CT Maternity Bundle Project

Stakeholder Advisory Committee

March 22, 2022 11am – 12 pm

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Agenda

Topic	Timing
• Opening Remarks • Meeting Attendee Introductions	15 Minutes
• Project Objectives and Prior Work Review • Data Review • DSS Direction for Maternity Bundle	15 Minutes
Health Equity Framework • Overview • Section 1 Template • Section 2 Template • Section 3 Template	25 Minutes
Next Steps	5 Minutes

Project Objectives: DSS Goals & Principles for Design

Goals: Develop an innovative and nation-leading value-based payment for maternity services that:

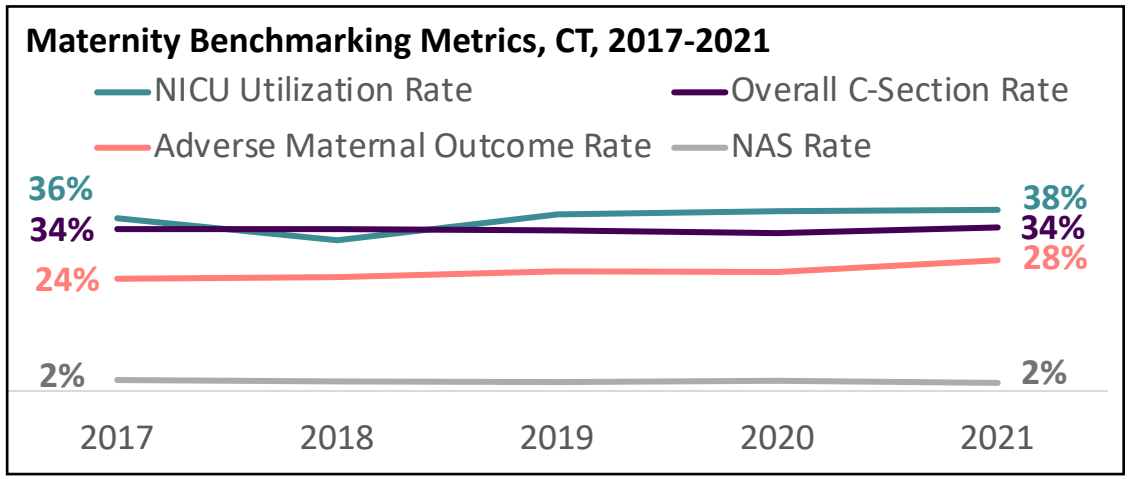
1. Addresses **racial disparities** in maternal health (including SUD) and birth outcomes
2. Reduces incidence of **unnecessary Cesarean procedures & early elective births**
3. Supports parity between OBs & midwives, and includes **access to doula services, CHWs and breastfeeding support**
4. Creates opportunities to **align payment models** across Medicaid and State Employee Health Plan (particularly quality measures)
5. Ensures implementation remains **cost neutral** for DSS budget, and ultimately program should **save money** attributable to improved maternal & newborn outcomes
6. Considers impact of **timing of enrollment** in limited benefits on maternal health and birth outcome

Principles: Use the following principles when making policy recommendations:

1. Align with DSS Goals
2. Use evidence-based practices and model after best practices, including aligning financial incentives across public payer & providers
3. Health Equity Plan
4. Consider stakeholder input and priorities in bundle design
5. Keep bundle methodology simple wherever possible

