national partnership for women & families

Opportunities for the Virginia General Assembly to Advance Maternal Health

Commonwealth of Virginia Joint Commission on Health Care

Maternal Health Briefing

Carol Sakala, PhD, MSPH

Director for Maternal Health

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About the National Partnership

- National non-profit, non-partisan organization based in DC
- Works for a just and equitable society in which all women and families can live with dignity, respect and security
- Health Justice and Economic Justice policy teams
- Celebrating 50 years of advancing key policies for women and families

I have no conflicts of interest to disclose

For far too many, maternity care is not

- Equitable
- Accessible
- Safe
- Respectful
- Effective
- Affordable

FOR MANY KEY INDICATORS, VIRGINIA'S PERFORMANCE IS ESSENTIAL SIMILAR TO NATIONAL

SEVERAL DOZEN VA COUNTIES ARE "MATERNITY CARE DESERTS"

Quality warning signs

- Rising maternal mortality
- Rising severe maternal morbidity
- Rising rates of preterm birth and low birthweight
- 1/3 cesarean rate for 10+ years despite "too high" consensus
- Widespread overuse of unneeded care, underuse of beneficial care (unwarranted practice variation)
- Broad inequities and unacceptable outcomes in best case
- Social needs have major impact, are largely out of view
- Compare unfavorably to peer nations (incl. baby outcomes)

https://www.nationalpartnership.org/our-work/resources/health-care/maternity-care-in-the-united.pdf
https://www.nationalpartnership.org/momsandbabies/

Cost (and quality) warning signs

- We likely have world's most costly maternity care system
- 4/5 of all dollars paid on behalf of woman and newborn across episode cover just the brief hospital phase of care
- High prices, procedure-intensive intrapartum care for all
- Cesareans payments are 50% greater than vaginal birth
- 85% with history of cesarean have another one
- NICU and neonatologist supply-induced demand with healthier and healthier babies spending time in NICUs

https://healthcostinstitute.org/images/pdfs/iFHP_Report_2017_191212.pdf
https://www.nationalpartnership.org/our-work/resources/health-care/maternity/archive/the-cost-of-having-a-baby-in-the-us.pdf
https://www.dartmouthatlas.org/Neonatal_Atlas_090419.pdf

Underfunding

- Prenatal care
- Postpartum care
- Social needs, care coordination and navigation
- Midwifery care
- Birth center care
- Doula support
- Services of community-led perinatal health worker groups
- Medicaid services

CHANGING THE FLOW OF RESOURCES IS ESSENTIAL

We need a two-tiered approach

- Maternity care system transformation
  - System performs well for very few
  - Embark on long-term effort involving new policies, tools, infrastructure and culture change
- Address urgent, dire needs now
  - In general, most harm is preventable
  - Increase access to proven high-performing care models

BOTH ARE ESSENTIAL AND WARRANT POLICY ATTENTION NOW

Maternity Care System Transformation

Long-Term Strategies

Leading transformation strategies

- Alternative payment models (APMs)
- New and strategic use of performance measures
- Health professions education
- Workforce composition and distribution
- Consumer engagement
- Priority research and evaluation

https://www.nationalpartnership.org/blueprint/

Vision for APMs and maternity care

Over time, this priority change strategy leads to

- Growing accountability for measures that matter
- Continuous use of QI improves practice, reduces unwarranted practice variation
- Increased ability to work as team toward shared goals
- Increased reliance on high-value forms of care for success
- Improved maternal-infant care, experiences, outcomes and across all, equity
- Wise use of resources
- Clinical culture change and delivery system reform

Prioritize APMs with greatest potential for impact

- Episode payment (pregnancy-birth-postpartum/infant)
- Maternity care home (aka pregnancy medical home, obstetric medical home, etc. – prefer to center birthing person) for care navigation and connection with social & community services

- Can be implemented together
- Can incorporate additional payment reforms

Recognize the long culture change/delivery system reform trajectory, the enormous potential benefit, and begin the journey however we can as soon as we can

See slide deck Appendix for

- Maternity care global fee billing codes are FFS, not APM
- Optimal features of maternity care episode payment
- Proposed performance measures for maternity care episode payment
- Importance of and ways to build equity into APM design
- Optimal features of maternity care homes
- Hypothesis: prioritize quality; wise spending will follow
- Resources for learning more

