Maternity Bundled Payment Workgroup

DR. ROBERT BREE COLLABORATIVE

January 8th, 2019

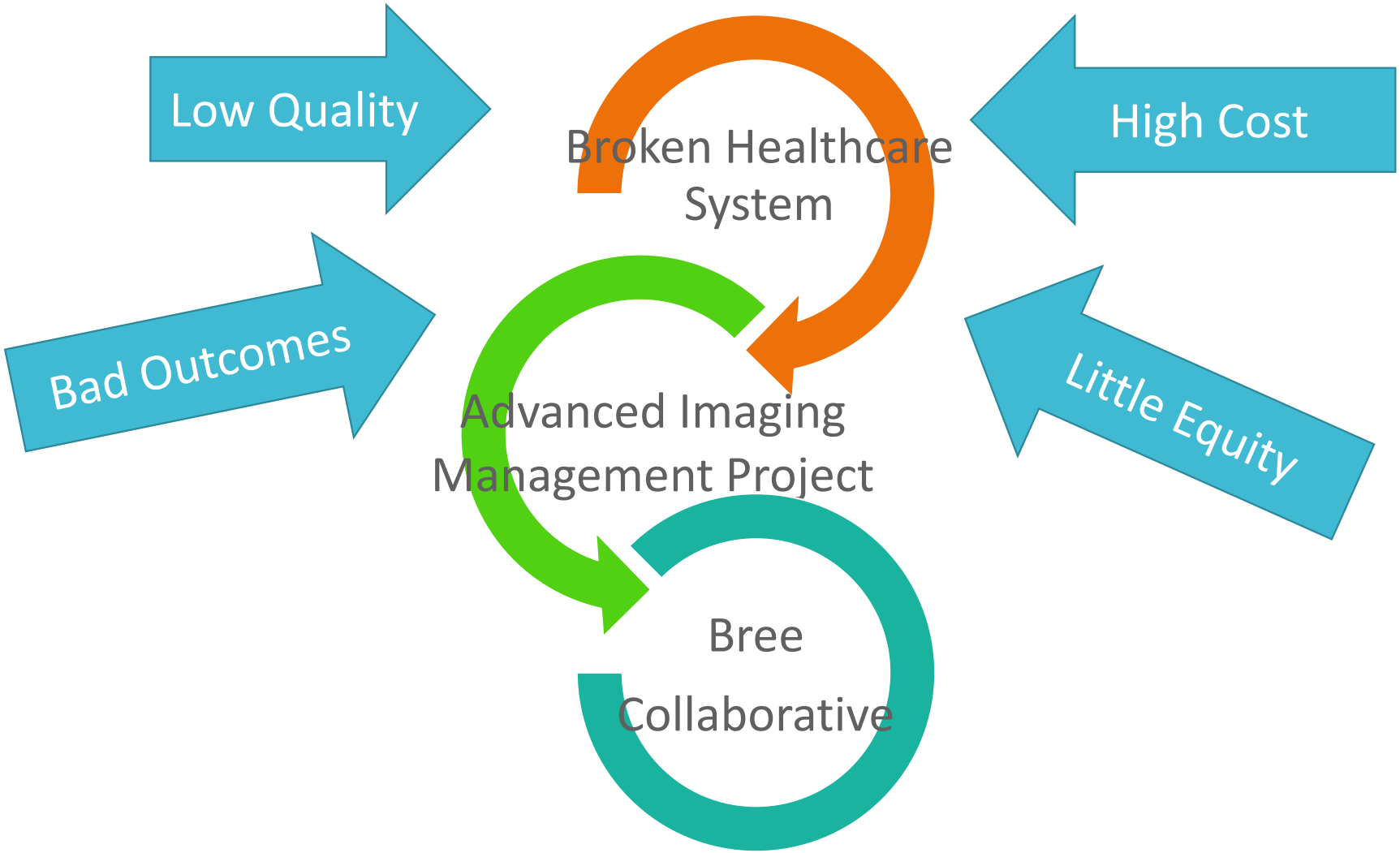
Agenda

- Welcome and Introductions
- Bree Collaborative Overview
  - Background
  - Past Work
  - Open Public Meetings Act
- Review Washington State Pregnancy and Perinatal Work
  - Additional workgroup members
- Review Available Data
  - Medicaid 2016 and 2017 data
  - Other sources?
- Preliminary Scope of Work
- Public Comments/Good of the Order

