VBPQIAC Workgroup 1 - Maternal and Newborn Health

Policy Issue:

Maternal and newborn health is a key area in which Texas can affect change through VBP, because Medicaid pays for over half the births in the state, yet there is large variability in outcomes and costs and significant disparities among population groups. Texas is a vast state, and some of the variability is driven by regional differences in population health and local social drivers.

Providers indicate the complexities of collecting and reporting data for a multitude of performance measures is a barrier to their new or continued participation in VBP arrangements. Providers also need data that is timely and actionable to enhance maternal health and improve birth outcomes.

Recommendation:

The following recommendations would enable better informed maternal and newborn health interventions as well as enable more uniform and meaningful performance measurement:

1) Establish a consensus endorsement of a set of standardized performance measures, measure specifications, and reporting periods for maternal and newborn care through a two-stage process:
   - Regional stakeholders in diverse pilot regions establish consensus measures and measurement approaches that address local needs, priorities, and barriers to provider participation
   - Convene stakeholders from DSHS, HHSC, and other relevant advisory committees and collaboratives to establish a statewide endorsement informed by regional needs

2) Establish a statewide de-identified database linking mothers and babies that enables providers to explore and improve on their performance on key measures in near real-time

Discussion:

<u>Standardization of Performance Measures</u>

Providers report that the multitude of differing performance measures, measure specifications, and reporting periods for various incentive programs and APMs is a barrier to their new or continued participation in APMs. For example, one Houston physician practice tallied that they had to report on more than 150 performance measures across all payers and programs for all disciplines. Some providers report that the administrative cost to track and report performance measures exceeds any incentives they can receive through participation in payer programs. This

administrative cost and complexity is a disincentive for providers to participate in VBP arrangements.

Because over half the births in Texas are paid for by Texas Medicaid, the stakeholders associated with Texas Medicaid have the ability to influence maternal health and birth outcomes. There is an opportunity to align measures among a variety of initiatives and programs, including legislative initiatives such as the required pregnancy medical homes pilots (S.B. 748, 86th Legislature, Regular Session) and HHSC quality initiatives such as the P4Q program and assessment of Medicaid alternative payment methodologies. DSHS implements and collaborates in a number of efforts to improve maternal health in Texas.

In a state as diverse and vast as Texas, any statewide endorsement of standardized measures should be informed by regional concerns. For this reason, the committee has recommended that regional stakeholders first convene in diverse pilot regions to establish consensus measures and measurement approaches that address local needs, priorities, and barriers to provider participation. They then can engage in regionally-based quality improvement efforts that use the selected measures to assess the outcomes of their efforts on addressing local priorities.

Selection of pilot regions should consider representation of both urban and rural areas and account for areas with diverse health concerns and community needs. Consideration could also be given to aligning the regions chosen for the measure standardization pilots with counties participating in the S.B. 748 pregnancy medical homes pilots. Lessons learned from existing S.B. 748 efforts could prove invaluable to the measure development process, and there will already be a ready group of stakeholders aligned around the activities and assessment of these pregnancy medical home pilots.

Participants in the pilot measure development process should include membership of perinatal regional advisory committees, Medicaid MCOs that serve the region, and other interested stakeholders. The goal of the regional pilot efforts would be to establish an agreement about a limited set of measures and measure definitions to recommend for further consideration at a statewide level.

Equipped with the recommendations resulting from the regional pilot process, DSHS, HHSC, and other stakeholders, such as interested advisory committee members and the Texas Collaborative for Healthy Mothers and Babies, could convene to assess the various maternal and newborn health measures and endorse a set of key measures, measure specifications, and reporting periods. HHSC could encourage the statewide use of the endorsed measures among Medicaid MCOs and for future quality initiatives to reduce administrative burden and encourage provider participation in APMs. Standardized measures also would enable more meaningful comparison of the outcomes of various programs and interventions.

As a starting point for measure consideration, stakeholders could look to Tennessee[1] and Ohio[2] for the measures historically used in their perinatal episodes of care models. The Healthcare Payment Learning & Action Network (HCP LAN) also developed a *Maternity Episode Payment Model Online Resource Bank*[3] that features a Robert Wood Johnson Foundation-supported *Buying Value Measure Selection Tool.*[4]

Statewide De-identified Mother-Baby Database

Performance measurement is most meaningful when the data is timely and actionable. Texas should establish a statewide de-identified database linking mothers and babies that enables providers to explore and improve on their performance on key measures in near real-time. The Texas Regional Advisory Committee—Perinatal Care Region Chairs Alliance also stated in late 2019 it "fully supports and emphasizes the critical need for a statewide de-identified patient-level Quality and Outcomes Database for Maternal, Fetal and Neonatal patients in the State of Texas."