Meeting Urgent Needs, Reducing Harm

Short-Term Strategies

High-performing care models

- Midwifery-led care
- Community birth: birth centers and home
- Doula support: both birth doula and extended model
- Community-based and –led perinatal health worker groups

THESE MODELS WORK FOR BOTH TIERS

- **FOSTER SUCCESS WITH APMS/PERFORMANCE METRICS**
- **READY TO MEET URGENT CURRENT NEEDS**

COMMUNITY-BASED AND -LED VARIANTS ARE ESPECIALLY POWERFUL

For more details on all four: https://www.nationalpartnership.org/improvingmaternitycare

These models share a set of attributes

- Appropriate practices minimizing both overuse of unneeded unneeded care and underuse of beneficial services
- Mission driven; meet birthing families where they are
- Individualized, relationship-based care and support that are dignifying, trusted and often culturally congruent
- Attend to physical, emotional and social needs; build resilience
- Possess skills and knowledge for physiologic childbearing
- Remarkable outcomes, e.g., ptb, cesarean, breastfeeding
- In surveys, desired by childbearing, esp. BIPOC, people greatly out of proportion to access and use

https://www.nationalpartnership.org/improvingmaternitycare

1. Midwifery care

- First-line provider in most countries; attend 10% of U.S. births
- Support holders of three nationally recognized credentials
  - Certified nurse-midwife (CNM)
  - Certified midwife (CM)
  - Certified professional midwife (CPM)
- Independent care provider with distinctive care model
  - Relationship-based care fosters trust and understanding
  - Health promoting practices
  - Education for making informed care decisions
  - Personalized care tailored to needs and preferences
- Strong track record, including 3 systematic reviews: care practices and outcomes similar to or better than physicians

https://www.nationalpartnership.org/improvingmaternitycare/

2. Birth center care

- Well-deserved attention due to CMS CMMI Strong Start results
  - Across the country, compared to Medicaid members w/ usual care, those w/ birth center care had lower preterm birth, low birth weight and cesarean rates at less cost
- Personalized, relationship-based, midwifery-led care for lower risk birthing people
- Compared to hospital care, greater choice of companions, freedom of movement, support for physiologic processes
- Manage first-line complications, option to consult or transport to hospital (rarely urgent)
- Other "community birth" setting – home – has similar care model

https://www.nationalpartnership.org/improvingmaternitycare/
https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/insurers-employers/Getting_Payment_Right-FEB202.pdf

3. Doula support

- Support person, not a clinician
- Provides information, emotional support and comfort measures
- Extended model includes support during pregnancy and in postpartum period
- Birth doula associated with fewer cesareans, less use of pain medication, and high satisfaction, among other benefits
- Extended model associated with less preterm birth and greater breastfeeding, among other benefits

https://www.nationalpartnership.org/improvingmaternitycare/

4. Community-based perinatal support, care

- Multi-functional, according to needs of community, individuals
- Trusted, respectful, cultural congruent support and – often – care
- Strongly evidence-based to extent that services include midwifery, birth center care and doula support
- Often includes training component
- This complex intervention has rarely been evaluated as a whole, is likely an essential part of solution to our maternal health crisis
- No current reliable payment for non-clinical services

https://www.nationalpartnership.org/improvingmaternitycare/
https://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf

See slide deck Appendices for

- Maps of state-level legal status of midwives with nationally recognized credentials
  - Certified nurse-midwife (CNM)
  - Certified midwife (CM)
  - Certified professional midwife (CPM)
- Map with state-level legal status of birth centers
- Map with state-level status of Medicaid coverage of doula support

- Importance of social drivers of maternal-infant health

Recommendations

Medicaid MCOs

- Create/implement maternity episode and maternity care home payment models (and foster all-payer APMs)
  - Design intentionally for improving equity, clinical care, experience, and outcomes (see payment reform appendix)
- Require early pregnancy physical, emotional and social risk screening and corresponding provision of support and services
- Create mechanisms for accountability via performance measures that can impact population (beyond HEDIS)
  - Require collection, reporting and tracking of access, experience, and outcomes, by race and ethnicity

