Session #5:

Value-based payment and maternity care: What have we learned so far?

June 16, 2021

WEBINAR SERIES OVERVIEW

- This is the last of a 5-part series focused on Value-Based Payment (VBP) for Providers.
- The objectives of this series include:
  - Provide an overview of VBP models as they apply to the Oregon landscape.
  - How VBP can support providers to improve patient outcomes through more comprehensive and flexible approaches to delivering healthcare services.
  - Enhance primary care, behavioral health and maternity care providers' readiness for VBP adoption.
- Sponsored by the Oregon Health Authority's Transformation Center in collaboration with Health Management Associates.
- 1.0 hour of CME is available through the American Academy of Family Practice, equivalent to AMA PRA Category 1 Credit™ toward the AMA Physician's Recognition Award. To receive the credit, you must complete the evaluation following-the session.

2021 Webinar Series, 12 – 1pm on:

- **March 17th (Recording available)**
- **April 21st (Recording available)**
- **May 19th (Recording available)**
- **June 2nd (Recording available)**
- **June 16th**

SPEAKERS AND DISCLOSURES

Faculty	Nature of Commercial Interest
 Janet Meyer Presenter	Ms. Meyer discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
 Art Jones MD Presenter	Dr. Jones discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. He is also employed as Chief Medical Officer of Medical Home Network, a non-profit that supports Medical Home Network ACO and other safety net clinically integrated networks to transform care are under advanced alternative payment models.
 Jeanene Smith MD, MPH Presenter and Curriculum Adviser	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. As a member of the American Academy of Family Practice (AAFP), she ensured the content met the AAFP CME requirements.

TODAY'S AGENDA & LEARNING OBJECTIVES

Agenda:

Welcome and Introductions

Overview of maternity care VBP demonstrations from Oregon and other states

Discussion of the major challenges of maternity care VBP

Applying the lessons from past efforts, discussion of potential approaches in Oregon

Q&A

Learning Objectives:

After this webinar, participants will be able to:

- Name the key 2-3 lessons learned from maternity care VBP from Oregon and other states' efforts to date.
- Describe the major challenges with maternity care VBP.
- Name 1-2 potential approaches for maternity care VBP in Oregon.

POPULATION HEALTH AND MATERNITY CARE

HEALTH MANAGEMENT ASSOCIATES

A NATIONAL IMPERATIVE - OPTIMIZING HEALTH AND WELLBEING FOR WOMEN AND CHILDREN

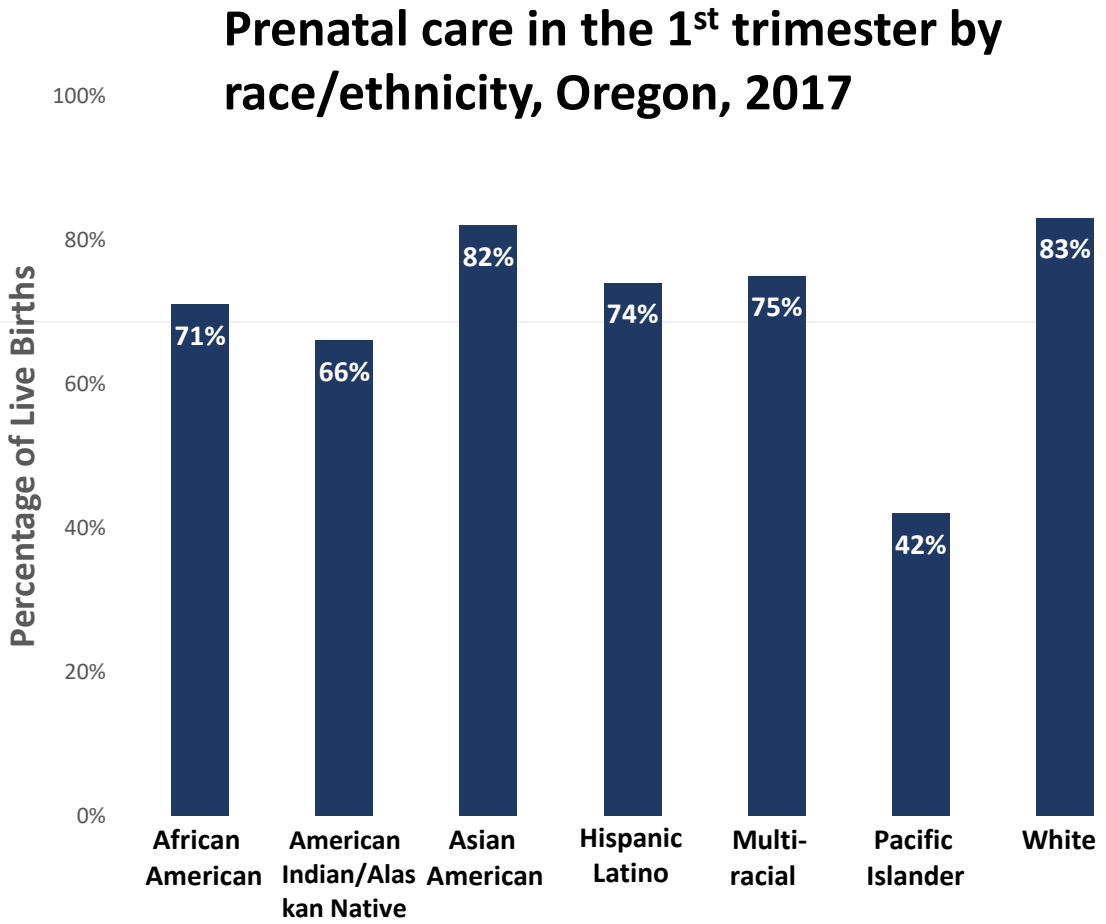
- U.S. maternity care crisis - higher cost AND worse outcomes than any other developed country.
- Every year approximately 700 women die from pregnancy-related causes in the United States and approximately 60% of these deaths were preventable.
- Non-Hispanic Black women are more than twice as likely to die during pregnancy and childbirth as White women.
- Mental health conditions continue to be a leading underlying cause of pregnancy-related maternal deaths, and they serve as contributors to even more maternal deaths.
- One in ten newborns are born premature – a leading cause of infant mortality and lifelong morbidity.
- The impact of poor outcomes in early childhood can reverberate throughout the life course.

