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Improving maternity care in Medicaid with uniform, transparent reporting

The introduction of alternative payment models (APMs) fundamentally changes the relationship between states, managed care organizations (MCOs), and providers. Understanding the challenges that MCOs and providers face in the implementation of APMs can help a state develop a framework and set of tools that will help MCOs and providers adapt to a value-based care environment.

There are some common and consistent challenges that we've observed with the implementation and successful adoption of APMs across multiple state programs:

Strengthening key stakeholder relationships: In a fee-for-service reimbursement model, the state as the payer generally carries the risk of rising healthcare costs, whereas under a managed care system, this risk is distributed between the state, MCO, and provider. There has historically been a lack of trust between these stakeholders, which has created hesitancy to enroll in voluntary APMs – especially those more challenging like maternity-based models.

Communicating expectations and performance: Transitioning from a fee-for-service reimbursement model to an APM model requires all stakeholders to understand the key performance metrics associated with reimbursement and have a common dashboard that shares consistent and actionable information on a regular basis. Enhanced visibility into the MCO and provider performance compared to their peers and competitors is critical to improving outcomes and maintaining program sustainability.

Standardizing contract management: The heterogeneity of APM contract terms and conditions creates a significant and potentially unnecessary amount of complexity for the state to implement and monitor the ongoing performance of each individual MCO. The financial, operational, and legal implications of managed care contracts require a less manual process and standardized terms, conditions, and performance metrics.

Improving administrative readiness: MCOs and providers accept additional investment risk through APMs. Not only do these stakeholders take on the financial accountability for the care delivery and member populations, but they must also make significant investments to prepare their organization for administration of the models. This administrative burden and capability investment are significant and can impair the adoption of risk-based models.

A growing deficit: Medicaid maternity model adoption and improved outcomes

The National Center of Health Statistics estimates "two out of every three adult women enrolled in Medicaid are in their reproductive years (ages 19-44), and Medicaid currently finances about 42% of all births in the United States."[i] States have implemented a variety of maternity models, including neonatal and perinatal episodes of care, upside-only incentive reimbursement, and maternity medical homes. However, outcomes continue to decline, and significant racial and ethnic disparities remain amongst Medicaid maternal members.[ii]

Several states have attempted to address these challenges, and specifically those related to maternity, with the following strategies:

- **Recommending a specific maternity model design but allowing MCOs a great deal of flexibility to determine how they are implemented.** This strategy was adopted by New York and Pennsylvania Medicaid. In the case of New York, the implementation of this strategy led MCOs to not select maternity models and instead select other, total population models.[iii]
- **Accepting the full responsibility of administering, tracking, and reporting performance post reconciliation of the models.** This allowed states like Tennessee, Ohio, and Arizona to create a single, statewide approach to maternity care. However, it also required them to develop new administrative capabilities that bypasses the role of MCOs, and are harder to sustain over time.[iv]

Improve maternal and infant health through standard performance tracking and reporting

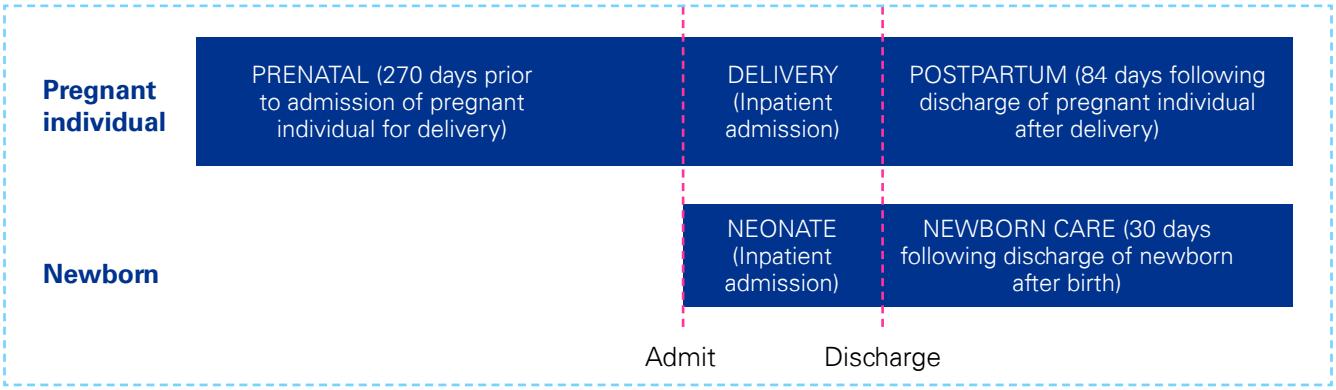
The Centers for Medicare and Medicaid Services (CMS) is increasing its focus on maternal and infant health, recently launching the next phase of the Maternal and Infant Health Initiative (MIHI) and linking waivers and funding to health equity concepts. Improving maternal and infant health through maternity value-based programs will be an important opportunity for states and should be a top priority on their strategic agenda.[v]