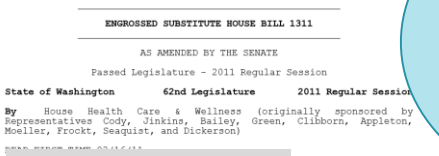
Roberts Rules of Order

- Quorum is 50%+1
  - Need quorum to make decisions
- Decisions made through motions
  - Making a motion
  - Seconding the motion
  - Debate (if needed)
  - Vote
  - Announcing results
- One person: one vote
- Voting limited to members present

Background
2011 Health Care Environment



Background
Members and Topic Selection



ENGROSSED SUBSTITUTE HOUSE BILL 1311

AS AMENDED BY THE SENATE

Passed Legislature - 2011 Regular Session

State of Washington 62nd Legislature 2011 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Cody, Jinkins, Bailey, Green, Clibborn, Appleton, Moeller, Frockt, Seaquist, and Dickerson)

House Bill 1311

QI Organizations

Employers

Hospitals

23 Members

Physicians

Health Plans

Others

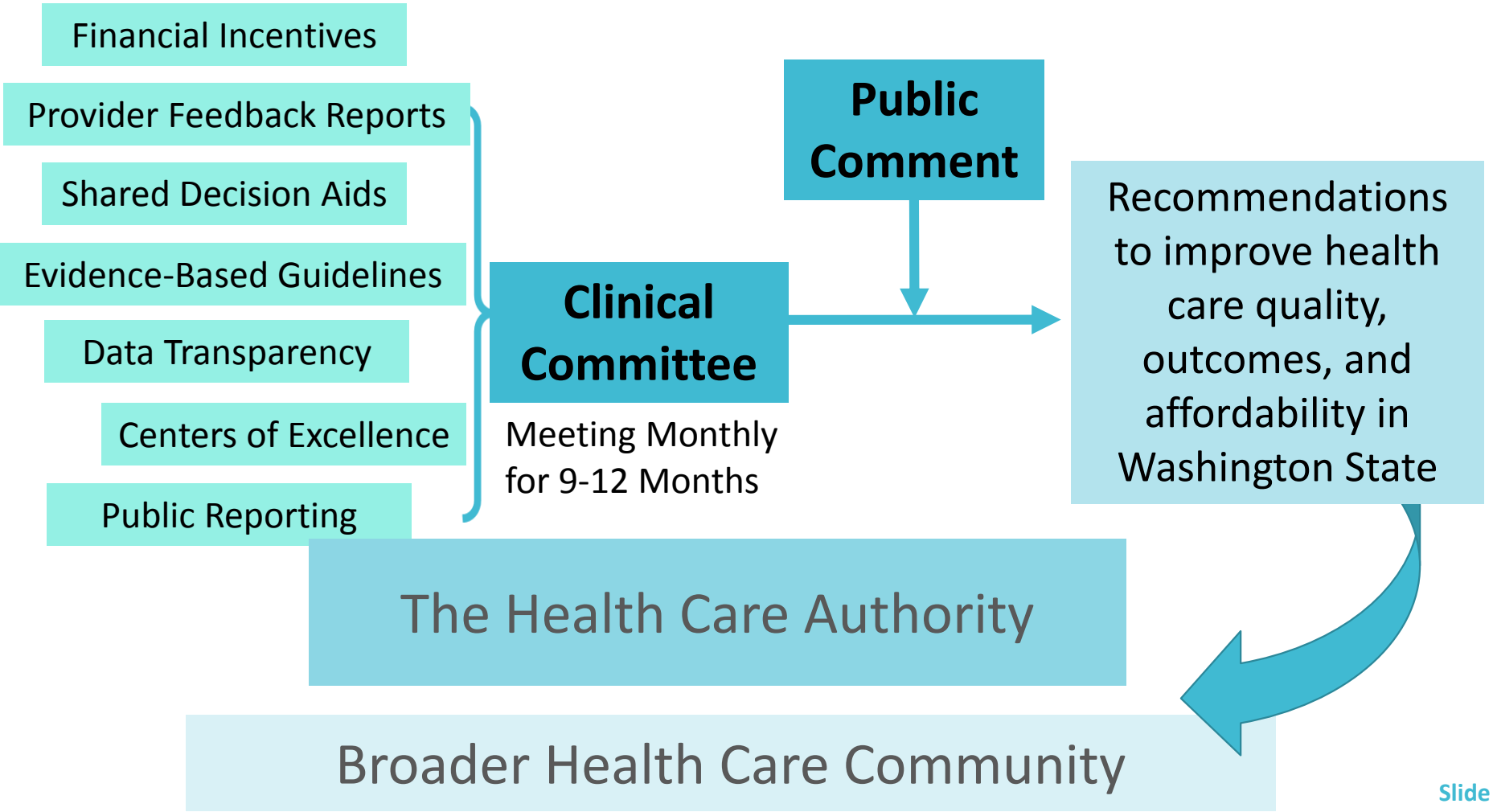
Public Purchasers

Identify health care services with high:

- **Variation**
- **Utilization**

Without producing better outcomes

Recommendations Formed in Clinical Committee



Report and Recommendation Process

Formulation

Select Topics

Bree Collaborative members discuss potential topics with high variation in the way that care is delivered, that are frequently used but do not lead to better care or patient health, or that have patient safety issues. Determination of three new topics by Bree Collaborative member majority vote.

Determination of workgroup Chair (typically Bree Collaborative member)

Convene Workgroup

Selection and recruitment of workgroup members including from health plans, providers, hospitals, and other relevant stakeholders including at least two members of the specialty or subspecialty society most experienced with the health service

Approval of workgroup charter and roster by Bree Members

Development

Workgroup develops initial scope, problem statement, and focus areas. Also identify barriers, drivers of change, and indicators or proxies for success

Updates at Bree Meetings

- Engagement with expert speakers
- Development of stakeholder-specific recommendations
- Development of implementation strategy and action steps (e.g., financial incentives, data transparency)

Presentation at Bree Meeting for vote for dissemination for public comment