There are some examples providers point to as a gold standard for implementing de-identified databases focused on maternal and birth outcomes. One example is the Vermont Oxford Network, which has over 1300 hospital participants collaborating to improve neonatal care outcomes.[5]

The California Maternal Data Center (MDC),[6] which was launched in 2012 and now supports data from Washington and Oregon as well, provides an example of the potential for a database that addresses maternal and newborn health outcomes more broadly. The Maternal Data Center is currently supported by participating hospitals and grants from the California Health Care Foundation (CHCF). The CHCF and the Centers for Disease Control and Prevention provided financial support for developing the Maternal Data Center. California has used the database to help it rank, according to America's Health Rankings, among the top ten states for measures such as maternal and infant mortality and avoiding low birth weight deliveries.[7]

The MDC is an online web tool that generates near real-time data and performance metrics on maternity care services for hospital participants. Hospitals submit

[1] Tennessee *Detailed Business Requirements for Perinatal Episode, v5.1*: https://www.tn.gov/content/dam/tn/tenncare/documents2/Peridbr2019v5.pdf and Tennessee *Detailed Business Requirements for Neonatal Episode, v1.1*: https://www.tn.gov/content/dam/tn/tenncare/documents2/NEO3236DBRV1.1.pdf

[2] Ohio Perinatal measures CY2019: https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/Threshold/Perinatal-Thresholds.pdf

[3] HCP LAN *Maternity Episode Payment Model Online Resource Bank*: https://hcp-lan.org/maternity-resource-bank/

[4] RWJF *Buying Value Measure Selection Tool*: http://www.buyingvalue.org/resources/toolkit/

[5] Vermont Oxford Network site: https://public.vtoxford.org/

[6] California Maternal Data Center site: https://www.cmqcc.org/maternal-data-center

[7] America's Health Rankings for California: https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/CA

patient discharge data to the MDC, which instantaneously links the discharge data to birth certificate or clinical data. The result is a low-burden tool that enables hospitals to compare their performance to statewide, regional and system benchmarks or generate provider-level quality metrics.

Texas could streamline and build on existing statutory and regulatory precedent for data-gathering in the perinatal arena for development of a Texas database linking available data about mothers and babies.[8] This could automate, to the extent possible, the generation of the standardized maternal and newborn health measures endorsed by HHSC, DSHS, and other Texas Medicaid stakeholders. Such a tool could become a driver of provider-specific quality interventions. It also could minimize provider administrative burden in collecting and reporting data that could facilitate participation in VBP arrangements and other quality initiatives.

Considerations for development of a de-identified mother/baby database should include:

- financing mechanisms,
- how providers could be incentivized to participate,
- how to minimize provider administrative burden to participate, and
- how to implement risk adjustment strategies to ensure apples-to-apples comparison of the performance of like providers with like patient risk profiles.

Consideration should also be given to whether data sources with existing data collection infrastructure could be leveraged for a Texas database. The UT Data Center has claims and other data from ERS, TRS, Medicaid, Medicare and many commercial payers. The Texas Health Care Information Collection (THCIC) has inpatient and outpatient discharges from Texas hospitals, including patient and facility characteristics, diagnoses, procedures, and charges. DSHS Vital Statistics collects birth certificate data. The Texas Healthcare Learning Collaborative portal has Medicaid quality data.

If identifying start-up funding is a challenge, leveraging existing data infrastructure could also be a component of a staged approach to database development that initially would be less resource intensive. For example, though more real-time data would be ideal, claims data can be analyzed to map ICD-10 metrics to ICD-10 diagnoses. In addition, it would be ideal to have data down to the individual

[8] Texas Health and Safety Code (HSC), Sec. 34.012, authorizes DSHS to establish an electronic de-identified database to track cases of pregnancy-related deaths and severe maternal morbidity. HSC, Sec. 241.183(d) states: "Each level of care designation must require a hospital to regularly submit outcome and other data to the department as required or requested." Per HSC, Sec. 32.017, each provider receiving reimbursement under the Maternal and Infant Health Improvement Act must maintain records and information for each applicant for or recipient of services. The legislature established the perinatal healthcare system under HSC, sec. 32.041, and under sec. 32.042 gave HHSC rulemaking authority for "requirements for data collection, including operation of the perinatal health care system and patient outcomes". HSC, sec. 32.074(5) requires that centers of excellence for fetal diagnosis and therapy must provide annual reports containing aggregate data on short-term and long-term diagnostic and therapeutic outcomes as required by DSHS and makes those reports available to the public.

provider level, but the initiative could start with unit level and higher data. Regardless, the registry would present a value proposition to hospital providers of diminishing some administrative burden in quality reporting and enabling a broader view of their performance, which may enable them to hone their health-promoting and cost-saving interventions.