Increase access to midwifery by

- Growing the profession
  - Support preceptors & entities providing clinical placements (CMS pays for medical but not midwifery residencies)
  - Provide support for midwifery education, adapting federal Midwives for MOMS Act (S. 1697/H.R. 3352)
  - Create additional midwifery education programs at public and/or historically Black universities (Virginia has just one midwifery education program, at Shenandoah U)
- Reducing midwifery barriers
  - CMs: eliminate requirement for written physician agreements; provide Medicaid reimbursement at parity with physicians
  - CPMs: assist with access to liability coverage or change Medicaid requirement to: disclose status

Increase access to birth center care by

- Fostering development of new centers, including in "maternity care desert" areas
  - Enact adaptation of federal BABIES Act (S. 1697/H.R. 3352)
- Enacting birth center licensure, in collaboration with centers
  - Avoid unnecessary barriers as noted in Appendix map
  - For sustainability of existing/future birth centers, either assist with on-ramp for costly accreditation, or do not require it
- Ensuring sustainable Medicaid payments for this high-value form of care
- Incorporating birth centers into maternity care APMs

Increase access to doula support by

- Ensuring the success of Virginia's Medicaid doula program
  - Engage community-based doulas in program planning, implementation and assessment
  - Provide fair and sustainable payments for doula services
  - Publicize the availability of the program to pregnant Medicaid beneficiaries
  - Incorporating doula agencies into maternity care episode and maternity care home APMs

Increase access to community-based perinatal support and care by

- Investing in community-based perinatal organizations
  - Pursue partnerships through such Medicaid levers as value-based contracts, MCO regulations, and state plan amendments
  - Create expectation across maternity care system that these health workers are essential component of the maternity care team
  - Integrate into clinical systems while preserving community leadership
- Incorporating these groups into maternity care home and episode APM programs

Other recommendations: health professions

- Support revamping of curricula at state health professional schools to integrate equity throughout, beginning with maternal health
- Require maternal health professional training in birth equity
  - Adapt California Dignity in Pregnancy and Childbirth Act and training: https://www.diversityscience.org/training/equal-perinatal-care/
- Support pipeline programs that would diversify the composition of maternal health professionals in the state
  - Physicians, midwives, nurses

Contact Info

Carol Sakala

Director for Maternal Health

csakala@NationalPartnership.org | 202.986.2600

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ChildbirthConnection.org

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Appendix:

Payment Reform Performance Measurement

Conventional maternity payment

Despite global fees, solidly aligned with FFS

- No accountability (for equity, outcomes, experiences, effectiveness, costs, …)
- Separate provider (mom, baby), facility (mom, baby), lab, imaging, pharmacy payments
- No incentives, and often no resource allocation, to reliably provide beneficial underused care
- No effective brakes on procedure-intensive overuse
- No effective brakes on high facility prices

Maternity Care Episode Payment

Optimal features, may not be possible at first

- Include both birthing person and infant (interim maybe mom)
- From pnc entry through postpartum and newborn periods
- Include vast majority of women, babies, at various risk levels
- Small number of very high-cost exclusions to limit provider risk
- Also limit provider risk with risk adjustment and stop-loss
- Single payment for whole episode (interim maybe 3 payments)
- Willing person coordinates

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

Maternity Care Episode Payment

Optimal features, continued

- Use population-impacting performance measures; adjust targets annually
- Both upside (gainsharing) and downside risk
- Succeed with high-performing forms of care (e.g., midwifery)
- Integrate into practice (e.g., data collection, payment mgmt)
- Meaningfully engage birthing people and families
- Quality improvement and continuing education
- Build equity into design

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

Proposed episode performance measures

Nationally endorsed by National Quality Forum – strongly preferred

- Cesarean birth (aka NTSV)
- Unexpected complications in the term newborn
- Exclusive breast milk feeding
- Contraceptive care – postpartum

Other priorities, no current nationally endorsement

- Person-reported experience of maternal-newborn care
- Person-reported outcomes of maternity care

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

Building equity into APM design

Approaches include

- Adjusting payments for social risk
- Equity-focused performance measures, including stratification by race-ethnicity and other key demographic variables
- Increased reward for reaching equity benchmarks
- Increased payments to safety net providers for infrastructure, social needs
- Relevant service enhancements, e.g., telehealth, support from community-based organizations

https://www.healthaffairs.org/do/10.1377/hblog20201119.836369/full/
http://ldi.upenn.edu/sites/default/files/pdf/PennLDI-Future-of-Value-Based-Payment-WhitePaper.pdf