Public Comments

Public comment opportunity including online survey and outreach to specific stakeholder groups.

Workgroup meets to address public comments and make any necessary changes to Report and Recommendations

Presentation at Bree Meeting for final adoption

Implementation

Approval by Director of the Health Care Authority.
"...all state purchased health care programs must implement the evidence-based best practice guidelines or protocols and strategies..."

Dissemination of final approved Reports and Recommendations.

Annual reports to Legislature and Governor's Office.

Working with hospitals, health systems, clinics, health plans, purchasers, patients, quality organizations, the Legislature, and the Health Care Authority to implement recommendations.

Re-review

Reports may be selected for re-review annually or if there is new evidence one year after adoption

Topic Areas

- Obstetrics (2012)
- Cardiology (2012)
- Elective Total Knee and Total Hip Replacement Bundle and Warranty (2013 and 2017)
- Elective Lumbar Fusion Bundle and Warranty (2014 and 2018)
- Elective Coronary Artery Bypass Surgery Bundle and Warranty (2015)
- Bariatric Surgical Bundled Payment Model and Warranty (2016)
- Low Back Pain (2013)
- Spine SCOAP (2013)
- Hospital Readmissions (2014)
- End-of-Life Care (2014)
- Addiction and Dependence Treatment (2015)
- Prostate Cancer Screening (2016)
- Pediatric Psychotropic Drug Use (2016)
- Behavioral Health Integration (2017)
- Guidelines for Prescribing Opioids for Pain (2015-Present)
- Opioid Use Disorder Treatment (2017)
- Alzheimer's Disease and Other Dementias (2017)
- Hysterectomy (2017)
- LGBTQ Health Care (2018)
- Collaborative Care for Chronic Pain (2018)
- Suicide Care (2018)

Areas for 2019

Guidelines for Prescribing Opioids for Pain
Ongoing

Maternity Bundled Payment Model

Palliative Care

Shared Decision Making

Harm to Self and Others

Reports

- What is the problem?
  - Is variation unwarranted?
  - Does it contribute to patient harm?
- What does it look like in Washington State?
- What are solutions within the medical system?
  - Focus areas
  - Stakeholder-specific recommendations
- How do we get there?

