NEW YORK STATE OF OPPORTUNITY. Department of Health

Maternity Care Value Based Payment Arrangement

Fact Sheet

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NYS Medicaid Value Based Payment

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This fact sheet has been prepared to assist payers and providers to more thoroughly understand New York State's Medicaid Maternity Care Value Based Payment (VBP) Arrangement. It provides an overview of the Arrangement including a summary of the components of care, the underlying episodes of care and the categories of measures recommended for use in Maternity Care Arrangements.

Introduction

The Maternity Care VBP Arrangement is designed to focus on integrated prenatal, labor/delivery, and postpartum care for pregnant persons and the option of newborn care for their babies. Quality measures related to each of these stages of care help to reinforce the care connections built into the Arrangement and provide a standardized set of measures for maternity care providers statewide.

VBP Contractors[1] have the opportunity for shared savings if they focus on evidence-based and guideline-driven interventions that lead to improved maternal care and newborn outcomes, including: health education, increased uptake of prenatal care, pre- and inter-conception counseling, appropriate C-Section rates and resource utilization, improved screening rates for postpartum depression, and evidence-informed home visits. Quality improvements are achieved through the integration and standardization of care, increasing cost-effectiveness for both mothers and babies. The Maternity Care VBP Arrangement also provides an impetus to streamline the continuum of maternity care, which can be overlooked in larger scale, population-based healthcare initiatives. Finally, attention to early health and developmental outcomes of newborns will help improve the well-being of the next generation of New Yorkers.

This fact sheet provides an overview of New York State (NYS) Medicaid's Maternity Care VBP Arrangement and is organized into two sections:

- Section 1 describes the care included in the Maternity Care VBP Arrangement, the method used to define the attributed population, and the associated costs under the Agreement;
- Section 2 describes the quality measure selection process and the categories of measures recommended for use in Maternity Care Arrangements.

Section 1: Defining the Maternity Care Episodes of Care VBP Arrangement

The Maternity Care Arrangement: Three Distinct Components of Care

The Maternity Care VBP Arrangement creates a comprehensive, integrated view of maternity care from three distinct components of care. Each component consists of groups of clinically related services, provided by physicians, midwives, doulas, and ancillary providers delivering care to mothers and newborns across multiple settings during a defined period.

As illustrated in Figure 1, the Maternity Care Arrangement consists of the following three components of care:

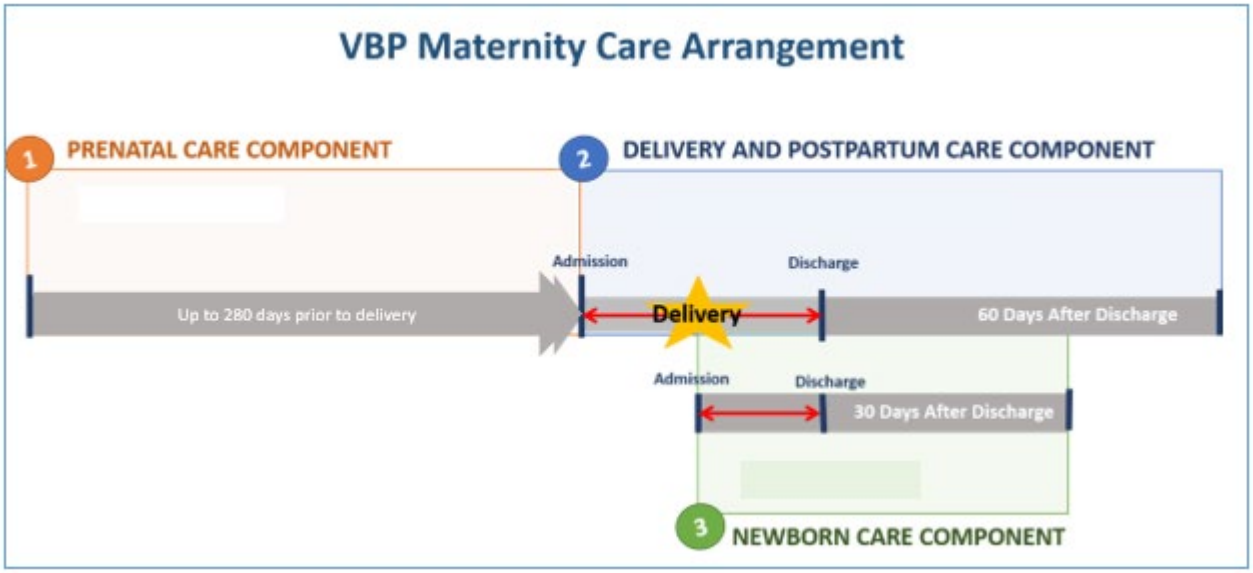
1. Prenatal Care;
2. Delivery and Postpartum Care; and
3. The option of Newborn Care.