Maternity Care Home

Optimal features, may not be possible at first

- Payment mechanism (e.g., per member per month)
- Personnel: prepared, tasked, resourced, held accountable
- Performance indicators (e.g., care planning) and targets
- Program incentives (e.g., infrastructure support, recognition program)
- Dual focus: community and social supports, care navigation

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

Maternity Care Home

Optimal features, continued

- Meeting individualized needs of all vs. premature segmentation
- Provide support from pregnancy through postpartum period
- Integration into practice (e.g., work flow, relationships with community services, communication across care team)
- Build equity into design

https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice

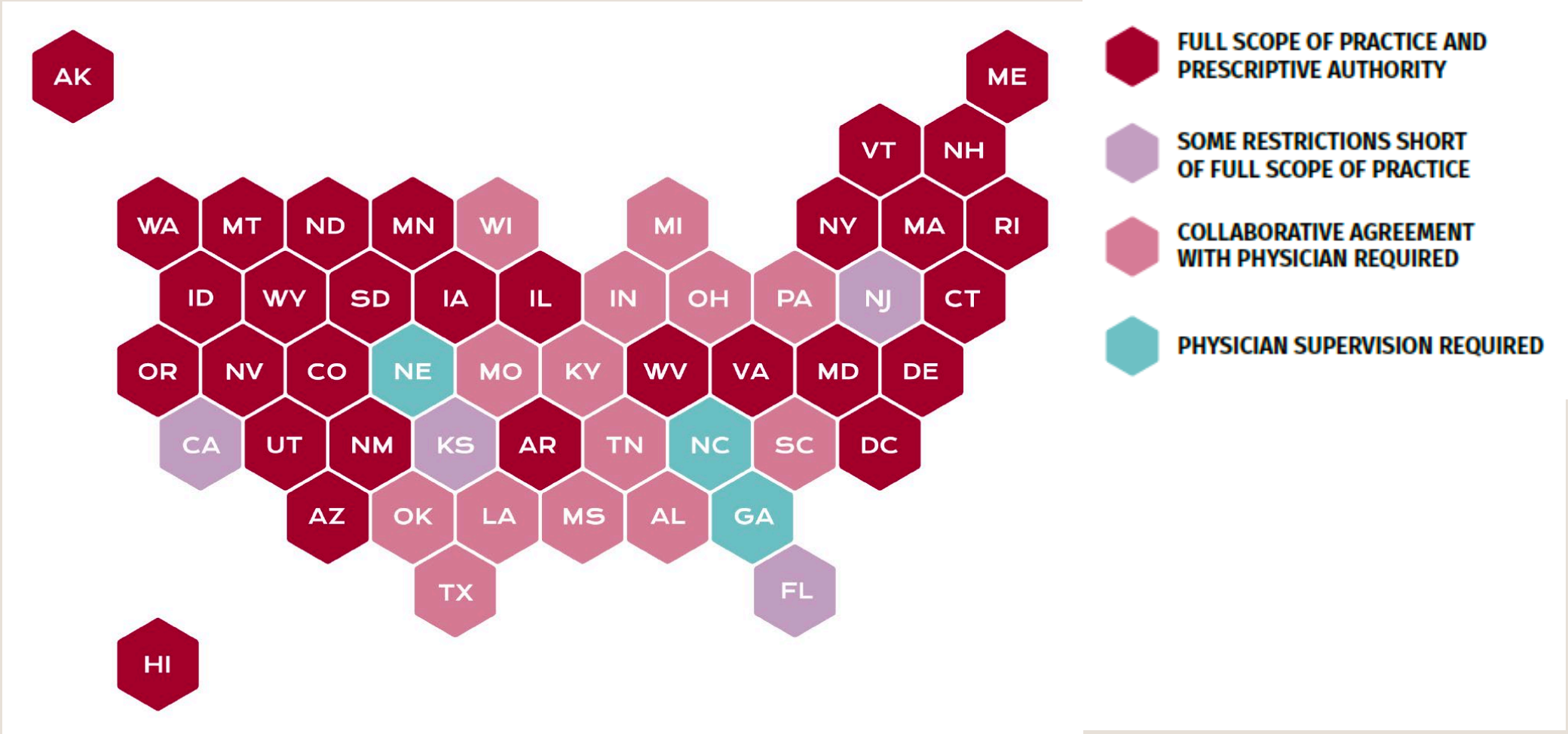
Hypothesis: Prioritize quality, wise spending will follow