Implementation

- **Agency Medical Directors Group** (AMDG) reviews and approves recommendations which are then forwarded to the Director of the Health Care Authority (HCA)
- **HCA Director** reviews and decides whether to apply to state-purchased health care programs
- Legislation does not mandate payment or coverage decisions by private health care purchasers or carriers
  - Delivery systems and providers not required to implement recommendations

Open Public Meetings Act

- Required of Bree Collaborative meetings and workgroup meetings
- Allows the public to view the “decision-making process
- Training

Roster

OPEN GOVERNMENT/RECORDS TRAINING ROSTER

Course Subject(s) (check all that apply):

- ☐ Open Public Records Act Training (RCW 42.56)
- ☐ Open Public Meetings Act Training (RCW 42.30)
- ☐ Records Retention/Management Act Training (RCW 40.14)

Course Title(s):

Organization(s)/agencies providing training:

Trainer(s):

Format (in person, online, webinar, etc.):

Date:	**Location:**	**Length of time:**
Trainee Name:	**Trainee Signature:**	

Conflict of Interest Form

705 Second Avenue, Suite 410
Seattle, WA 98104
(206) 682-2811
bree@qualityhealth.org
www.breecollaborative.org

Participant Conflict Disclosure

Permanent and ad hoc members of the collaborative or any of its committees may not have personal financial *conflicts of interest that could substantially influence or bias their participation. If a collaborative or committee member has a personal financial conflict of interest with respect to a particular health care service being addressed by the collaborative, he or she shall disclose such an interest. The collaborative must determine whether the member should be recused from any deliberations or decisions related to that service.*

Conflict of Interest decisions must be disclosed and balanced to ensure the integrity of Bree Collaborative decisions while acknowledging the reality that interests, and sometimes even conflicting interests, do exist. Individuals that stand to gain or lose financially or professionally, or have a strong intellectual bias need to disclose such conflicts.

Example: The fact that a member is a health care provider that may provide a service under review creates a potential conflict. However, clinical and practical knowledge about a service is also useful, and may be needed in decision making.

Procedure
Members must sign a conflict of interest form. The Bree Collaborative Chair and/or Bree Collaborative Steering Committee shall make a decision as to whether a conflict of interest rises to the level that participation by the conflicted member could result in a loss of public trust or would significantly damage the integrity of the decision.

The Health Care Authority (HCA) defines conflict of interest as any situation in which a voting member has a relationship with a manufacturer of any commercial products and/or provider of services discussed or voted on during the meeting. Relationship extends to include immediate family member(s).

A relationship is considered as:

1. Receipt or potential receipt of anything of monetary value, including but not limited to, salary or other payments for services such as consulting fees or honoraria in excess of $10,000.
2. Equ… 5%
   ow…
3. Sta… tion
   rep…

Proposed Work Plan

- Monthly meetings starting in January 2019
- Present Roster and Charter January 2019
- Engage experts, talk through barriers
- Final product Fall 2019

Nearly Dying In Childbirth: Why Preventable Complications Are Growing In U.S.

December 22, 2017 • The rate of life-threatening complications for new mothers in the U.S. has more than doubled in two decades as a result of pre-existing conditions,

LOST MOTHERS

Severe Complications for Women During Childbirth Are Skyrocketin — and Could Often Be Prevented

The rate of life-threatening

CNN Health » Food | Fitness | Wellness | Parenting | Live Longer Live TV

After Serena Williams gave birth, 'Everything went bad'

'If You Hemorrhage, Don't Clean Up': Advice From Mothers Who Almost Died

August 3, 2017 • We've heard from 3,100 women who survived life-threatening complications of pregnancy or childbirth. They told us what they wished they had known and what they would say to new and expectant mothers.

FEATURE

Why America's Black Mothers and Babies Are in a Life-or-Death Crisis

The answer to the disparity in death rates has everything to do with the lived experience of being a black woman in America.

U.S. Has The Worst Rate Of Maternal Deaths In The Developed World

May 12, 2017 • More American women are dying of pregnancy-related complications and that rate is rising.

