Improving perinatal outcomes The next phase for HCA's maternal care model

Stakeholder webinar

March 28th, 2023

Washington State Health Care Authority

Agenda

- Update on team transition
- Goals for pregnant, birthing, postpartum, and infant populations on Apple Health (Medicaid)
- Takeaways from 2022 work
- HCA's shift in direction -targeted initiatives
- Potential projects
- Feedback and questions

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
- 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

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

Work in 2022

Work in 2022

- Governor's office and legislature support for improving pregnancy and postpartum health and addressing disparities
- Maternity bundle/episode of care from Bree Collaborative
- Extension of postpartum Apple Health coverage from two months to twelve months in June 2022
  - https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/after-pregnancy-coverage

Work in 2022 (cont.)

- Implementation of a maternity episode of care in Washington-based commercial lines of business
- HCA/Washington participation in three-year Institute for Medicaid Innovation learning collaborative to increase access to midwifery-led care with focus on equity
- Investment in Infant and Early Childhood Mental Health policy, programs, and dedicated resources

Value based purchasing and maternity care elements

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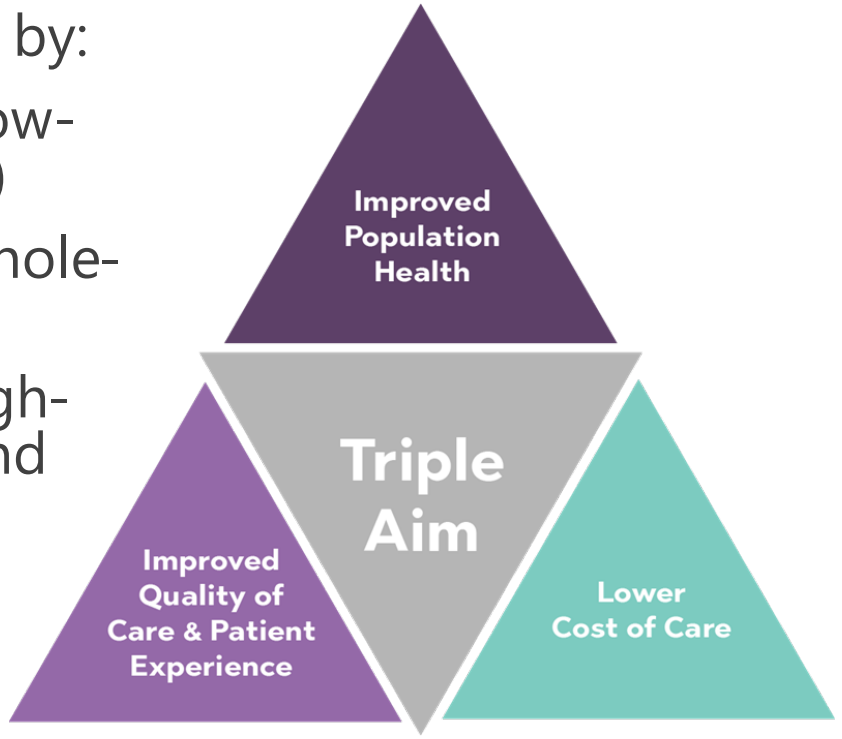
Strategy for value-based purchasing (VBP)

Payment drives transformation.

VBP may achieve the triple aim by:

- Reducing unnecessary and low-value health care (lower cost)
- Rewarding preventive and whole-person care (better health)
- Rewarding the delivery of high-quality care (better quality and experience)



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

Apple Health data

Apple Health data

Based on 2019 data	
Total deliveries (just under half of all births in WA)	34,756
Number of deliveries by managed care organizations (MCO)	28,904 (83%)
Percent of deliveries by c-section	27.9%
Percent of pregnancies with substance use disorder (SUD) diagnosis (excluding cannabis, 2020 data; OUD 4.2%)	12.9%
Percent of pregnancies delivered by midwives (majority are certified nurse midwives, less than 4% are licensed community-based midwives)	13%
Percent of deliveries where there is a: • FQHC provider • Tribal provider	Pending (attribution is a significant challenge)

Apple Health data (cont.)

Based on 2019 data	
Percent of providers delivering 95% of babies	35%
Number of providers with 500+ deliveries (1000+ = 3)	10
Number of deliveries with a BH diagnosis	20% (suspect BH concerns/symptoms are 30-40%)
Percent of Apple Health deliveries with MSS services provided (In 2009 69% of eligible Apple Health clients utilized MSS)	40.7%
Patient Voice Measure	Pending/feasibility is sig. barrier
Percent of patients that initiate care first trimester care (QTR metric: 2020)	AH- 66.5% (non AH –81.2%)
Percent of patients with any post-partum care (60 days)	73.6% (MCO only)

Summary of feedback

Summary of feedback

- Current state:
  - Current care lacks coordination and continuity between prenatal and delivery, postpartum care, and between various care providers and systems
  - Providers not coordinating or providing warm handoff to primary care or care provider of patient's choice for the 12-month postpartum period
  - Providers have a wide array of experiences (only 9 participants), the value of MSS was consistently elevated
  - Providers feel reimbursement is too low (especially from midwifes delivering in community settings)

Summary of feedback (cont.)