- Give priority to dire, in many cases worsening, situation
- Design APMs for equity and improvement
- Savings will accrue: e.g., ↓ preterm birth, ↓ cesareans and repeats, ↓ NICU stays, ↑ breastfeeding
- Need to sort out appropriate and now-imbalanced allocation of resources by type of payer and phase of care

Appendix:

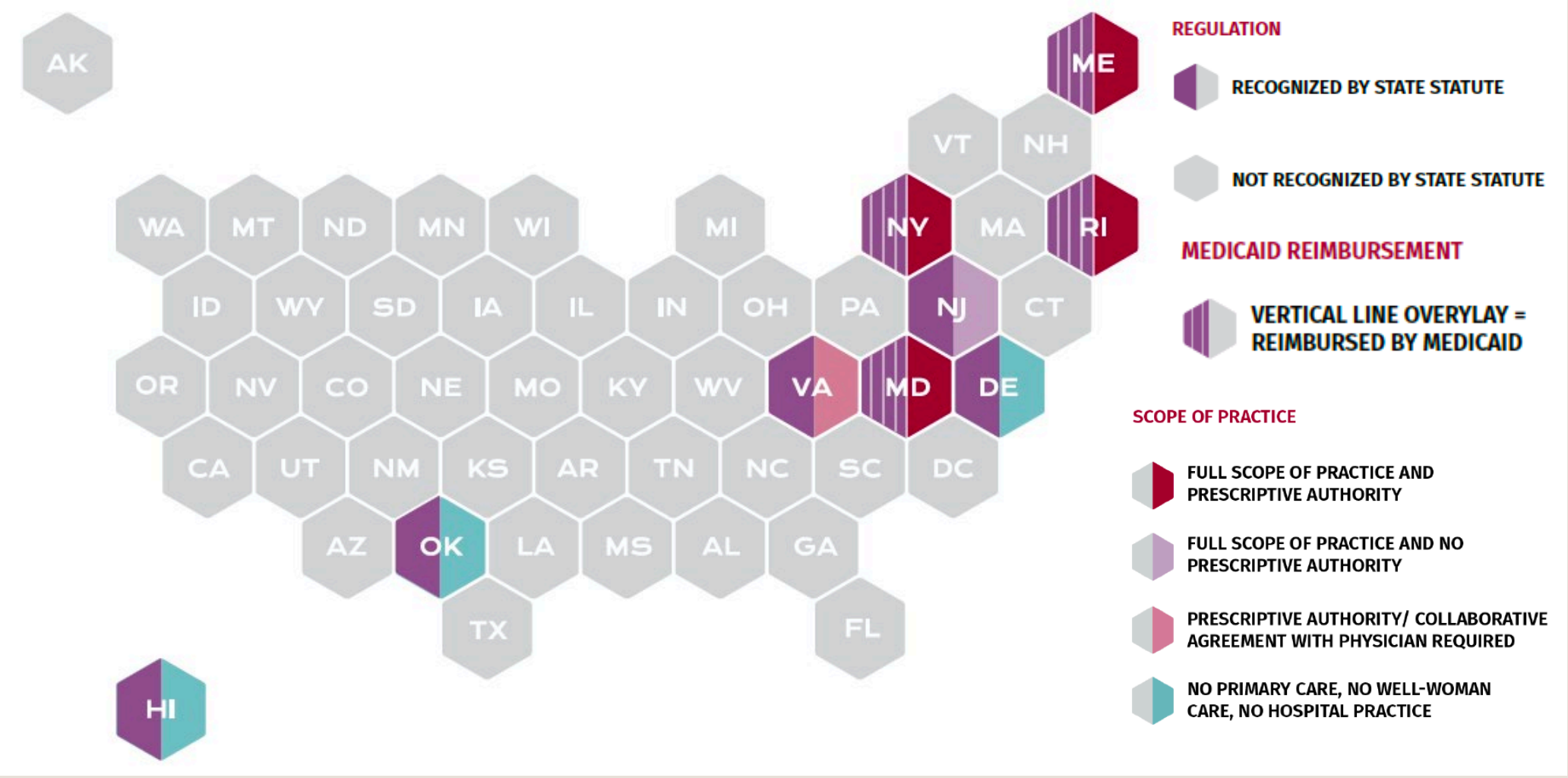
Maps Describing State-level Status of Midwifery, Birth Centers, Doula Support