> ***"Maternal health and well-being . . . may determine the health of the next generation and, ultimately, the health of the nation." ****

*Source: Fuentes-Afflick et al. "Optimizing Health and Well=Being for Women and Children". https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01504

MATERNITY CARE IN OREGON

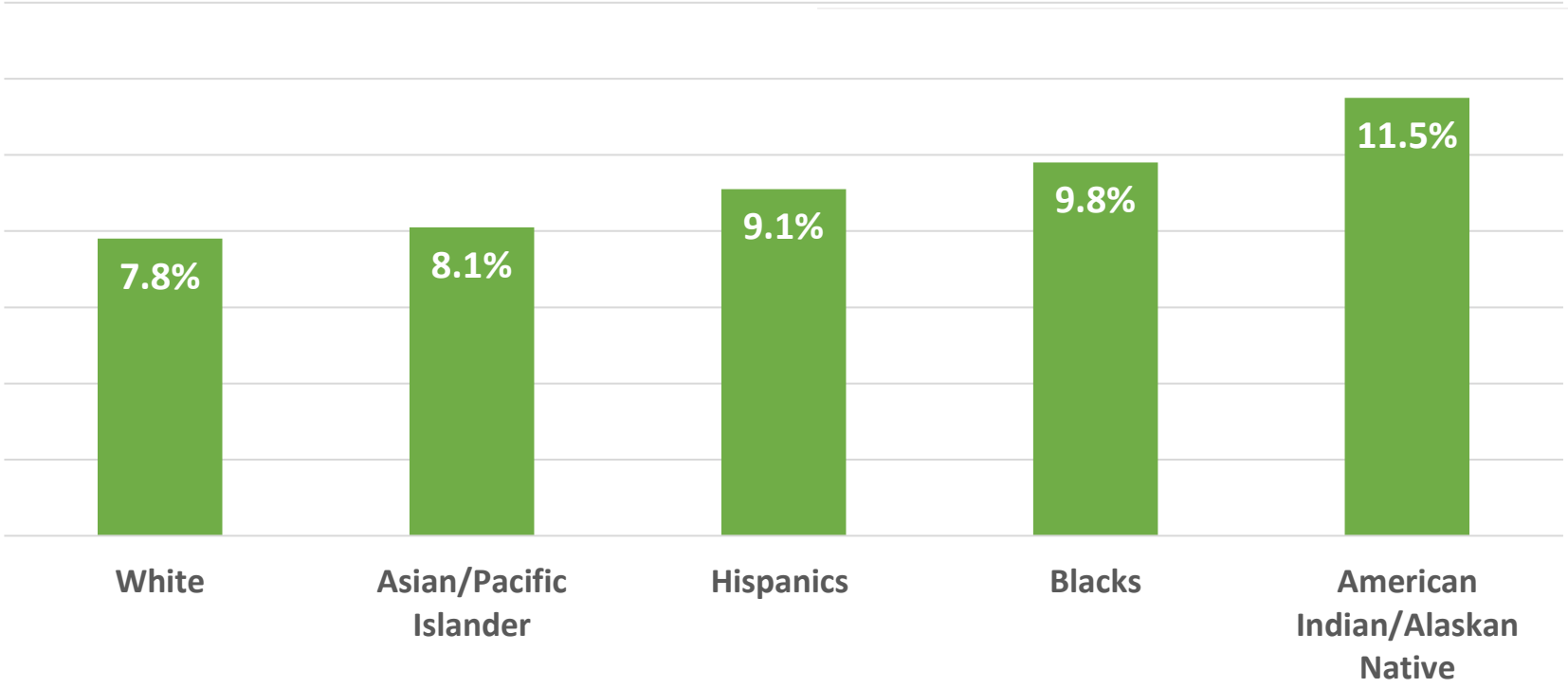
- CDC data shows that C-Sections accounted for 28% of all live births in Oregon in 2019.
- Postpartum care: 68% of women on OHP getting care through a CCO had a timely postpartum care visit in 2019. This was an 11% increase from 2018.
- Opioid use complicates at least 10% of births in Oregon.



Notes: All other groups exclude Hispanic ethnicity
Source: Oregon Birth Certificate Data

Source: Oregon Health Authority – 2019 CCO performance report available at https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-CCO-Performance-Report.pdf and Public Health Division data at https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/Opioids-Pregnancy-Poster.pdf https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/BIRTH/Documents/2018/facilcesarean18.pdf

Oregon Preterm Births 2019 By Demographic Group (Statewide Preterm Birth Rate = 8.3%)



Source: National Center for Health Statistics https://www.marchofdimes.org/peristats/tools/prematurityprofile.aspx?reg=41

NEWS ON EXTENDING COVERAGE POST PARTUM IN MEDICAID

- The Oregon Health Plan (OHP) covers about 50% of all births in Oregon.
- Nationally:
  - Medicaid covers 1 in 5 women of reproductive age and helps make prenatal and delivery care accessible for nearly half of women giving birth.
  - More than half of pregnant women in Medicaid experienced a coverage gap in the first 6 months post-partum and disruptions in Medicaid coverage often led to periods of uninsurance, delayed care, and less preventive care.
- The American Rescue Plan Act of 2021 gives states a new option to extend Medicaid postpartum coverage from 60 days to 12 months.*
  - Tennessee recently passed a budget to extend postpartum care for the Medicaid TennCare population to 12 months.
  - Illinois is the first state to provide continuity of full Medicaid benefit coverage for mothers by offering extended eligibility for a woman during the entire first year after delivery.

*Source: CMS Announcement- April 2021 available at: https://www.hhs.gov/about/news/2021/04/12/hhs-marks-black-maternal-health-week-announcing-measures-improve-maternal.html

MATERNITY CARE DELIVERY AND PAYMENT CHANGES DURING COVID-19

- Some OB-GYNs advised patients to induce labor at 39 weeks without medical indication. Some payers agreed to reimburse.
- Moms delayed or avoided hospital admissions for labor due to concerns regarding COVID-19.
- Blood pressure cuffs for home monitoring was prescribed but there were challenges getting coverage under DME for pregnancy.
- Challenges for Doulas to support birthing individuals due to Covid-19 hospital restrictions.

University of Michigan Redesigned Prenatal Care

- **Had already moved to fewer visits both virtual and in-person before the pandemic, increased efforts;**
- **Identified those services that couldn't be done remotely;**
- **Moved to 4-1-4: Interspersed 4 in-person visits, one formal ultrasound, and 4 virtual visits;**
- **Provided anticipatory guidance and psychosocial support – online;**
- **Included option to join group sessions and private chats with those in similar gestational stages;**
- **Found positive care experiences in access, quality, safety and satisfaction; and**
- **Continues to assess payment, gaps in connectivity for some patients, and ensuring equitable care.**

Source: "Maternity Care Delivery and Payment Changes During COVID-19" available at www.maternalhealthhub.org)