- Current state:
  - Tribal members often referred out from the only care system they've known which is often not welcoming, compassionate, or culturally relevant
  - MCOs want to know when their members are pregnant and engaging in prenatal care
  - People with SUDs have a difficult time getting into care, perhaps due to:
    - Lack of provider experience and training with the population
    - Logistic difficulties serving these patients (sporadic attendance)
    - Stigma, including other patients showing disrespect

Summary of feedback (cont.)

- Episode of care model concerns
  - Pay for performance (P4P) metrics and lack of control over results (e.g. postpartum care)
  - Protocol, capacity, and ability to look at data on outcomes and peer-to-peer support
  - Unintended consequences must be considered as part of the model
  - MSS is considered an important tool and providers are curious how this effort is different

Summary of feedback (cont.)

- Common goals
  - People are aware of and have intention to address the racial and ethnic disparities in outcomes. Looking to the state to lead.
  - Patients are the ultimate judge of high quality and equitable care – how to incorporate patient voice and standardized approach?

Episode of care

Remain focused on North Star

- Improve health outcomes and narrow gap in health disparities
- Ongoing, significant investment to implement episode of care
- The system is stressed
  - Quality information- not readily accessible and delayed
  - Providers lack time to analyze, implement new practices and adjust service delivery
- Payment model must align with accountability on cost and quality
  - Is there evidence that payment will drive care transformation to meet our goals?
- EoC requires practice level information, including customer feedback, counseling and action, and continuous process improvement
- Lead/parent organization must lean in to support practices

Implementing episode of care

- Three options for administering a maternity EoC
  - Vendor
  - HCA
  - MCOs
- Vendor
  - Expensive
  - Unpredictable outcomes
  - McKinsey does not have practice transformation approach
  - Signify no longer available
- HCA
  - Significant investment of staff and resources
  - Will take at least one year

Implementing episode of care (cont.)

- MCOs
  - Practice transformation will be challenging
  - Difficult to prioritize as one component of a large contract
  - Likely to be chaotic for the provider community
  - Risk of little traction given the required investment since 4 of 5 MCOs have low numbers
  - Outcomes will be difficult to assess
  - Like HCA, MCOs have no experience with maternal VBP

Implementing episode of care (cont.)

- No compelling evidence from other states of improved outcomes or meeting cost goals
- Would likely exclude many providers, including:
  - FQHCs
  - Other cost-based providers
  - OB providers with smaller #s
  - Most vulnerable populations (AI/AN)
- No evidence for equity advancements or increased use of midwives or doulas
- Limited evidence for better care/outcomes for those with SUD, SMI, anxiety, depression, or chronic illness

Episode of care recommendation

- Discontinue episode of care design
- Pivot strategy
  - Targeted projects and initiatives with logic models and evidence to meet our goals
- Remain open to episode of care
  - HCA will continue to track data from around the country
  - Now is not the time for Washington

Thinking about our North Star

- Improve population health outcomes, especially for BH and people with SUD
- Intentionally address disparities
- Improve postpartum care
  - Defined as more than one six-week visit
- Improve coordination of care
  - Dyadic nature of care, including full year postpartum
- Support health care system stressed by competing priorities, increased demand, changing expectations, and workforce turbulence/shortage

Thinking about our North Star

- Use the levers we have, including payment, to increase high value care resulting in better patient outcomes for dollar spent
- Provide practice level information and actionable data including customer feedback to highlight opportunities for improvement
- Support patients to identify their priorities and provide whole person care
  - Physical
  - Mental
  - Psychosocial
  - Social

MMRP analysis and recommendations

Of the preventable pregnancy-related deaths the MMRP reviewed, what percentage might have been prevented by each type of recommendation?	
Type of Recommendation	**Percent potentially impacted**
Increase clinical skill and quality of care	80%
Increase knowledge of patients, families, providers, and communities	78%
Improve screening for mental and behavioral health, social determinants of health, intimate partner violence, firearm access, pregnancy, and pregnancy risk	49%
Reduce bias and stigma in the health care system	46%
Increase support structures to improve access for pregnant people and families to perinatal support providers, care coordination, and perinatal resources.	41%
Increase knowledge, available care, and treatment options for mental and behavioral health issues	39%
Meet people's basic needs for food, housing, transportation, and income	32%
Increase access to care: care in rural places, care for behavioral health, and co-located care	31%
Increase reimbursement rates for patients with complex circumstances, for mental and behavioral health care, and for longer patient visits	27%
Increase availability of home visiting and telehealth	19%
Improve care, referrals, and social supports for victims of intimate partner violence	17%
Reduce access to firearms through evidence-based public health interventions including safe storage, licensing requirements, and community awareness	10%

Percentage of 2017–2020* preventable pregnancy-related deaths impacted by each type of recommendation made by the maternal mortality review panel of Washington state

https://doh.wa.gov/sites/default/files/2023-02/141-070-MaternalMortalityReviewPanelReport-2023.pdf?uid=640f86122eb78

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Potential projects

Process for choosing potential projects

- Identify one short term (under 2 years) and one long term (3-5 year) project
- Temporal factors
  - Current Leg session/pending mandates
  - Ongoing work
  - Where is the momentum and opportunity?
- Will prioritize and rank potential projects with standard criteria
- What can we effectively take on and evaluate to make progress on our goals?