SEARCH

CDC A-Z INDEX

About Us + Pregnancy-Related Deaths

Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why

December 7, 2017 · 7:51 PM ET

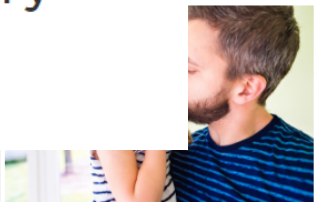
Heard on All Things Considered

Infertility +

Assisted Reproductive

defined as the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of

Rounds



- Video: https://nowthisnews.com/videos/politics/black-women-die-from-childbirth-complications-at-alarming-rates

Review Washington State Pregnancy and Perinatal Work

Carl Olden, MD

Family Physician

Pacific Crest Family Medicine, Yakima

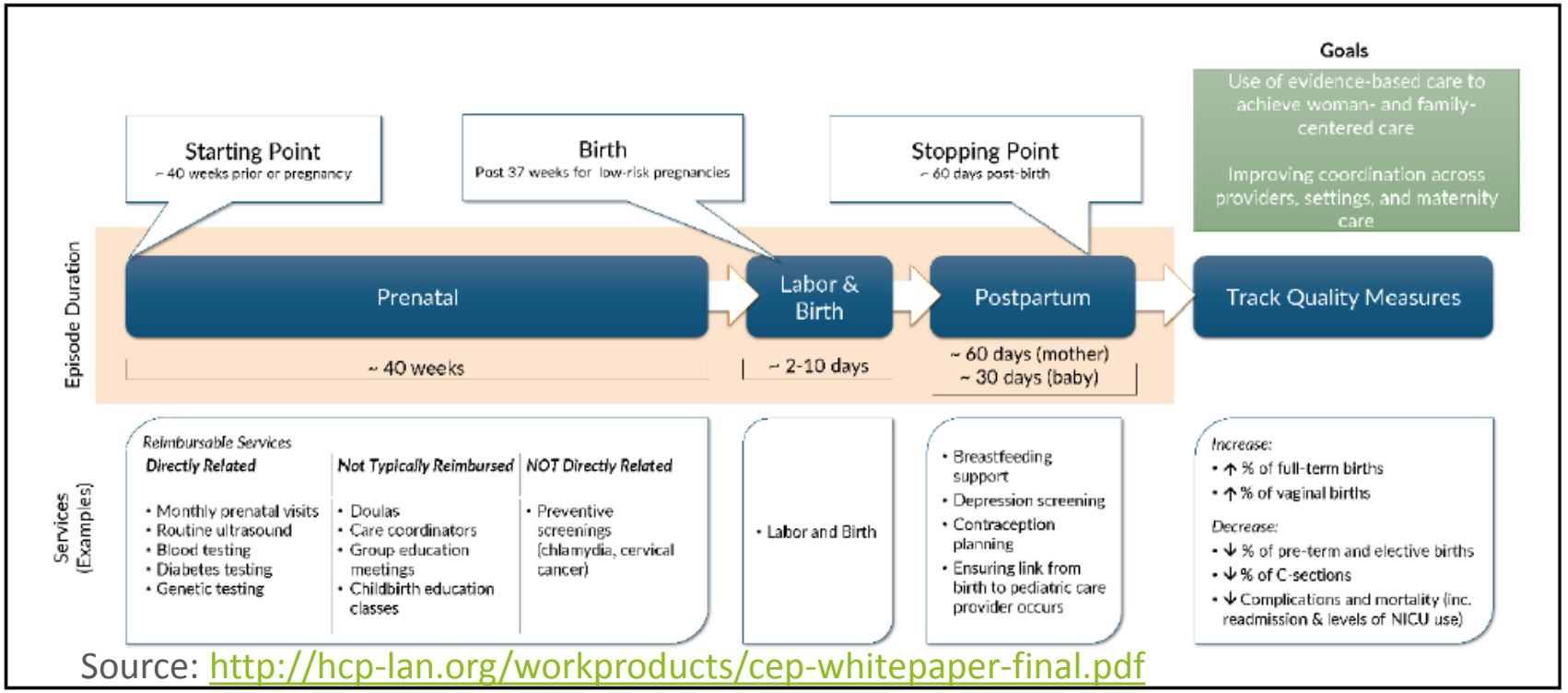
Review Available Data

Anaya Balter, RN, CNM, MSN, MBA
Clinical Director for Women's Health, Clinical Quality and Care Transformation
Washington State Health Care Authority

Preliminary Scope of Work

- When does bundle start? (e.g., conception, 270 days before delivery)
- When does bundle end? (neonatal care, 30-days post delivery)
- Include high-risk pregnancies? (e.g., BMI, HIV, high-risk baby)
- Blended case rate? (Vaginal and C-Section)