Certified nurse-midwives (CNMs): scope of practice



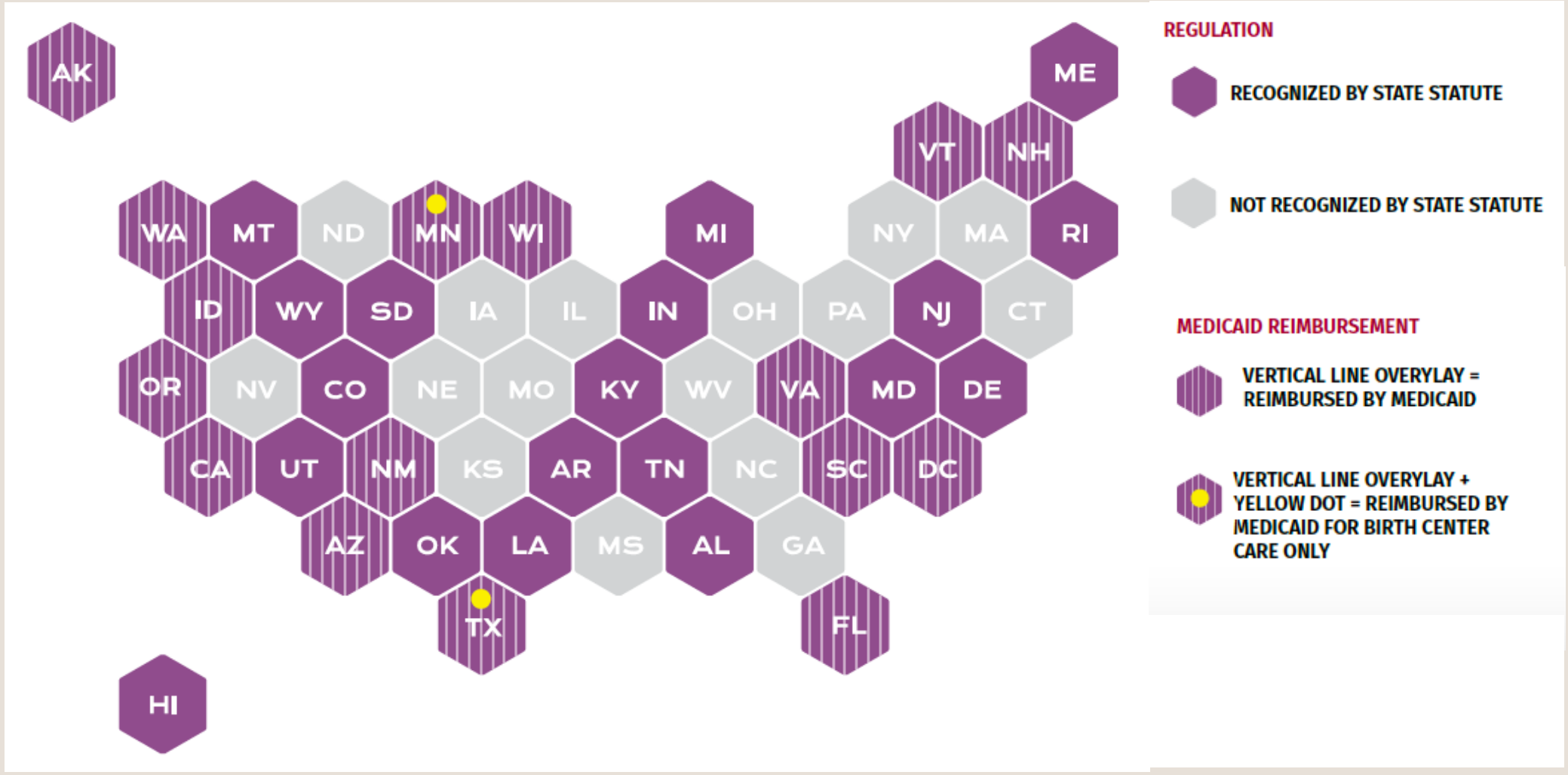
VA has full-scope CNM practice; physician-CNM Medicaid payment parity