To Improve the Quality of Care and Address Costs

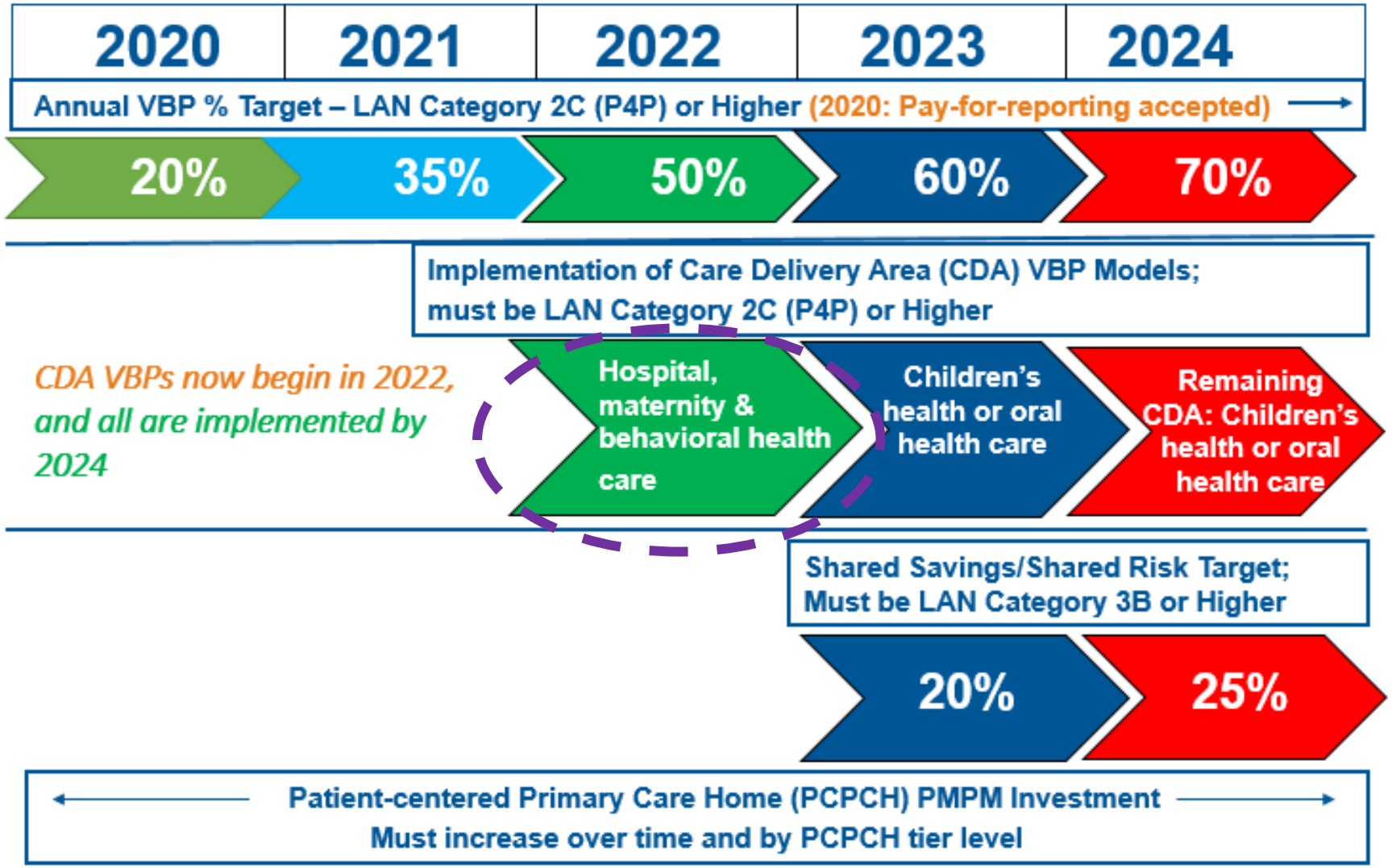
- Maternity Care is a major spending area for commercially insured and Medicaid populations.
- Rising costs aren't correlated with improved outcomes, there is significant variation in care across providers and across different populations, and cesarean birth rates are a significant contributor.
- Fee-For-Service payments don't promote team-based care, care coordination across the distinct phases of prenatal care, labor and birth, and postpartum care.
- There are enormous opportunities within the delivery of maternity care to engage women and their families in a way that supports person-centered care and may positively affect outcomes for women and babies.
- A VBP such as an episode-based payment approach for maternity care can motivate providers to provide enhanced services, like continuous labor support, or doula care, and breastfeeding support interventions which can improve birth outcomes and lower costs.

Source: HCP-LAN Maternity Multi-Stakeholder Action Collaborative "Issue Brief: The Business Case for Maternity Care Episode-Based Payment" available at: https://hcp-lan.org/workproducts/MAC-maternity-care-VBP-business-case.pdf