Potential projects 1

- **Establish high performing maternity pool**
  - Resources and funding needed
  - Links to episode of care strategy
  - Payment incentive on specific metric/s
  - Set goals, infrastructure, standards, thresholds, and payment methodology
  - Provide practice performance results (actionable opportunities for QI) that are accessible, timely, and relevant to providers
  - P4P metrics that were prioritized during design of episode of care or focus on an equity-specific metric
    - Prenatal/PP care -Timeliness of prenatal care and postpartum care
    - Behavioral health risk assessment for pregnant women
    - Chlamydia screening
    - Preterm births
    - Respectfulness maternity care (or other patient reported outcome)

Potential projects 2

- **Partner with MCOs – collaboration and continuous QI**
  - 85% of the target population is enrolled in managed care
  - No funding needed
  - What are the MCO priorities in the perinatal space? What are they already working on?
  - What are successes? Are best practices being shared and spread? What hasn't worked?
  - How are they risk adjusting and what case management do they provide based on those high risks?
  - What are their current analytics and broader analytic capacity?
  - How do they share information with providers? What is making an impact?
  - What patient education/support/outreach do they provide?
  - How are value-enhanced services being used? What are the outcomes?
  - How are they approaching:
    - 12-month postpartum coverage: tracking utilization to better understand who and what kinds of services are accessed
    - Require a comprehensive behavioral health assessment
    - Early postpartum visit at 1-3 weeks
    - Require SDoH assessment

Potential projects 3

- Fee-for-service reimbursement strategy
  - Target specific services
  - Resources needed
    - Require a comprehensive BH assessment (ACOG, USPSTF recommendation
    - Early postpartum visit at 1-3 weeks
      - Telehealth
      - Lactation support
    - Require SDoH assessment
    - Separate and enhanced payment for first prenatal visit
      - Requiring additional components
      - Expecting longer duration
      - Would identify those on AH who initiate prenatal care
    - Care coordination for patients with more complex needs

Potential projects 4

- Strategy for population not enrolled in Managed Care
  - Those enrolled in fee-for-service, for whom HCA is the payor
  - Resources needed
- About 15% of the target population is enrolled in FFS
  - Over-representation of AI/AN, those who are not federally qualified, and other smaller groups
  - Create FFS risk adjustment methodology and provide case management based on those high risk
  - Share information and actionable data with providers
  - Develop patient education
  - Consider value-enhanced services

Potential projects 5

- Maternity support services (MSS) program
  - Develop targeted campaign to increase the AI/AN access to MSS and a targeted reporting collaborative (no funding needed)
  - Leverage stakeholder feedback- need greater understanding on why and how MSS promotes better outcomes in health and reduction of disparities (no funding needed)
  - Potential mandate and funding to modernize MSS
    - Context 2023 Leg session – SB 5580
    - Multiple components: update screening tool (health equity, SDOH), care coordination, evaluate the program, goal to increase utilization by increasing the benefit and the reimbursement rates
    - Funding needed

Potential projects 6

- Increase the use of shared decision making (SDM). Either certified PDAs or broader context.
  - Unclear if funding needed
  - Embed within MSS
  - Require MCOs to embed in their network contracts
    - We have in ERB contracts, using SDM and 90-minute training
  - Develop differential provider payment that incentivizes SDM

Potential projects 7

- Midwives/midwifery models of care
  - Require MCOs to include information on midwives as a provider option in all outreach
  - Require MCOs to have network adequacy standard for midwives, hospital birth, and community birth models of care
  - Outreach with those making MSS and prenatal care referrals (CSO, WIC) and provide information and tutorials on high-quality maternal care, services, and data/evidence
  - Increase financial support for freestanding birth centers and home births (funding required)

Potential projects 8

- Doulas
  - Funding required to implement model, rate, and needed supports
  - On path for Medicaid benefit for doulas. DOH developing voluntary credential with doulas
  - HCA will partner with doulas in Spring and Summer 2023 to develop draft model, rate, and associated supports
  - Anticipate bill next session directed at HCA
- Embed CHWs and CHRs into perinatal system of care
  - Funding required
  - Planning can be done within available resources
  - OB clinics and service delivery system
    - MSS already includes CHWs
    - Mirror the authority being considered for the pediatric CHWs (proviso grant funded currently – 1/1/23-12/31/24)

Potential projects 9

- Partner with OB COAP to use clinical data at EMR level
  - Identify focus areas with OB COAP
    - No resources needed
    - Clinical data has detail we cannot approach with claims
  - Applying OB COAP data
    - Implement provider incentives
    - Aim for full statewide participation
    - Resources needed, necessary resources for abstraction is a barrier
  - OB COAP has about 2/3 of all Washington birth data, including community birth module

Questions? Feedback?

Are there other potential projects that you would elevate as a priority for the Medicaid population?

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