Provide an update on the Washington Maternal Care Model design
- Review design spec components and potential measures
- Project timeline update
- Q&A session
- Avenues for feedback and resources

Maternal care model goals

- Incentivize high-quality, high-value clinical obstetric care that improves perinatal health outcomes and addresses racial and ethnic disparities
  - Improve quality and increase utilization of prenatal and postpartum care
  - Reduce maternal morbidity and mortality
  - Reduce racial and ethnic disparities in perinatal outcomes
  - Improve birth outcomes
  - Increase care coordination between health care providers for birth parent and infant including leverage of the full 12 months of postpartum Medicaid coverage

Logic model

Incentivize high-quality, high-value care that improves perinatal health outcomes and addresses racial and ethnic disparities

Goals

- Increase utilization of and improve quality of prenatal and postpartum care
- Reduce maternal morbidity and mortality
- Reduce racial and ethnic disparities in perinatal outcomes
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Examples of Intervention Levers

- PP care defined by more than one comprehensive visit at 6 weeks
- Systematic BH screening, referral as needed and follow-up during pregnancy and the full year post partum
- Increase physiologic birth and patient informed choice (e.g. reduce c-sections and unnecessary interventions, improve satisfaction)
- Expand the appropriate use of midwives and incorporate doulas and other multi-disciplinary care team members
- Appropriately manage chronic conditions across the continuum – from initiation of prenatal care through end of 12mo PP (and transition to ongoing care)
- Increase attention to SDOH, including universal screening, referrals and linkage, support and follow up
- Leverage quality and reporting metrics to drive better, evidence-based care and improved outcomes
- Consider additional interventions that have demonstrated impact in reducing perinatal disparities: group prenatal care, home visiting, medical home models

Research and feedback

- Two webinars with large stakeholder group
- Two tribal listening sessions
- Conducted an environmental scan
- Conversations with other state agencies
  - Tennessee
  - New Jersey
  - Colorado

Strategies used by other states

- Episode of Care
  - This model frequently has a shared-savings and a risk-sharing threshold
    - Based on costs
    - Can be either up- and down-side risk or up-side only
  - Quality is incorporated as a “floor” that must be met or as pay-for-performance
    - Focus on limited selected quality outcomes
  - A lot of variety in evaluation findings
    - Quality metrics and birth outcomes

Strategies used by other states

- Health Home Model or Maternal Medical Homes
  - Accomplishes similar objectives
    - Health Home Model focuses on the primary care provider and incorporates the use of a patient-directed Health Action Plan
    - Maternity or Pregnancy Medical Home focuses on assessing and targeted services for high-cost, high-need populations

Strategies used by other states

- Health Home Model or Maternal Medical Homes
  - May be appropriate in the extended postpartum period
  - Evaluations of the Health Home Models specifically for beneficiaries with chronic conditions have found:
    - Better quality of care
    - Improved care coordination and management
    - Greater integration of behavioral and primary care
    - Increased rates of transitional care
    - Improved access to social services and community-based supports

MATERNITY CARE DESIGN ELEMENTS

Episode Definition

Episode includes maternity and newborn care for the majority of pregnancies that are lower risk, as well as for women with elevated risk conditions for which there are defined and predictable care trajectories.

Episode Timing

Episode begins 40 weeks before the birth and ends 60 days postpartum for the woman, and 30 days post-birth for the baby.

Patient Population

The population is women and newborns who are lower-risk, as well as women who may be at elevated risk due to conditions with defined and predictable care trajectories.

Services

All services provided during pregnancy, labor and birth, and the postpartum period (for women); and newborn care for the baby. Pediatric services are not included. Other service exclusions should be limited.

Patient Engagement

Engage women and their families in all three phases of the episode (prenatal, labor and birth, and postpartum/newborn).

Accountable Entity

Accountable entity chosen based on readiness to both re-engineer change in the way care is delivered to the patient, and to accept risk. Shared accountability may be required, given that a patient may be cared for by multiple practitioners acrossmultiple settings.

Payment Flow

Payment flow – either retrospective reconciliation or prospective payment – depends on the unique characteristics of the model's players.

Episode Price

The episode price should balance single and multiple providers and regional utilization history. It should reflect the cost of services needed to achieve the goals of the episode payment model.

Type and Level of Risk

Ultimate goal is both upside reward and downside risk, with strategies in place to mitigate risk, encourage provider participation, and support inclusion of a broad patient population

Quality Metrics

Prioritize use of metrics that support the episode goals, including measures of clinical outcomes and patient reported outcomes, for use in payment, accountability, quality scorecards, and other tools to communicate with and engage patients and other stakeholders.

http://hcp-lan.org/workproducts/maternity-infographic.pdf

Draft design specs

Design Element	Specification
Episode Trigger	Delivery with look back and forward for entire episode
Episode Timing	Start date: 270th day before delivery. End date: 84th day post-delivery
Patient Population	All birth parents in MCOs
Services	Maternity-related services (e.g., not including infant expenses)
Accountable Entity	TIN level

Draft design specs (continued)

Design Element	Specification
Payment Flow	Funds flow through MCOs to providers
Episode Cost	TBD
Type and Level of Risk	TBD
Quality Metrics	Identify five quality measures to use for performance incentives and five additional measures for reporting
Benchmarks	TBD

Potential measures

Pay-for-Performance Examples

- Chlamydia Screening (CHL)
- Cesarean Section Rate
- Prenatal/Postpartum Care (PPC)
- Behavioral Health Risk Assessment
- Respectful Maternity Care
- Breastfeeding Initiation
- Low Birth Weight
- Preterm Births
- Unexpected Complications in Term Newborns

Pay-for-Reporting Examples

- Contraceptive Care
- Group B Streptococcus Maternal Screening
- Initiation and Engagement of SUD services
- Care Coordination Quality Measure for Primary Care
- Percent Homeless/housing instability

Proposed EOC timeline

December 2022	Preliminary design
January – December 2023	Vetting and implementation development
December 2023	Contract with MCOs
January – December 2024	MCO infrastructure build
January 2025	Model Go-Live

Questions, input, reactions ?

Resources and contact information

- HCA Maternal Care Model Website - https://www.hca.wa.gov/about-hca/clinical-collaboration-and-initiatives/maternal-care-model
  - Webinar slides and recording will be posted here
  - Describes goals of the Maternal Care Model
  - Lists upcoming events
  - Updated regularly as model development and implementation proceeds

- Contact information
  - HCAMaternalCareModel@hca.wa.gov

Thank you!

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