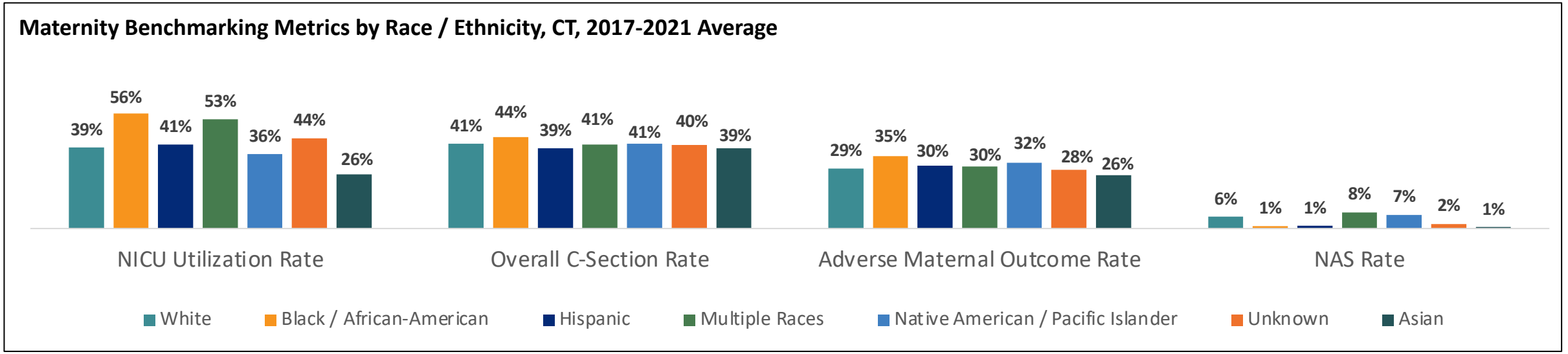
Reflected in work completed to date

Equity-Based Maternity Benchmarks



Key Takeaways:

- **NICU utilization rose by two percent** and **Adverse Maternal Outcome rates increased by 4 percentage points** over the past five years.
- **Black/African American and multiple race members have the highest NICU** rates as compared to other race/ethnicity categories.
- **Black/African American members have the highest c-section** rate, three percentage points greater than white individuals.
- **Black/African American members have the highest Adverse Maternal Outcomes rate**, six percentage points greater than for white individuals.
- **Individuals of multiple races and Native American/Pacific Islanders have the highest rate of NAS** as compared to other race/ethnicity categories.



Source: CT DSS Provided Data

Notes: ***NICU*** – Race based on baby's member record. Defined by a stay under revenue codes 0174 or 0203 prior to baby turning 29 days old. ***C-Section*** – Race based on mother's member record. Determined by match in the C-Section value set. ***Adverse Maternal Outcome*** – Race based on mother's member record. Current outcomes defined as Adverse Maternal Outcomes: Acute Myocardial Infarction, Cerebral Infarction, Disseminated Intravasular Coagulation, Eclampsia, HELLP Syndrome, Hemorrhage, Maternal Death within 1 year, Peripartum Cardiomyopathy, Placenta Accreta, Placenta Increta, Placenta Infarction, Placenta Percreta, Placenta Previa, Preeclampsia, Premature Separation of Placenta, Stillborn, Thrombosis Embolism. ***NAS*** – Race based on baby's member record. Determined by diagnosis code P96.1 on baby's birth claim.

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Maternity Bundle Key Design Elements (From 2021 Public Sessions)

This framework from 2021 offers high-level direction on each maternity bundle elements. Subsequent working sessions of this group will dive deeper into the specifics of each element within the context of the established framework (e.g. finalize services included in prospective vs retrospective bundle payment approach, finalize initial quality measures, and which ones would be pay for reporting vs. pay for reporting, etc.)

	Design Element	Straw Recommendation
Episode definition and population	**Episode Definition** Bundle Inclusions/ Exclusions	Episode defined as a **Comprehensive Bundle** inclusive of services across all phases of maternal health (prenatal, labor and delivery, postpartum).
	Accountable/ Contracting Entity	All Obstetrics (**OB)/**Licensed **Midwife practices** in CT's Medicaid program, as well as Family Medicine providers who provide OB services
	Population Newborn care?	**Newborn care is initially excluded from the bundle**. • Over time, phase in newborn care.
	Population Any exclusion criteria?	All Medicaid births, except those excluded for **administrative reasons** (e.g. non-continuous enrollment, death, etc). Evaluate using a **financial proxy** to define high-cost episodes to be excluded from the bundle. Identify **limited clinical risk exclusion criteria**, so key diagnoses such as SUD are not categorically excluded from the program.
Services	**Services included in Bundle**	Included services: • **Prospective payment** dollars – **routine pregnancy** related visits that providers can impact • **Retrospective payments** – those **services that may not always be necessary** during pregnancy Excluded services: • Not included to ensure there is **not adverse fallout for needed services that may be more costly to providers**
Metrics	**Quality Metrics**	**Combination of State Employee Health Plan (SEHP) quality measures and Medicaid core maternity bundle measures**: 6 SEHP measures + ~4-6 additional measures including Vaginal Birth After Cesarean (VBAC), early elective delivery, prenatal timeliness of care, and postpartum care.* **Stratify all measures by race/ethnicity** **Update measures & measure specifications as quality best practices evolve.**