CCO VBP REQUIREMENTS AND KEY CONSIDERATIONS

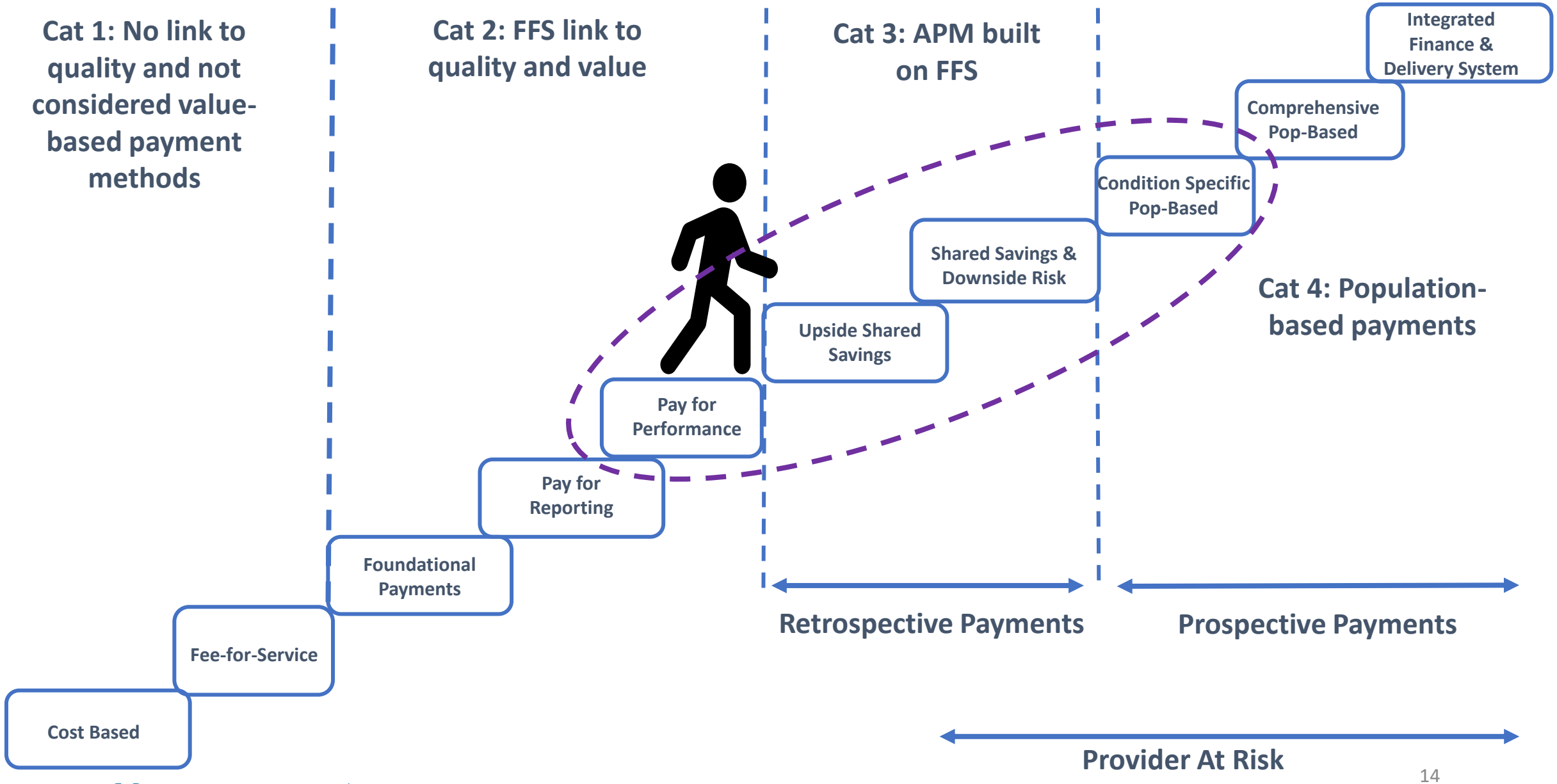
HEALTH MANAGEMENT ASSOCIATES

CCO 2.0 VBP REQUIREMENTS



Timeline Reflects COVID-19 Revisions

PROGRESS IN PURSUIT OF VALUE-BASED PAYMENT: LAN VBP CATEGORIES



MATERNITY CASE RATE – OHA PAYMENT METHOD FOR CCO MATERNITY COSTS

- In general, CCOs are paid a per member per month rate for enrollees based on their eligibility category.
- CCOs also receive supplemental payments for certain types of covered services, including maternity services.
- CCOs receive a blended supplemental maternity case rate for eligible members who incur a delivery event.
- Maternity case rates are established for each CCO individually to consider such factors as A/B vs DRG hospital costs, out of state births, and C-Section rates.
- In 2021 the maternity case rates ranged from $9,957 to $16,479 per delivery (includes CCO administrative costs) and covers the facility and professional costs for the prenatal care, delivery, and postpartum care.
- These supplemental payments are similar to a LAN 3B episode-based payment but since there is no link to quality, they are classified as a LAN 3N.

OREGON – KNOWN & UNKNOWN

- We know that VBP requirements are measured according to the percent of payments to providers.
- We know that In 2022, 50% of CCOs' payments to providers need to be LAN 2C (P4P) or higher and they must pilot VBPs in hospital, maternity and behavioral health care delivery areas.
- In 2023, 20% must also be in LAN 3B (shared risk) or higher with additional pediatric or oral health care delivery VBP pilot.
- We don’t know what type of strategies the CCOs might develop, for example:
  - The current incentive metric for increasing timely postpartum visits could be leveraged for a maternity VBP.
  - They may combine 2 areas such as maternity and SUD into VBP pilots.
  - A CCO strategy could focus on facility costs or strictly professional fees.

Examples of Maternity Care VBP

HEALTH MANAGEMENT ASSOCIATES

MATERNITY CARE AND VBP

- VBP payment models are emerging in maternity care, particularly in Medicaid, with a wide variety of outcomes-related incentive payments, as well as bundled payment programs.
- Recent survey of 20 states* reported that most had programs and payment incentives intended to support better, more timely access to perinatal care and to improve birth outcomes. These included:
  - financial incentives,
  - perinatal quality measurement and performance improvement projects, and
  - broader multi-stakeholder efforts.
- Common targets include:
  - **Preterm/Low Birth Rates:** financial incentives to reduce preterm birth or low birthweight rates (three states).
  - **Cesarean-sections (C-sections):** Non-payment for medically unnecessary C-sections (five states), tying reimbursement to C-section rates (two states), or annual risk-adjusted costs that include a set C-section rate (one state).
  - **Early Inductions:** Non-payment or low payment for early elective inductions (four states)

*Hill I, Benatar S, Courtot B, et al. Strong Start for Mothers and Newborns evaluation: Year 4 annual report, 2 vols. Centers for Medicare & Medicaid Services 2018;1-110.

MATERNITY CARE AND VBP

- Options for value-based payment in maternity care include:
  - **Enhanced payments** for care management/social worker/group visits, or for improved outcomes (e.g., lower rates of elective C-sections or preterm births).
  - **Bundled payments** for prenatal care, and separately bundled payments for hospital and physician delivery services, and/or infant care.
  - A **blended payment rate** for cesarean and vaginal births that assumes a lower rate of elective C-sections and eliminates the financial incentive for C-sections for hospitals and physicians but runs the risk of disincentivizing medically indicated C-sections if payments are not correctly calibrated.
  - Full **episode of care** payment that treats the entire pregnancy and delivery as a single episode.
  - Include maternity care in **total cost of care** payment shared savings/shared risk arrangements
- The most comprehensive bundling creates the most financial risk but also provides the most flexibility to providers to manage the care and associated costs, and the strongest incentive to limit the care provided.
- The role of quality metrics is critical in all VBPs but especially so in maternity care.

Rodin & Kirkegaard "Aligning Value-Based Payment with the CenteringPregnancy Group Prenatal Model: Strategies to Sustain a Successful Model of Prenatal Care" available at: https://www.healthmanagement.com/knowledge-share/briefs-reports/white-paper-prepared-by-hma-aligns-centeringpregnancy-with-value-based-payment-models/

Ohio Episode-Based Payments

- Initiated Ohio Pathways Community HUB model in 2000 to include community care coordinators to link women with high-risk pregnancies to social service needs.
- Initiated pay for performance starting in 2014, fully implemented by 2016.
- Multi-payer alignment (Medicaid and commercial) covering about 90% of Ohio's population.
- The episode covers only the mother from 280 days prior to delivery and extending through 60 days post delivery:
  - Prenatal care and complications,
  - Delivery care, and
  - Post partum, including readmissions.
- Accountability to the provider/group that delivers the baby.
- Traditional FFS with retrospective reconciliation.

Source: Health Care Payment Learning and Action Network. "Maternity Episode Payment Models". 2018 at https://hcp-lan.org/workproducts/mac/Establishing-Maternity-Episode-Payment-Models.pdf

TennCare Perinatal Episode of Care

- Launched in 2014 beginning with preview reports then began linking payments to episode performance.
- Covers only the mom with low to medium risk pregnancies.
- Episode begins 280 days before and ends 60 days after delivery :
  - Prenatal Care including medications and ED claims,
  - Delivery claims,
  - Post partum days 1-30 for non-inpatient admission, ED claims not resulting in readmission, pharmacy, professional and facility claims, and
  - Post partum days 31-60 covers all related medical claims and medications.
- Accountable entity is the physician or midwife that delivers the baby.
- Traditional FFS with retrospective reconciliation.

Source: Health Care Payment Learning and Action Network. "Maternity Episode Payment Models". 2018 at https://hcp-lan.org/workproducts/mac/Establishing-Maternity-Episode-Payment-Models.pdf

Both states focused on improving quality and lowering costs

- Both states were seeking to improve quality by transforming delivery through value-based payment, not just for maternity care, but for non-maternity-related conditions and procedures as well.
- Notable Outcomes:
  - **Ohio** focused on transparency in key quality measures, such as C-section rates, which reflect variation from best practice.
  - **Tennessee** demonstrated increased screenings for strep and HIV, 9.2% savings per episode ($632) but did not demonstrate a change in C-section rates (30.5%, 31.6%, 30.6%, 31.2%, 30.8% - CY 2014-2018)
- Both recognized that the spend on maternity for their populations was extremely high.
  - In Ohio, maternity claims are the single largest Medicaid claim type.
  - In Tennessee, more is spent by Medicaid on maternity care than on the next seven conditions in their value-based payment episode portfolio combined.