Certified midwives (CMs): regulation, scope of practice

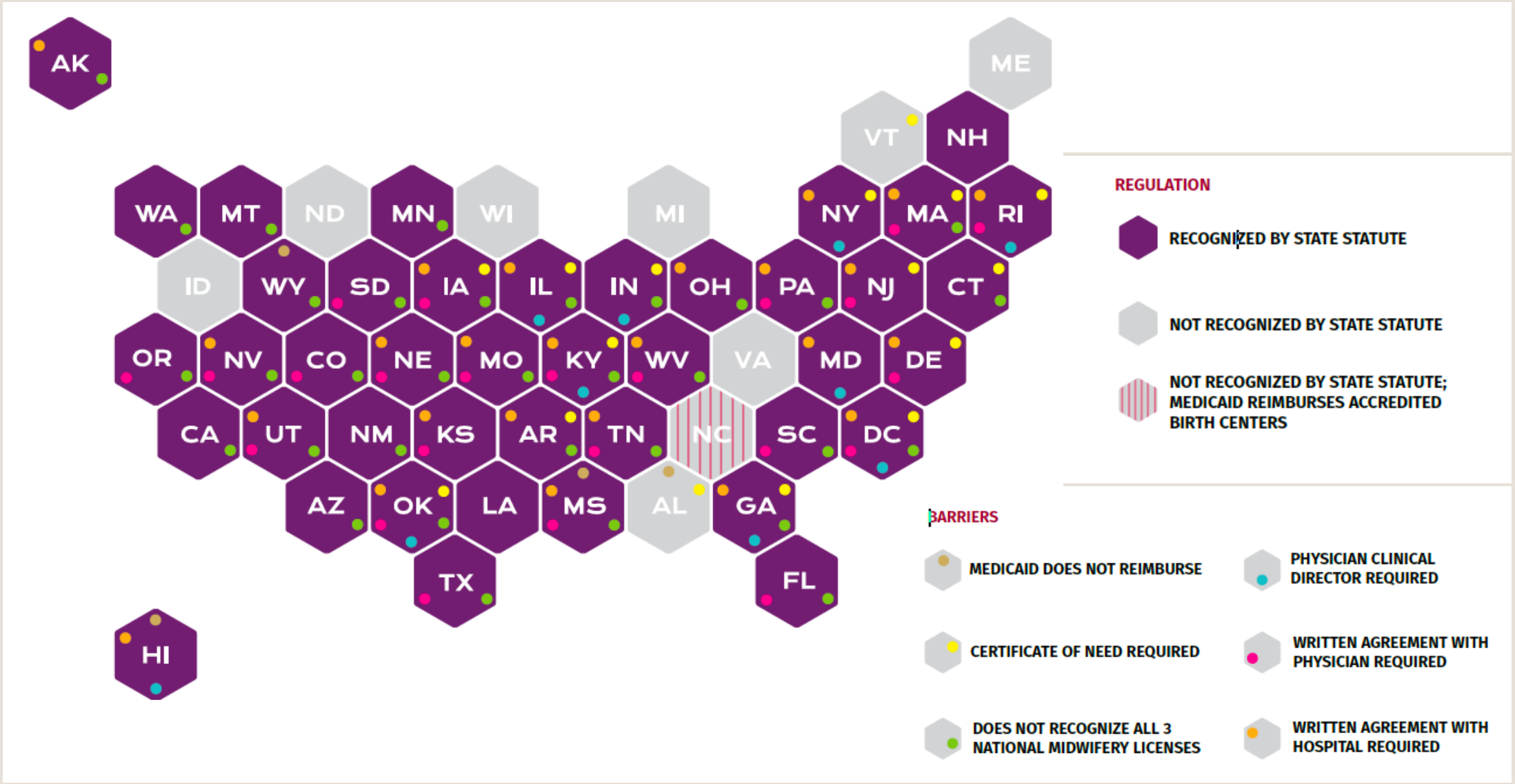


VA Medicaid does not reimburse CMs
VA requires CM collaborative agreement with physician