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	Design Element	Straw Recommendation
Financial Model	**Payment Flow**	Hybrid financial model of **prospective payment** for services provided by OB + **retrospective reconciliation** for related services outside OB practice.
	Episode Timing	**40 weeks before birth/at least 60 days postpartum,** with plan to extend to longer postpartum time period
	Episode Pricing	**Phased approach, such as:** Year 1: Upside Only Years 2-3: Asymmetric upside/downside (larger upside potential than downside exposure) Year 4: Symmetrical up/downside risk
	Type and Level of Risk	Blended price using statewide and provider-specific utilization history (50/50 ratio in Phase 1), including single blended rate for c-sections and vaginal births. Also adjusted for any reimbursement rate changes. Risk-adjust based on clinical risk; consider adding social determinants.
	Impact of Quality Performance on Payment	Select key measures as pay for performance (P4P), with remaining reporting only (P4R). Move more measures from P4R to P4P over time. Use stratification of performance by race/ethnicity/language to incent improvements in quality disparities.

Building Blocks for Maternity Bundle

DSS will advance two building blocks of Medicaid Maternity Bundle concurrent with design of the full program: doula integration support & blended case rate payment.

Doula Integration
Launch Date: Summer 2022

Support for doulas/doula organizations to facilitate partnerships and capacity building prior to bundle launch

Blended Case Rate Payment for Births
Launch Date: TBD

Create a blended case rate* across C-sections & vaginal deliveries as a building block toward bundled payment, targeting reducing unnecessary c-sections

Open policy decision: Launch blended case rate as a phase-in to Maternity Bundle or in conjunction with Maternity Bundle?

Maternity Bundled Payment Program
Launch Date: Late 2022/Early 2023 (Exact date TBD)

Comprehensive Maternity Bundle to achieve DSS' objective to develop an innovative & nation-leading value-based payment for maternity services

*The blended case rate will be specific to professional fees.

Overview of the "Health Equity Yardstick"

Promoting health equity is a central component of CT DSS' work.

- The team created a Health Equity Framework that aims to help DSS intentionally apply an equity lens at each program stage of development: initiation, design/implementation, and evaluation
- This tool will be used to ensure that equity is the driving force for all aspects of design and implementation of new DSS programs and existing program updates
- The Maternity Bundle Project will be the first opportunity to put this tool into practice

Section 1: Design Readiness Checklist

- Completed at the beginning of project work and the answers should be consistent throughout the project, but this section is open to changes as we learn more throughout the design process

Section 2: "The Equity Yardstick" for Design & Implementation Principles

- Completed for each element of design so is expected to potentially be completed several times and may have different responses (Ex. Responses for Doula Integration details may be differ from those related to Blended Case Rate)

Section 3: Post-Implementation Evaluation of the Overall Program

- Completed for each element of design to evaluate whether the program goals are being met and to identify changes or updates that may be needed to the program design

Note: The current draft of the health equity framework is intended for feedback and discussion. All questions and comments pertaining to the tool are welcome.

Section 1: Design Readiness Checklist

Complete this section once prior to conducting the detailed design of a program. As needed, revisit and update this section as additional information is gathered.

Goals

- What does this program aim to achieve? What problem(s) does it solve?
- What are the explicit health equity goals for this program?