Source: Health Care Payment Learning and Action Network. “Maternity Episode Payment Models”. 2018 at https://hcp-lan.org/workproducts/mac/Establishing-Maternity-Episode-Payment-Models.pdf

Both states look to providers as key to success for their VBP

- Provider would have to:
  - Understand the model and become well-versed in how to interpret their performance data;
  - Understand their role as driver for the episode;
  - Buy into the episode payment model as a strategy for addressing the maternity care problems that the states are seeking to address; and
  - Be responsible for encouraging patients' behavioral changes in order to have the goal of improving health outcomes for the mother and the baby.

Challenges and Support:

- In Ohio – Lots of discussion regarding epidurals during labor and patient choice to address concerns:
  - Cost of anesthesiologist;
  - Reduced use may impact rate of elective deliveries that are linked to pre-term births; and
  - Quality of care and cultural issues.
- In Tennessee – The managed care plans developed educational video materials, operational support materials for performance data reports.

Source: Health Care Payment Learning and Action Network. "Maternity Episode Payment Models". 2018 at https://hcp-lan.org/workproducts/mac/Establishing-Maternity-Episode-Payment-Models.pdf

Both states set payment thresholds, rather than episode budgets:

- Based on average historical Medicaid costs, using multiple years of historical data,
- Developed resource utilization and clinical quality thresholds for shared savings, financial downside risk or no change in payment from the negotiated reimbursement rate.

Issues with budget setting:

- Spending variation was built in by using historical costs,
- There were risk adjustment concerns that high-risk patients would drive up costs.
- Tennessee felt they had developed an accurate episode payment structure because:
    - Perinatal care is data-rich for the purposes of risk adjustment, with known length of episode and a lot of claims data per patient;
    - However, pregnancy can be their entry into Medicaid, so there can be limited pre-pregnancy data on the patient.

Source: Health Care Payment Learning and Action Network. “Maternity Episode Payment Models”. 2018 at https://hcp-lan.org/workproducts/mac/Establishing-Maternity-Episode-Payment-Models.pdf

LAN CATEGORY 4 EXAMPLE – NY'S EPISODES OF CARE FOR MATERNITY CARE

New York Medicaid's Maternity Care VBP

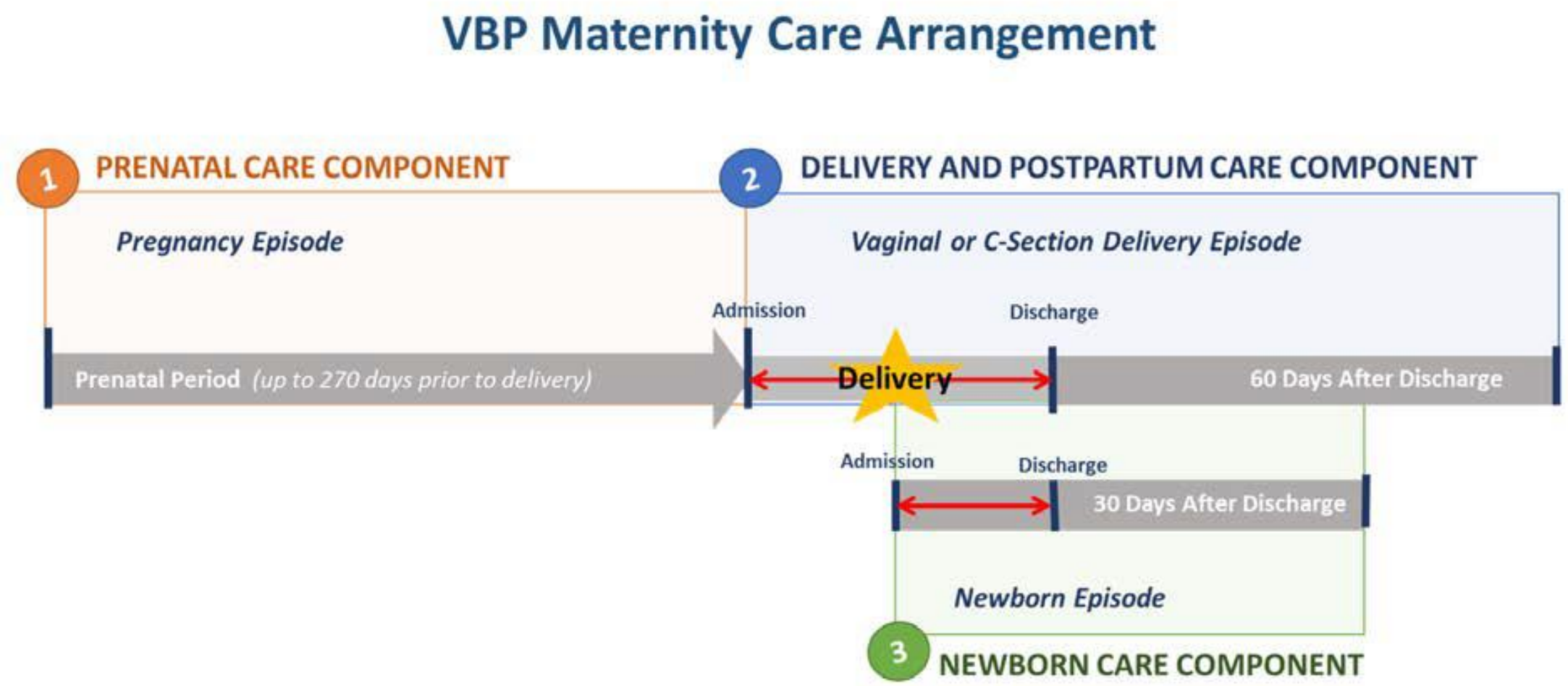
- Dedicated all-inclusive budget across 3 components
  - Pregnancy
  - Delivery and early postpartum
  - Newborn care

- Payment based on Episodes of Care using the PROMETHEUS analytics system and include quality measures.

