May 23, 2016

VIA ELECTRONIC MAIL

Lew Sandy, MD
Chair
Clinical Episode Payment Work Group
Health Care Payment Learning and Action Network

Re: Comments on Draft White Paper: Maternity

Dear Chair Sandy:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")[1] commends the work of the Health Care Payment Learning and Action Network's ("LAN") Clinical Episode Payment Work Group ("Work Group") on its draft White Paper on Maternity Care\ Framework ("White Paper" or "Framework"). The Task Force appreciates the opportunity to provide comments to the Work Group, and looks forward to collaborating with the LAN and all of its work groups to help facilitate widespread health care delivery transformation.

As a general consideration, we continue to advocate for full transparency in all matters related to bundled payment programs, including the specific methodology and data for setting target prices and the way issues such as attribution are handled. We also believe that bundled payments can promote greater transparency for patients in the evaluation and selection of health care providers. Transparency, in general, will lead to shorter cycle times to refine program designs while also creating greater confidence in the technical aspects of any bundled payment program.

[1] The HCTTF is a group of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.

Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

The Task Force is supportive of the LAN's draft proposal of a maternity care payment model, and we agree that both mothers and their babies would greatly benefit from a comprehensive model that supports person-centric, interdisciplinary care across the prenatal, labor & delivery and postpartum episode. We also support models that promote vaginal births, and reduce primary Cesareans for low-risk first births and prevention of early elective deliveries that are not medically indicated.

Our recommended refinements to the Maternity Care Model design include:

Episode Timing

The Task Force advocates adjustment of the episode definition and price based on differing numbers of prenatal visits. According to the Bureau of Maternal and Child Health Bureau data in 2011, 73.7 percent of women giving birth received early prenatal care in the first trimester, while 6 percent either received first prenatal care in the third trimester or did not receive prenatal care at all.[2] In States where Medicaid has not been expanded, frequently women experience coverage continuity issues due to loss of benefit eligibility. This leads to delay in first perinatal.

Patient Population and Transparency in Episode Creation

As a general consideration, we continue to advocate for full transparency in all matters related to bundled payment programs, including the specific methodology for setting target prices for each hospital or participant. Data is key to fostering consensus and reaching agreement on appropriate structures to manage bundled payment programs. We believe greater transparency will lead to shorter cycle times to refine program designs while also creating greater trust in the technical aspects of any bundled payment program.

In order to ensure access to maternity care, we agree with the LAN's support of the broadest possible patient population, with risk and severity adjustment to account for maternal age, BMI, complexity and socioeconomic factors. We believe this should be acknowledged at the start, and should be considered by the LAN as a challenge to be addressed by constructing episodes that work for a broader set of patients. It is critical to include both the mother and baby in the episode so as to effectively assess the true 'quality of care' that was provided. We are in agreement that models should incorporate high-value support services, such as nutrition, mental health services, advanced practice nurse/practitioner, doula care and prenatal and parenting education.

[2] http://mchb.hrsa.gov/chusa13/health-services-utilization/p/prenatal-care-utilization.html

Services

We support the White Paper's inclusion of services that are not commonly covered but beneficial to maternity care including care provided by doulas, care navigators, group prenatal visits, and breastfeeding support. We also recommend adding home visits to these services.

Patient Engagement

Ensuring the mothers have a 'voice' in their care decisions is of primary importance regardless of the payment structure that reimburses these services. Therefore, we support notifying mothers of their involvement in a bundled model via a beneficiary notification, but we do not recommend requiring an active agreement to participate in the model.

The Importance of an Accountable Entity

In our view, episode definitions should not prescribe who can be an accountable entity in bundled payment contracting. We believe a wide range of organizations dedicated to integrating and coordinating the work of practicing physicians and health care providers across care setting may be appropriate for assuming risk and managing a bundled payment program. We urge the LAN to be inclusive, rather than exclusive, on the accountable entity question to encourage innovation and foster market-based arrangements dedicated to bundled payments.

Notably, the CEP Work Group was agnostic on this issue in its EJR bundling white paper. While recognizing that the maternity bundle white paper explains why the position taken here, we believe the better course of action from a policy perspective is to have consistent positions on the accountable entities across all bundle types. Thus, the HCTTF respectfully requests that the LAN adopt the inclusive position proposed above.

Payment Flow

Initial determination of whether a mother is considered 'low risk' can be made at the first prenatal visit. However, this status can change during the course of pregnancy. For this reason, a retrospective payment model may be a better choice than a prospective payment model for maternity care.

Type and Level of Risk

As mentioned previously, initial determination of whether a woman is 'low risk' can be made at the first prenatal visit. A 'high-risk' pregnancy is one which puts the mother, the developing fetus, or both at an increased risk for complications during or after pregnancy and birth. Clinical parameters for identifying a high-risk pregnancy can include:

1. Pre-existing health conditions: diabetes, hypertension, epilepsy, HIV, liver disorders, renal disease, coagulation disorders, cardiovascular disease, cancer, obesity (BMI > 30), advanced maternal age (mother's age 35 and older), mental health condition

2. Life-style choices: cigarette smoking, alcohol use and illegal-drug use
3. Previous pregnancy complications: genetic or congenital disorder, stillborn, preterm delivery
4. Pregnancy complications (can also arise during the pregnancy): multiple gestation, oligohydramnios, polyhydramnios, fetal growth restriction, rhesus isoimmunization, prolonged premature rupture of membranes, intrauterine fetal demise (IUFD), placenta abnormality (previa, accreta, increta, percreta, previa, vasa previa and abruption)

The bundle implies fee-for-value payment, and the methodology needs to account for outlier case management much like other bundles, including Comprehensive Care for Joint Replacement (CJR) have done.

Suggested exclusions might include: NICU care for prematurity, intrauterine growth restrictions, known congenital conditions and other selected exclusions which would be paid separately from the bundle.[3]

Patient-Focused Quality Metrics

We support the use of patient-reported outcome and functional status measures. However, we recommend that providers only be subject to performance in quality metrics that have been validated by sufficient data and accepted by institutions such as the National Quality Forum or the Perinatal Core Measures. In the CJR model, patient-reported outcome measures are not mandatory and providers are only being held accountable for the collection of the information, not the measures themselves. As these tools become widespread, the LAN should review and recommend which quality metrics show actual improvement in patient lives and have a dedicated group to continuously review quality metrics and ensure that they are aligned with other value-based arrangements.

We also recommend consideration of a provider portal, likely separate from provider EHRs, where providers can access their individual average quality, costs and utilization across episodes over a given period of time. This proved to be a key component of the Arkansas Health Care Payment Initiative Perinatal Bundle.[4]

[3] "Toolkit to Support Vaginal Birth and Reduce Primary Cesareans." California Maternal Quality Care Collaborative, 2016.
[4] http://www.iha.org/sites/default/files/resources/issue-brief-maternity-bundled-payment-2013.pdf.

Please contact HCTTF Executive Director, Jeff Micklos, at jeff.micklos@leavittpartners.com or (202) 774-1415 with any questions about this communication.

Sincerely,

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