Washington Apple Health Maternal Care Model Update

September 27, 2022

Mary Fliss
Beth Tinker

Washington State Health Care Authority

Today’s goals

- Provide updates
- Receive feedback

Agenda

- Why we care
- Related work
- Project timeline
- Questions and feedback
- Resources and contact info

Washington State Health Care Authority

Why we care

- The U.S. spends more than any other country on maternity care and yet has some of the worst perinatal and infant health outcomes.
  - Rising maternal mortality nationally – only developed country in the world
  - The c-section rate in WA is 27.9% - way higher than benchmarks and indicating over-medicalization of birth
  - Our preterm birth rate of 8.3% is lower than the national average of 9.85%, but significantly higher in Black and Indigenous People of Color (BIPOC) population
  - Are not adequately addressing behavioral and social needs, limited postpartum (PP) support

Why we care

- The Washington State Maternal Mortality Review Panel determined that 60% of maternal deaths are preventable.
  - A significant number are tied to lack of access to behavioral health evaluation, treatment, and support.
  - There is significant disparity in outcomes. For example, Native American/Alaska Native women were nearly ten times as likely to die of a pregnancy-associated cause than white women.
- Apple Health (Medicaid) pays for just under half the births in Washington – over 36,000 in 2020

Building from a host of complementary work and initiatives

- The Bree Collaborative (a group of WA-based providers and advocates) developing and refining a maternity bundle/episode of care
- Extension of postpartum Apple Health coverage from two months to twelve months in June 2022
- Implementation of a maternity episode of care in WA-based commercial lines of business
- Health Care Authority (HCA)/WA participation in a three-year Institute for Medicaid Innovation learning collaborative on increasing access to midwifery-led care and focused on equity
- Investment in Infant and Early Childhood Mental Health -- policy, programs, and dedicated resources

What is the Bree perinatal bundle?

- An episode-based payment model, or bundled payment, for a defined period of care with required evidence-based clinical components, reporting metrics, and opportunity for gain-sharing
- Highlights: prenatal, labor and delivery, postpartum for 12m, infant included for 30 days
- Promoting physiologic birth
- Increased attention to screenings and appropriate tx: CV, BH
- Improving postpartum care and tailoring
- Elevating patient-centered care (e.g. shared decision-making)

Maternal care model goals

- Incentivize high-quality, high-value clinical obstetric care that improves perinatal health outcomes and addresses racial and ethnic disparities
  - Increase utilization 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 Apple Health coverage

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

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

Pregnancy and substance use disorder

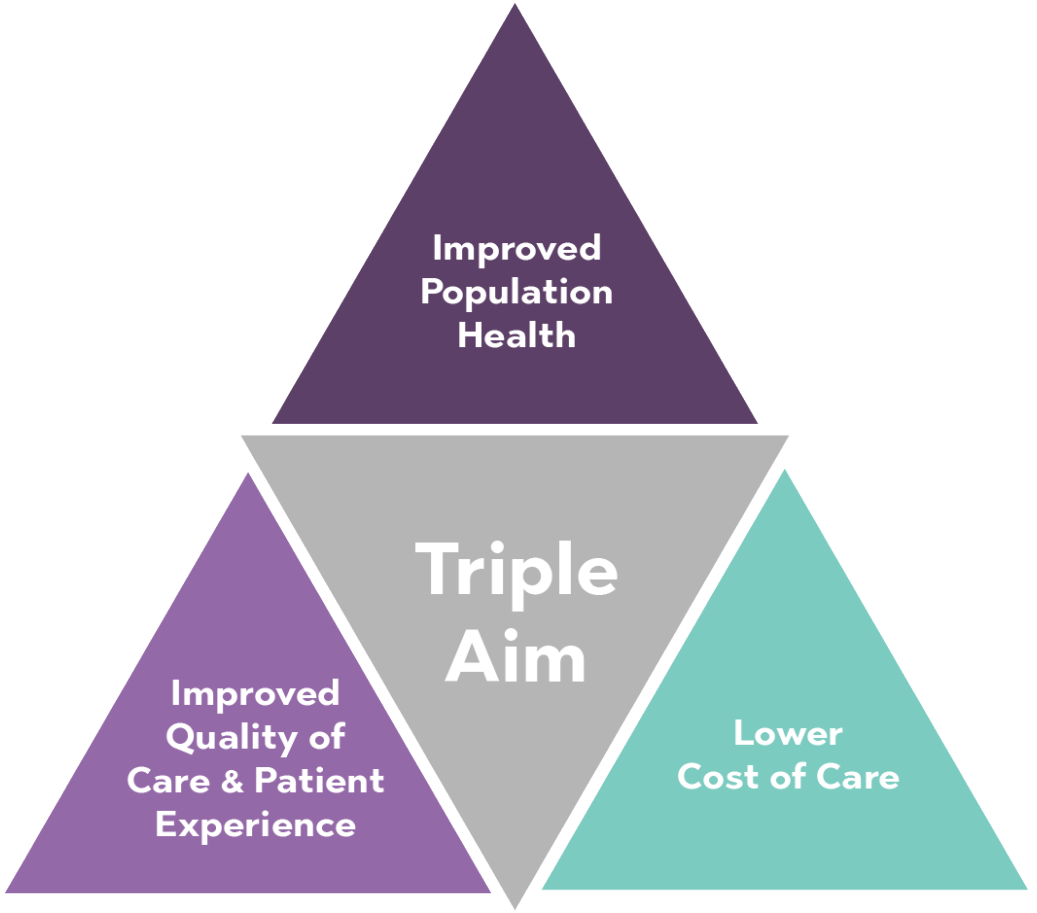
How will HCA pull these levers?

- Value -based purchasing (VBP) is sometimes called “pay for performance” or “paying for value” as opposed to “paying for volume”.
- Plan to utilize VBP structure across the prenatal, labor & delivery, and year postpartum. Linking payments to improved performance by health care providers.
- An episode of care structure is planned for the care episode from initiation of prenatal care through 3 months postpartum.

Q: Why VBP?
A: Payment drives transformation

VBP should 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)



Washington State Health Care Authority

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

Quality measures

- The process we're using
  - Developing criteria for inclusion
  - Review of potential measures
  - Determining how measures are incorporated into the design
  - Vetting the measures with appropriate stakeholders
  - Approval through HCA Quality Measurement, Monitoring, and Improvement (QMMI) program measure selection process

Quality measures

- The criteria being considered
  - Technical considerations like adequate patient volume, administration (claims-based and validated)
  - Alignment with the stated maternal care model goals
  - Inclusion on the Washington State Common Measure Set and the Bree developed measure set
  - Aligns with HCA QMMI measure selection criteria

Project timeline

Date	Activity
June – July 2022	Initial engagement sessions, review of the work done in other states
August – September 2022	Draft the model design based on the environmental scan and input shared
October – November 2022	Re-engage with tribes and stakeholders with draft of design
December 2022	Finalize model components and create implementation strategies
January – December 2023	Prepare for implementation and, if needed, receive funding
January 2024	Implement Maternity Care Model in Medicaid

Questions and considerations

- Initial feedback on key goals and identified levers of the maternal care model or anything shared today?
- What additional considerations should we address as we design this model?
- Other questions?

Resources and contact information

- HCA Maternal Care Model Website
  - 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!

Mary Fliss
Deputy, Clinical Strategy and Operations
Phone: 360-725-0822
Email: mary.fliss@hca.wa.gov

Beth Tinker
Clinical Nurse Consultant
Phone: 360-972-5506
Email: beth.tinker@hca.wa.gov