- Stop-Loss provisions can be added to the contracts in the case of NICU admissions, other high-cost components

Source: New York Department of Health, July 2017. "Maternity Care Value Based Payment Arrangement" available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2017-08-01_maternity.htm

NY'S MATERNITY CARE EPISODES OF CARE VBP



Source: New York Department of Health, July 2017. "Maternity Care Value Based Payment Arrangement" available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2017-08-01_maternity.htm

MECHANICS OF AN EPISODE PAYMENT – OHIO's NEONATAL EPISODE OF PAYMENT

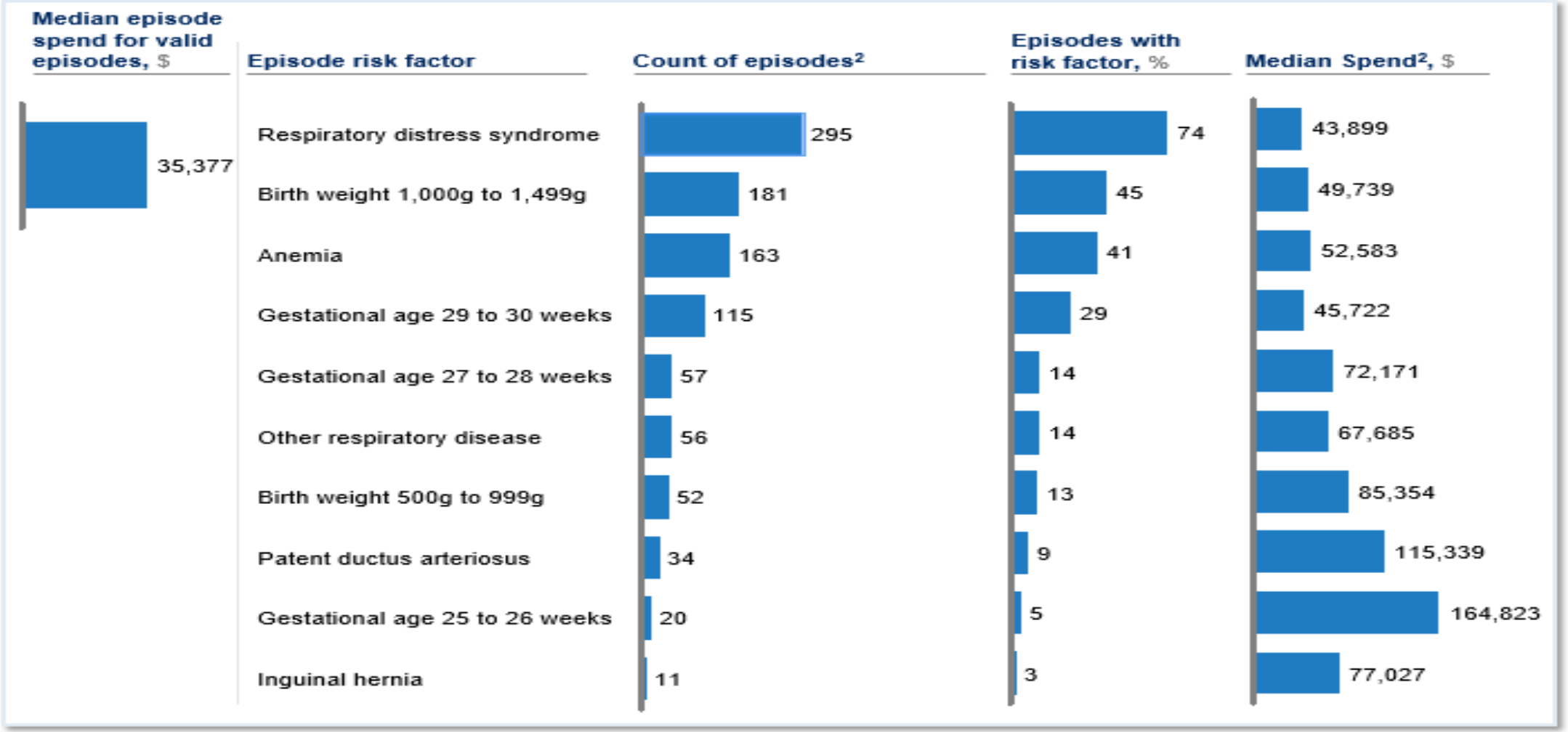
- **Triggers**
  - An episode is triggered by a live birth in the inpatient setting.
  - Each are sorted based on gestational age into low-, moderate-, or high-risk episodes.
  - A Principal Accountable Provider (PAP) is assigned – for neonatal, is the facility where the newborn is born:
    - Most of the care and spend for neonatal episodes happens in the initial hospitalization.
    - Often will require multidisciplinary care coordination during the admission.

- **Episode Duration and Included Services/Claims**
  - Begins at birth and ends at seven days after discharge.
  - Quality monitoring extends for 30 days post discharge for informational purposes.
  - Claims included in the episode are based on inclusion logic that the service was provided during the episode and is understood to be directly or indirectly influenced by the PAP.
  - Medical, surgical/procedural and drug spend included.

- **Risk Adjustment**
  - Select risk factors and exclusions are applied.
  - Examples of risk factors include jaundice, neonatal abstinence syndrome, and respiratory distress syndrome.

Source: State of Ohio Overview of the Neonatal Episode of Care, available at: https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/DEF/neo-low.pdf