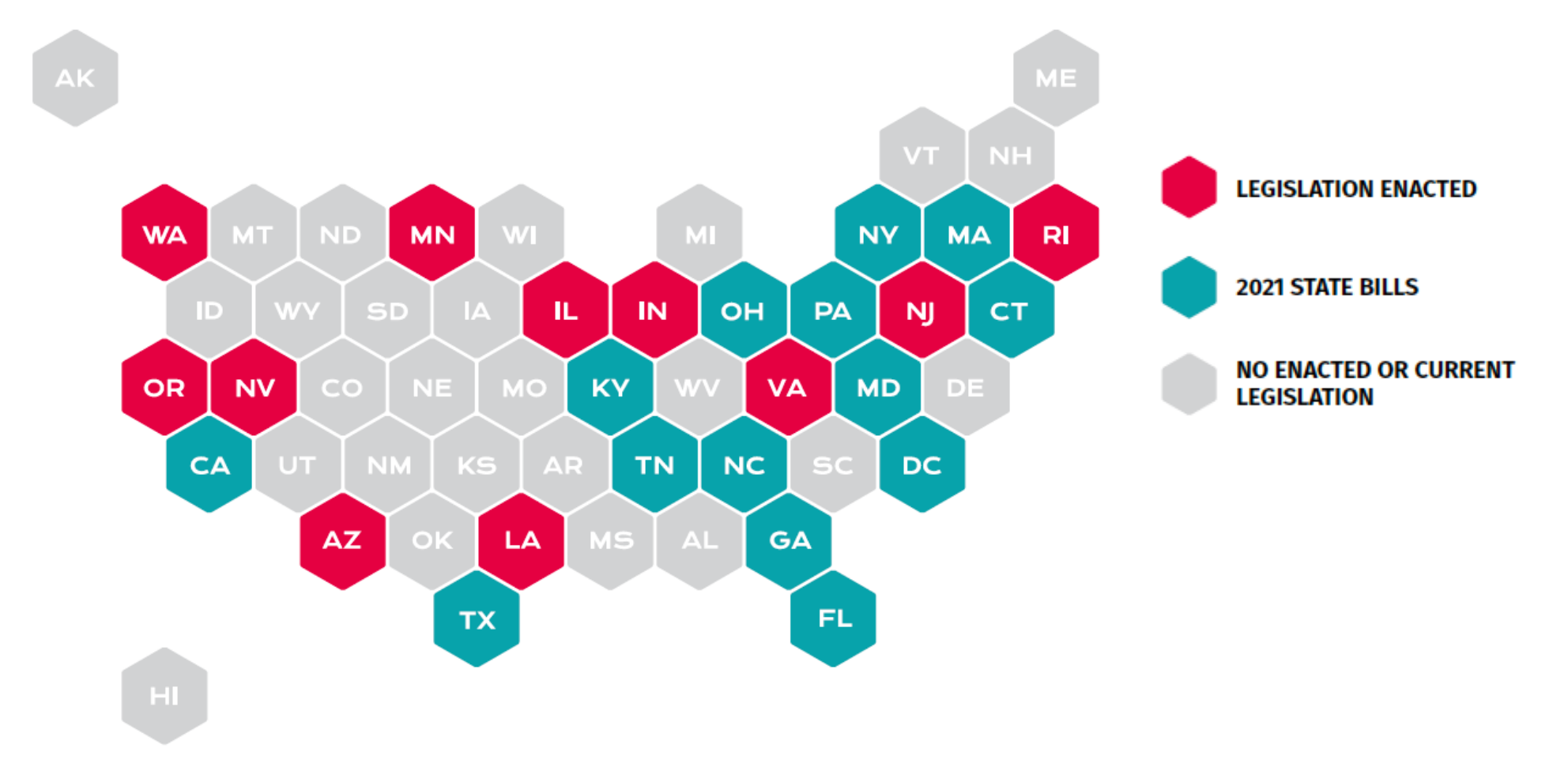
Certified professional midwives (CPMs): regulation, Medicaid reimbursement



Birth center regulation and barriers



Medicaid coverage of doula support



VA has filed state plan amendment for Medicaid coverage of doula services

Appendix:

Social Drivers of Maternal-Infant Health

Social drivers affecting maternal-infant outcomes include

- Access to paid leave
- Built environment
- Climate-related heat
- Homelessness
- Immigration
- Incarceration
- Intimate partner violence
- Mental health
- Racism
- Substance use disorder

Find ten bulletins showing the impact of these social factors on maternal and infant health, their outsized adverse effects on communications of color, and recommendations for improvement at: https://www.nationalpartnership.org/momsandbabies/