Figure 1: Maternity Episode Definition and Timeline



Source: http://hcp-lan.org/workproducts/cep-whitepaper-final.pdf

Four Cycles from previous bundled payment models

- Document disability due to X (e.g., spinal abnormality) despite conservative therapy
- Ensure fitness for surgery
- Provide all elements of high-quality surgery
- Facilitate rapid return to function

Table 2: Summary of Maternity Care Episode Recommendations

Episode Definition	The episode is defined to include the large majority of births, including the newborn care, that are lower-risk. While not necessarily lower risk, episode payment may also be considered appropriate for women who may be at elevated risk due to conditions that have defined and predictable care trajectories, such as gestational diabetes. As the CEP model matures, some groups with significant high-risk pregnancy experience and capacity may seek to manage the entire continuum of risk.
Episode Timing	The episode should begin 40 weeks before the birth and end 60 days postpartum for the woman, and 30 days post-birth for the baby.
Patient Population	The episode should primarily include the large majority of births, including newborn care, that are lower-risk. The Work Group also supports CEP for women who may be at elevated risk because of predictable risk factors that have defined care trajectories, such as gestational diabetes.
Services	Covered services include all services provided during pregnancy, labor and birth, and the postpartum period (for the women) and newborn care for the baby. Exclusions should be limited. Initiatives should also consider including high-value support services, such as doula care and prenatal and parenting education.
Patient Engagement	Engaging women and their families is critical in all three phases of the episode—prenatal, labor and birth, and postpartum/newborn—to contribute to the foundation for healthy women and babies.
Accountable Entity	The accountable entity should be chosen based on readiness to re-engineer change in the way care is delivered to the patient and to accept risk. In this model, the accountable entity will likely require a degree of shared accountability, given the number of clinicians working to care for a patient.
Payment Flow	The unique circumstances of the episode initiative will determine the payment flow. The two primary options are: 1) a prospectively established price that is paid as one payment to the accountable entity; or 2) upfront FFS payment to individual providers within the episode with retrospective reconciliation and a potential for shared savings/losses.
Episode Price	The episode price should strike a balance between provider-specific and multi-provider/regional utilization history. The price should: 1) acknowledge achievable efficiencies already gained by previous initiatives; 2) reflect a level that potential provider participants see as feasible to attain; and 3) include the cost of services that help achieve the goals of episode payment.
Type and Level of Risk	The goal should be to utilize both upside reward and downside risk. Transition periods and risk mitigation strategies should be used to encourage broad provider participation and support inclusion of as broad a patient population as possible.
Quality Metrics	Prioritize use of metrics that capture the goals of the episode, including outcome metrics, particularly patient-reported outcome and functional status measures; use quality scorecards to track performance on quality and inform decisions related to payment; and use quality information and other supports to communicate with, and engage patients and other stakeholders.

Source: http://hcp-lan.org/workproducts/cep-whitepaper-final.pdf

Learning from Other Examples

Source: http://hcp-lan.org/workproducts/cep-whitepaper-final.pdf

- **Tennessee Health Care Improvement Innovation Initiative**
  - 40 weeks prior to delivery through 60 days after delivery or discharge
  - Mother only
- **Arkansas Health Care Payment Improvement Initiative**
  - Roughly 40 weeks before delivery through 60 days postpartum
  - Mother only
- **Community Health Choice (TX)**
  - Mother: 270 days prior to delivery through 60 days post discharge
  - Mother and newborn
- **Providence Health & Services** (OR)
  - Positive pregnancy confirmation until 6 weeks after delivery
  - Mother and newborn
- **Geisinger Health System**
  - Prenatal: Identification of pregnancy in the first or second trimester
  - Mother only
- **Pacific Business Group on Health** (CA)
  - Hospital labor and delivery only
  - Mother only
- **American Association of Birth Centers (PA)**
  - Enrollment in freestanding birth center through and including 6-week postpartum care visit
  - Mother and newborn care through first 28 days of life
- **Baby+ Company (NC, TN, CO)**
  - Initial OB visit at birth center through 6 weeks postpartum
  - Mother and newborn
- **The Minnesota Birth Center's BirthBundleTM**
  - 270 days prior to delivery and 56 days postpartum
  - Mother and newborn
- **Ohio Episode-Based Payment Model**
  - 280 days prior to delivery until 60 days post delivery
  - Mother only