High Risk Episode: Episode Count and Spend by Episode Risk Factor

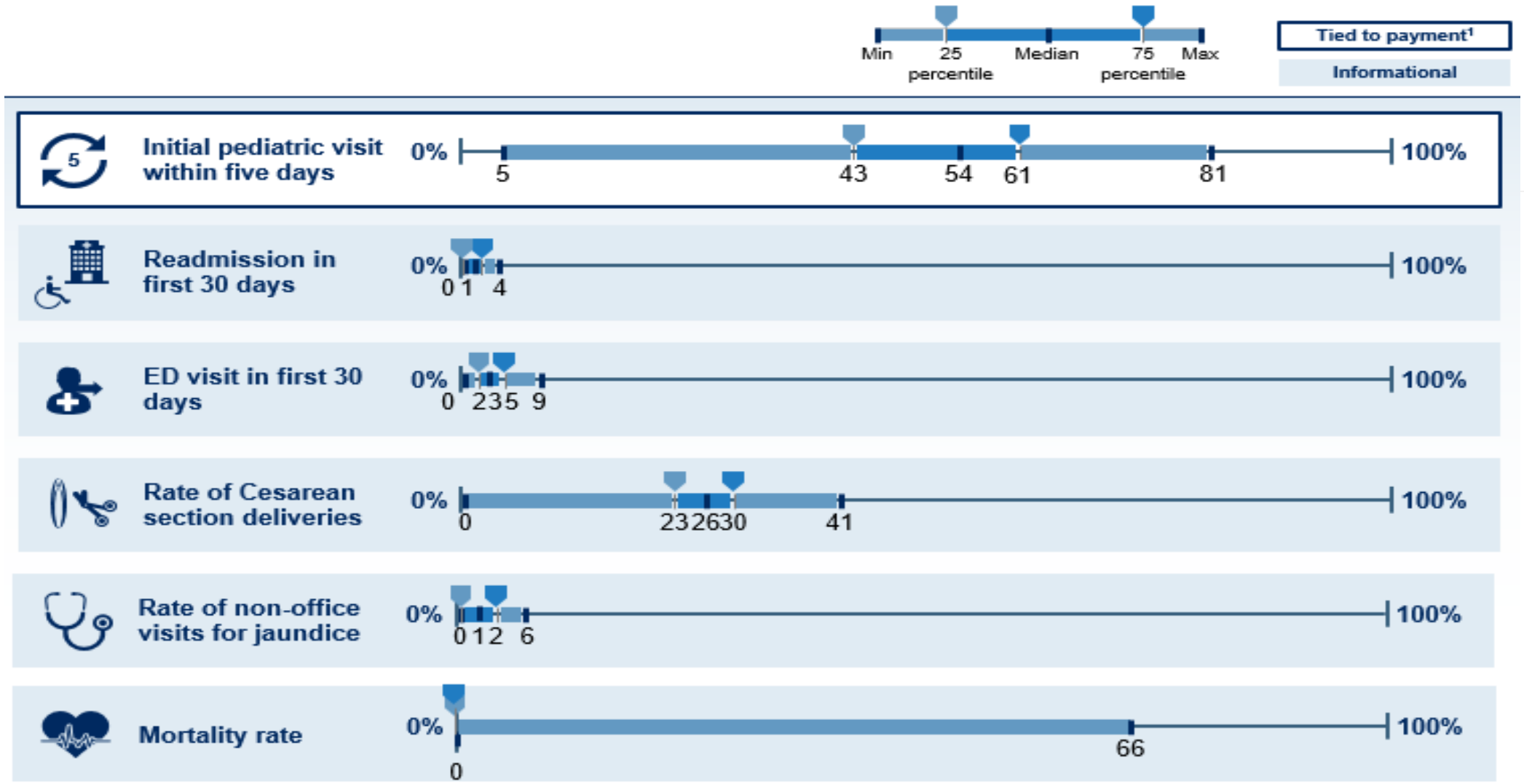


(2) For episodes with this risk factor; one episode can have multiple risk factors

Source: State of Ohio Overview of the Neonatal Episode of Care. Available at: https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/DEF/neo-low.pdf

OHIO NEONATAL EPISODES: EXAMPLE OF LOW-RISK EPISODE "Quality Scorecard"

PRINCIPAL ACCOUNTABLE PROVIDERS (PAPs) PERFORMANCE ON EPISODE QUALITY METRICS



Source: State of Ohio Overview of the Neonatal Episode of Care. Available at: https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/DEF/neo-low.pdf

VBP DESIGN IN MATERNITY CARE – OTHER CHALLENGES

Analytics

- Requires accurate predictive analytics to ensure that global payments are sufficient to cover the cost of care.
- Need to ensure service enhancements and payment incentives are meaningful.

Attribution

- Critical part of value-based payment models.
- Can be a challenge for a patient population that may experience housing instability and lack of continuity in their source of care between prenatal, delivery, and postpartum care (which women and providers also often feel hurts the quality of perinatal care).

Care Coordination:

- Innovative models require working across traditional siloes between different types of providers and services.
- Lack of access to behavioral health care services, especially for Medicaid enrollees, further exacerbates the challenges in care coordination for maternity patients.
- Social determinants of health have profound effects on maternal and infant health outcomes, and many providers have limited capacity to screen for and address issues that are not directly health care service related, such as housing instability, food insecurity, intimate partner violence, and many more.

Potential Approaches in Oregon

HEALTH MANAGEMENT ASSOCIATES

VALUE-BASED PAYMENT MODELS CREATE OPPORTUNITIES FOR NEW MODELS OF CARE

Payment Reform *without*
Practice Transformation
doesn't
change outcomes.

Delivery System Transformation

Payment System Transformation

Practice transformation
without a
financial model
is not
sustainable.

MATERNITY VBP - OUTCOMES

- In the first year of *Arkansas*' program during which it implemented a maternity episode and four other clinical episodes, the state saw:*
  - 5% decrease in cesarean birth rates, though an increase in the length of stay for the condition, perhaps indicating a shift to more clinically appropriate cesarean birth.
  - Improvements were made in screenings for asymptomatic bacteriuria, hepatitis B specific antigen, use of ultrasound, and screening for gestational diabetes.
  - More Medicaid providers improved their cost profile than worsened their cost performance.

- *Horizon Blue Cross Blue Shield of New Jersey* saw success in important clinical outcomes, such as the Caesarean section rate.**
  - New Jersey has a much higher rate of cesarean births than the country (more than 40 percent vs. 32 percent).
  - Enrolled 300 providers in maternity care episode.
  - Horizon reported in 2017 a 32% reduction in the number of cesarean births among its Episode of Care provider partners (compared to its non-Episode of Care Partners).

*Statewide Tracking Report. Arkansas Center for Health Improvement. January 2015. www.achi.net/Docs/276/

**"University Hospital in Newark and Horizon Blue Cross Blue Shield of New Jersey Announce Value Based Collaborative." Horizon Blue Cross Blue Shield of New Jersey press release. www.bcbs.com/news/press-releases/.

Project Nurture

- An innovative model that integrates maternity care, substance use treatment, and social service coordination for Medicaid/Oregon Health Plan beneficiaries.
- Implemented in 2015 by a coalition of maternity care and substance use treatment providers at three sites in Portland and supported by one of Oregon's coordinated care organizations.
- The model provides pregnant women with peer support, clinical care, and links to social services with the goal of safe and healthy parenting in an environment that patients view as respectful and nonjudgmental
- Among the "treatment" population of opioid-dependent women enrolled in Medicaid, Project Nurture was associated with reductions in the following areas:
  - Child maltreatment and placement of children in foster care
  - Increases in both prenatal visits and maternal lengths-of-stay in the hospital
- Project Nurture is showing results and VBP arrangements are being developed

Source: McConnell, J et al "Project Nurture Integrates Care And Services To Improve Outcomes For Opioid-Dependent Mothers And Their Children available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01574

MATERNITY CARE MODELS - STRONG START INITIATIVE

- The Strong Start for Mothers and Newborns Initiative, a program of the Center for Medicare and Medicaid Innovation funded through the Affordable Care Act to test models of prenatal care.
- Aimed to improve maternal and infant outcomes for women covered by Medicaid and the Children's Health Insurance Program (CHIP) during pregnancy.
- Funding awards were to 211 provider sites across 32 states, the District of Columbia, and Puerto Rico.
- Three models of prenatal care were tested during the 5-year initiative:
  - CenteringPregnancy or group care: prenatal care provided in a group setting,
  - Maternity care home sites: medical model prenatal care enhanced with the addition of health educators or other community health workers who offered additional support and services to clients, and
  - Birth center care: 1) prenatal care following the midwifery model, which is a holistic and wellness approach to pregnancy and birth that is more time-intensive than typical OB/GYN care; and 2) psychosocial support, health education, and referrals to additional resources provided by a "peer counselor."
- Findings included a dramatic reduction of preterm, low birth weight, and cesarean births for women participating in birth center care compared with women of similar risk levels in usual care.

Source: Strong Start for Mothers and Newborns Evaluation: YEAR 5 PROJECT SYNTHESIS available at: https://innovation.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf

CENTERINGPREGNANCY MODEL

The CenteringPregnancy (CP) model is an evidence-based, patient-centered framework for providing healthcare in a group format.