To be successful, states need to establish a foundation in data analytics, tracking, and reporting. There is a middle ground for states looking to support improved transparency and unity in maternity payment models across MCOs without needing to run all aspects of the model themselves and without immediately forcing a common model choice. Below are a few simple steps states can take to improve uptake of APMs for maternity populations:

Step 1

Select a maternity episode as the statewide APM of choice. Most commonly, this will be a bundled episode approach that combines the pre-partum, delivery, and first 30 days of neonatal care (see Exhibit 1). Examples of past and current state maternity bundled APMs include the Medicaid programs for Pennsylvania (forthcoming), Tennessee, Ohio, Arkansas, and New York (design only), as well as the Connecticut state employee health plan. There are many commercially available episode grouper products that states can leverage or contract with to perform the associated bundling and outcomes calculations.

Exhibit 1: Common bundled maternity episode



Step 2 Start by reducing informational asymmetry between MCOs and providers by creating and sharing (risk-adjusted) Maternity Performance Scorecards by MCO and provider. In order to do this, the state will need to take on the role of calculating maternity episode costs and quality. This approach will allow providers to understand how they are performing by MCO, as well as relative to their peers.

- In its Maternity Scorecard approach, the state can incorporate measures of equity based on the data available e.g., Healthcare Effectiveness Data and Information Set (HEDIS) scores by race and ethnicity.
- If clinical data is available to the state, codes may also be incorporated into quality measure calculations and risk adjustments.
- While publishing Maternity Scorecards does not immediately mean that MCOs will start to take up the models on which the Scorecard is based, it will afford all parties the same insights on good versus less-than-average performance. The driving assumption here is that a provider's rating as an excellent, average, or below-average performer in maternity care should not change based on the way in which a MCO implements the payment model.

Step 3 Leverage the insights from the Scorecards to support consensus-building for one or a limited set of maternity APMs among MCOs across the state. As consensus is achieved, the original Maternity Performance Scorecards become useful third-party audit tools that help identify to what extent the chosen models are being adhered to and can also be increasingly used by maternity providers to double check the results being presented to them by MCOs.

As states take on these steps, they may consider codifying quality and cost of maternity episodes into the MCO maternity "kick payment" process. While maternity quality measures are often already part of the MCO rate setting process, the combined concept of cost and quality in an episodic form is not. While consensus-building among MCOs may be a more collaborative approach, states also have the option to tie more direct financial incentives in their payments to MCOs through adjustments to the maternity kick payments.

Exhibit 2 depicts our recommended Maternity Scorecard with key performance metrics for MCOs and providers. Exhibit 3 depicts an example of data dashboards that states would make available to MCOs and providers to help understand comparative performance.

Exhibit 2: Overview of recommended Maternity Scorecard metrics for MCOs and providers