Intended Populations for Impact

- What is the target population or subpopulations? *Think about who will be most impacted (neighborhoods, regions, racial/ethnic groups, income groups) by the program, and consider whether the design will benefit different population groups the same, less so, or more so (e.g: Will Latino populations benefit more or less than Black populations? If yes, why?).*
- How is the design intended to improve health outcomes for the targeted population?

Community Context

- Identify the history and current reality of structural barriers that negatively impact the affected communities. *Examples include unequal social determinants of health in education, income, neighborhood characteristics, housing, access to care, safety, and food stability and manifestations of systemic racism, such as redlining, mass incarceration, the racial pay gap, etc.*
- What does the data tell us about the current context? (e.g. current health disparities data)
- What are the potential barriers, challenges, or risks that may limit the ability of this program to achieve its intended outcomes for the target population? What specific design elements have been incorporated to mitigate these challenges?

Community Engagement

- How are those most affected actively involved in defining the problem and shaping the solution? Who is missing and how can they be engaged?
- Feedback loop: What mechanism is in place to provide and receive timely feedback as issues arise?

Data Analysis & Measurement

- How is data related to health disparities collected for this program? What are future plans for collecting this data?
- Can the measures be stratified by race/ethnicity, language, disability (RELD) and other demographics? What barriers to effective stratified data collection do you anticipate for this program and how have they been addressed?

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Section 2: "The Equity Yardstick" for Design & Implementation Principles

Complete this section to guide design and implementation of each element of a program to ensure health equity focus – e.g. risk adjustment, quality metrics, member and/or provider eligibility, etc

Goals

- Proposal
  - What is the design element under consideration?
  - What are the expected results and outcomes of design element?
- Equity Alignment
  - How does the proposed design element impact existing inequities?
  - How does the proposed design element align with the project's overall equity goals?

Community Context

- What are the potential barriers, challenges, or risks that may limit the ability of this program to achieve its intended outcomes for the target population? What specific design elements have been incorporated to mitigate these challenges?
- Consider each impacted population and how the potential design(s) could create barriers or unintended consequences. *Example: geographic distribution of doula providers – are you solving a problem in one area, but creating a problem in another area?*
- What plan or strategies will be utilized to mitigate unintended consequences by the design?

Community Engagement

- How was community voice considered for this design element? *Ensure community members especially those who are most impacted by the program been informed, meaningfully involved, and authentically represented in the development of the program or initiative.*

Data Analysis & Measurement

- What measures will be used to assess effectiveness of design? What are the success indicators and progress benchmarks? Do these measures reflect the equity goal(s)?
- What methods will be used for data tracking, reporting, and communication of the metrics selected?

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Section 3: Post-Implementation Evaluation of the Overall Program

Complete this section after the program has been implemented to evaluate program impact and alignment its health equity goals.

Goals

- What were the initial goals of the program?
- What were the outcomes of the program implementation?
- Identify whether program goals were met. What changes are needed to achieve the desired outcomes and/or to align with health equity goals?

Intended Populations for Impact

- Based on the outcomes, who has benefited so far? Are there additional populations or subgroups that can or should be targeted further to receive greater program benefit?
- What has changed (improved/declined) for the targeted population?

Community Engagement

- What feedback have impacted communities provided about the program? Do they believe the program is having its intended impact?
- What barriers or challenges have been identified that limit the ability of this program to achieve its intended impact and/or to achieve its health equity goals?

Data Analysis & Measurement

- Are the data providing the appropriate detail to evaluate whether metrics have been met?
- Are the design metrics providing the appropriate detail to evaluate program success?

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Next Steps and Plan for Future Stakeholder Meetings

Next Steps

- Incorporate feedback from today's discussion into the Health Equity Tool
- Prepare Doula Integration concepts to be discussed at the April Stakeholder meeting

Upcoming Meetings (Additional committee meetings and subcommittee meetings to be scheduled as needed in 2022)

Month	Agenda Topic
March	Opening Remarks; DSS implementation plan; Health equity tool
April	Revisit Health Equity tool; Doula Integration
May	Blended payment rate
June	Building blocks for the bundle – what, who, how
July	Services included in the bundle
August	Quality measures
September	Payment methodology
October	Final bundle design review