- Clinical intervention implemented by providers that uses the healthcare visit as the touchpoint for engaging patients in their own care and connecting them to other patients and support services.
- Replaces individual appointments with group appointments , however individual appointments can always be used to supplement group appointments.
- Defined by a standard set of guiding principles referred to as the Essential Elements of Centering and adheres to quality and practice standards established by Centering Healthcare Institute.
- Traditional Fee For Service payment do not typically reward the added value that CP can achieve.
- CP could be sustainably financed along the continuum of value-based payment, from enhanced payments per visit, to bonuses for improvement in outcomes, to use of a bundled maternity payment with CP as one of the care delivery options.

Source: Rodin & Kirkegaard "Aligning Value-Based Payment with the CenteringPregnancy Group Prenatal Model: Strategies to Sustain a Successful Model of Prenatal Care" available at: https://www.healthmanagement.com/knowledge-share/briefs-reports/white-paper-prepared-by-hma-aligns-centeringpregnancy-with-value-based-payment-models/

CENTERINGPREGNANCY MODEL FOR MATERNITY CARE - OUTCOMES

Evidence suggests the CP model reduces costs, improves outcomes and leads to high satisfaction

Preterm Birth Risk Reduction

A multi-site randomized control study of 1,047 women found a 33% reduction in risk of preterm births in CP patients compared to those receiving only individualized prenatal care.*

The reduction among African Americans was even higher at 41%.

A 2012 retrospective cohort study compared 316 women in CP programs to 3767 in traditional care and found a 47% reduction in risk of preterm birth in CP patients compared to those receiving only individualized care.**

*Matched cohort study – Ickovics, et al 2007

** Retrospective cohort study – Picklesimer, et al 2012

STRONG EVIDENCE FOR TELEMEDICINE USE TO IMPROVE PRENATAL ACCESS AND OUTCOMES

Author	Year	Participants	Intervention	Outcome
Butler Tobah et al.	2019	300 pregnant women from the Midwest, United States	Prenatal virtual visits supplemented by fetal home monitoring devices	While maintaining standards of practice, telemedicine resulted in: • higher patient satisfaction • lower prenatal stress • reduced number of clinician appointments
Cuneo et al.	2019	368 pregnant women from medically underserved areas in Colorado	Remote, off-site telemedicine fetal cardiac monitoring consult evaluation	Remote telemedicine consult provided • comparable diagnostic quality • ninefold reduction in travel-related costs
Marko et al.	2019	88 women with low-risk pregnancies from Washington, DC, area	Mobile prenatal care app to facilitate reduced in-person visits	Telemedicine via mobile app resulted in • fewer in-person visits • no associated reduction in patient or provider satisfaction
van den Heuvel et al.	2018	Systematic review of 71 studies investigating role of telemedicine in obstetrics	Studies spanned areas of smoking cessation, gestational diabetes, mental health, remote monitoring, and teleconsulting	• Telemedicine interventions are suitable and safe alternatives to usual care • Further studies are needed to investigate superiority of outcomes and cost

(Source: "Improving Access to Care: Telemedicine Across Medical Domains April 2021 available at: https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-090519-093711

CONCLUSION: VBP CAN OFFER OPPORTUNITIES TO IMPROVE THE QUALITY OF MATERNITY CARE

+ Your strategy
+ Your program model
+ Your partners
+ Your role in the delivery system
+ Your quality program
+ Your level of integration

Q & A

Send your questions to the host via the Question function.

RESOURCES

- Fuentes-Afflick et al. “Optimizing Health and Well=Being for Women and Children”. Health Affairs 40, No. 2 (2021): 212–218 https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01504
- Dzau, et al “ Vital Directions for Health and Health Care: Priorities for 2021”. Health Affairs 40, No. 2 (2021): 197–203. Available at: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.02204
- CMS Announcement- April 2021 available at: https://www.hhs.gov/about/news/2021/04/12/hhs-marks-black-maternal-health-week-announcing-measures-improve-maternal.html
- Oregon Health Authority:
  - 2019 CCO performance report: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-CCO-Performance-Report.pdf
  - Public Health Division data: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/Opioids-Pregnancy-Poster.pdf and https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/BIRTH/Documents/2018/facilcesarean18.pdf
- Hill I, Benatar S, Courtot B, et al. Strong Start for Mothers and Newborns evaluation: Year 4 annual report, 2 vols. Centers for Medicare & Medicaid Services 2018;1-110.

RESOURCES

- Health Care Payment Learning and Action Network (LAN) materials:
  - "Maternity Episode Payment Models". 2018 at https://hcp-lan.org/workproducts/mac/Establishing-Maternity-Episode-Payment-Models.pdf
  - Maternity Resource Bank
  - HCP-LAN Maternity Multi-Stakeholder Action Collaborative "Issue Brief: The Business Case for Maternity Care Episode-Based Payment" available at: https://hcp-lan.org/events/session-1-making-the-business-case/
- Rodin & Kirkegaard "Aligning Value-Based Payment with the CenteringPregnancy Group Prenatal Model: Strategies to Sustain a Successful Model of Prenatal Care" available at: https://www.healthmanagement.com/knowledge-share/briefs-reports/white-paper-prepared-by-hma-aligns-centeringpregnancy-with-value-based-payment-models/
- State of Ohio Overview of the Neonatal Episode of Care, available at: https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/DEF/neo-low.pdf
- New York Department of Health, July 2017. "Maternity Care Value Based Payment Arrangement" available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2017-08-01_maternity.htm
- Statewide Tracking Report. Arkansas Center for Health Improvement. January 2015. www.achi.net/Docs/276/
- "University Hospital in Newark and Horizon Blue Cross Blue Shield of New Jersey Announce Value Based Collaborative." (2017) Horizon Blue Cross Blue Shield of New Jersey press release. www.bcbs.com/news/press-releases/.

RESOURCES

- McConnell, J et al "Project Nurture Integrates Care And Services To Improve Outcomes For Opioid-Dependent Mothers And Their Children available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01574
- Strong Start for Mothers and Newborns Evaluation: Year 5 Project Synthesis (October 2018) available at: https://innovation.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf
- Centering Healthcare Institute: https://www.centeringhealthcare.org/
- Barbosa et al. "Improving Access to Care: Telemedicine Across Medical Domains". April 2021 available at: https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-090519-093711
- CMS Issue Brief August 2019: Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf
- Catalyst for Payment Reform. "Payment and Benefit Design for High-Value Maternity Care" available at: **Click here**
- California Maternal Quality of Care Collaborative - Mother & Baby Substance Exposure Initiative Toolkit available at: https://www.cmqcc.org/resources-toolkits/toolkits/mother-baby-substance-exposure-initiative-toolkit
- Alliance for Innovation on Maternal Health (AIM) and AIM-Community Care (AIM-CCI) – Maternity Safety Bundles- available at: https://mchb.hrsa.gov/maternal-child-health-initiatives/aim-cci
- Catalyst for Payment Reform "Maternity Care Payment Brief" available at: http://catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Maternity_Care.pdf

UPCOMING FROM THE OHA TRANSFORMATION CENTER

- Please complete the evaluation that will be sent out after the webinar.
- CME credit will be emailed to participants completing the evaluation.
- Slides, webinar recording will be available at: **https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx**
- Follow-up questions?

  Contact: **OHAVBPQuestions@healthmanagement.com**