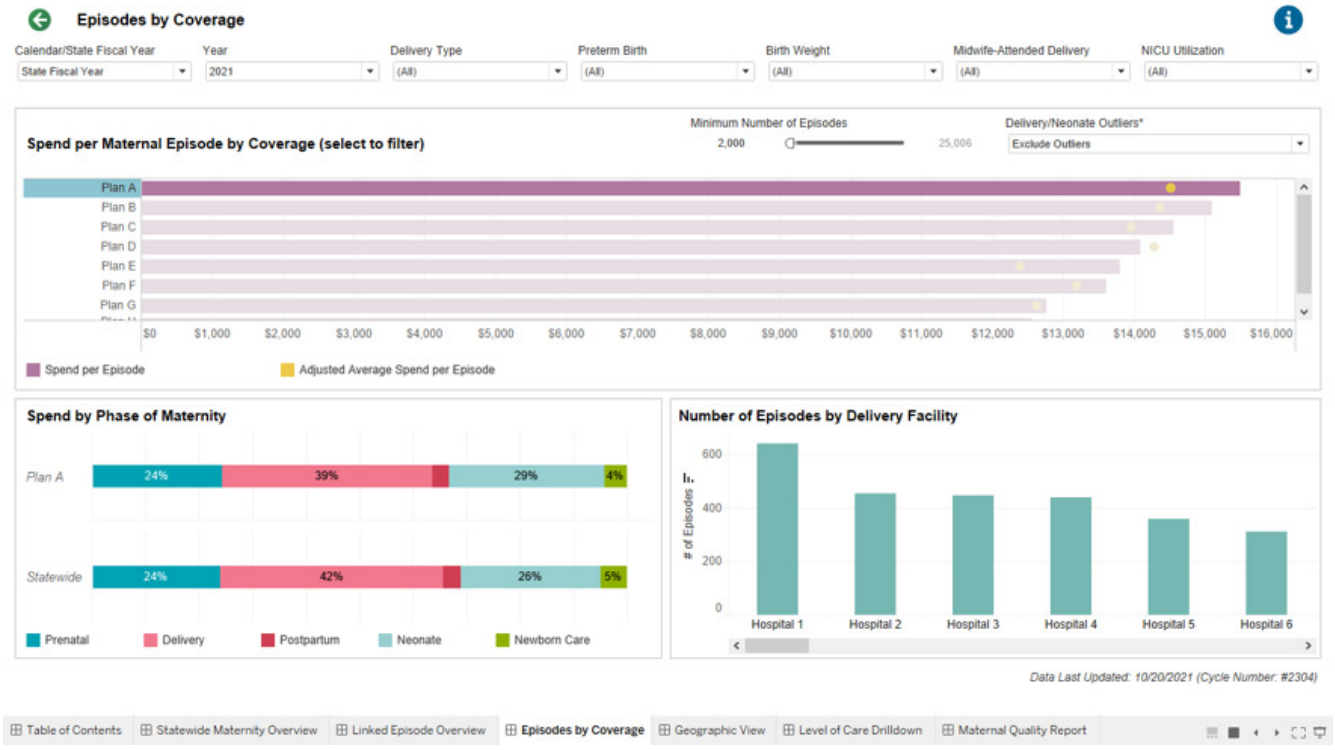
MCO metrics

- Severe Maternal Morbidity rate by race and ethnicity (Alliance for Innovation on Maternal Health (+AIM(R)))
- Cardiovascular: Evidence of meeting The Joint Commission standards for perinatal safety
- Obstetrical Needs Assessment Form (ONAF) screening: Number of completed forms turned in
- Postpartum care 7–84-day follow-up (modified HEDIS®) also including maternal home visiting and telehealth visits in the numerator
- Prenatal Care Screening (Agency for Healthcare Research and Quality (AHRQ))
- C-section: Nulliparous women with a term, singleton baby in vertex position delivered by C-section
- Vaginal birth after C-section
- Early Elective Deliveries (NQF #0469, The Joint Commission)
- Birth outcomes: Birth weight and length of stay of the neonate

Provider metrics

- Social Determinants of Health Screening: One Social Determinants of Health Screening during the episode duration
- Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS®)
- Timeliness of Prenatal Care (HEDIS®)
- Postpartum Care (HEDIS®)
- Prenatal Depression Screening and Follow-up (HEDIS®)
- Postpartum Depression Screening and Follow-up (HEDIS®)
- Prenatal immunization status (HEDIS®)
- Well child visits (Modified HEDIS®): Children who receive two or more well-child visits with a primary care physician within the first 60 days after birth

Exhibit 3 Example of a Maternity dashboard depicting MCO comparative performance



Start today and impact generations

Over the past decade, there has been a deterioration in maternal and infant health outcomes that will chart the course for generations to come.[vi] Successful implementation of maternity-based models that improve health outcomes does not require complete uniformity. It requires a transparent, consistent approach by the state to define and report baselines, benchmarks, inclusions/exclusions, quality, and cost metrics that inform the payment and outcome of the care provided. We encourage states to evaluate their current reporting methods and technology infrastructure to identify gaps and opportunities to establish a centralized repository and reporting function to assist MCOs and providers in their payment reform journey.

[i] National Center for Health Statistics, Key Birth Statistics (2018 data, released 2019) and the Centers for Disease Control and Prevention (CDC) National Vital Statistics System (NVSS) Birth Data, NVSS - Birth Data (cdc.gov).

[ii] MACPAC, Value-Based Payment for Maternity Care in Medicaid: Findings from Five States, September 2021. Value-Based Payment for Maternity Care in Medicaid: Findings from Five States (macpac.gov)

[iii] 2019 New York Scorecard on Medicaid Payment Reform, VBP Scorecard (ny.gov).

[iv] Division of TennCare Episodes of Care, Episodes of Care (tn.gov); Arkansas Division of Medical Services Episodes of Care, Episodes of Care - Arkansas Department of Human Services; and Ohio Department of Medicaid Episodes of Care Program, Episode-based Payments (ohio.gov)

[v] Medicaid.gov, Maternal and Infant Health Care Quality, https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html.

[vi] National Institute for Healthcare Management Foundation, "The Uneven Burden of Maternal Mortality in the U.S.," August 2022. The Uneven Burden of Maternal Mortality in the U.S. (nihcm.org)

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