Together, these three components of care reflect the prenatal care delivered up to 280 days prior to the

[1] A VBP Contractor is an entity a provider or group of providers – engaged in a VBP contract.

admission associated with delivery (the Prenatal Care Component), the care provided to the mother from inpatient admission for delivery through 60 days after discharge (the Delivery and Postpartum Care Component), and as an option, the care provided to the newborn from birth to 30 days after discharge (the Newborn Care Component).

Figure 1: VBP Maternity Care Arrangement



Constructing the Maternity Care Arrangement Episodes: Trigger Events, Time Windows, and Services

The Maternity Care Arrangement is driven by the delivery event, which triggers the process of identifying, linking, and constructing the episodes within the three components of care. The components of the Arrangement provide a view of the events which occurred prior to delivery, along with outcomes of the delivery and subsequent care. The procedure codes for delivery (Vaginal or C-Section Delivery) are considered "trigger codes" for the pregnancy and delivery episodes of care, and the first newborn claim triggers the newborn episode. This initiates a review of claims from the components of maternal and newborn care to construct the episodes based on clinically relevant services.

The Underlying Components of the Maternity Care Arrangement

Pregnancy Component

- The Pregnancy Episode is triggered by the delivery (procedure codes for Vaginal or C-Section delivery).
- The episode time window includes a look back window of 280 days prior to the admission for the delivery, to capture all prenatal care services delivered from the beginning of the pregnancy to the admission for delivery.
- The Pregnancy Component should include all prenatal care services such as office visits, laboratory tests, and ultrasound examinations, as well as any medications and pregnancy-related hospital admissions and complications up to delivery.

Delivery Component (Vaginal or C-Section Delivery)

- The Delivery Component begins at admission for the delivery and extends to 60 days after discharge from the hospital. The Episode includes all relevant services including services provided during the inpatient stay for the delivery, as well as for postpartum care.
- The Delivery Component is considered complete 60 days after discharge of from the hospital.

Optional Newborn Component

- The Newborn Component is triggered by newborn diagnosis codes indicating a baby has been born, either by vaginal delivery or C-Section.
- This Component begins with the first service provided for the newborn as indicated by the initial claim. The episode time window extends from this initial service to 30 days after discharge from the hospital for the newborn. All services provided to the newborn during the episode time window, including services during the inpatient stay, such as neonatal intensive care unit services, laboratory or diagnostic tests and professional services (e.g., neonatologist and Primary Care Physician (PCP) services), are included in the Newborn Component.
- This component is considered complete at the close of the time window, 30 days after discharge from the hospital.

Eligible Patient Population

The eligible patient population for the Maternity Care Arrangement includes all Medicaid Managed Care Organization (MCO) patients with the following exceptions:

- **Medicaid patients for whom Medicaid is not the sole payer:** Medicaid patients with contract year services for which Medicaid is not the sole payer are excluded (e.g., dually eligible patients and patients with Medicaid as payer of last resort on a commercial premium).

Patient Attribution

State guidance for attribution recommends that the episodes within the Maternity Care Arrangement be attributed to the obstetrician or midwife who provides the plurality of the prenatal care. In cases where there is no obstetrician, family physician, or midwife identified as the billing provider for prenatal care services, the delivery and three associated components of care should be attributed to the provider performing the delivery procedure.

VBP Contractors and the Medicaid Managed Care Organizations (MCOs) can adopt standards for attribution in their contracts not in alignment with the guidance above, so long as the contract receives State approval for meeting VBP contracting requirements. The NYS Roadmap details attribution guidelines for VBP Contractors and Medicaid MCO for each arrangement.[2]

Calculation of Episode Costs

The total cost for the population under the Maternity Care Arrangement is designed to account for all episode-related, Medicaid-covered care provided to the attributed patients during the contract year The aggregate costs (defined as the total amount paid by the Medicaid MCO) can be further analyzed to identify and understand variation across the underlying episodes and by service type, leading to opportunities for improvement in quality of care and resource use.

Components of the Maternity Care Arrangement to Consider

Certain factors, such as a neonatal intensive care unit admission for a newborn, can easily skew the cost

[2] New York State Department of Health, Medicaid Redesign Team, Value Based Payment (VBP), VBP Roadmap. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm

of the Newborn Care Component of the Arrangement, exposing providers to excessive risk. To help mitigate this risk, VBP Contractors in the Maternity Care Arrangement should consider adding stop-loss provisions to their contracts if newborns are included to exclude episodes of care with a total cost above a certain threshold.

Other aspects of this population should be reviewed for inclusion in the Episode such as age, stillbirths, and multiple live births.

Section 2: VBP Quality Measure Set for the Maternity Care Arrangement

The Maternity Care Quality Measure Set is created in collaboration with the Maternity Clinical Advisory Group (CAG). The Maternity Care Quality Measure Set is intended to encourage providers to meet high standards of patient-centered clinical care and coordination across multiple settings through pregnancy, delivery and the postpartum period, as well as for newborn care from birth to the first 30 days post-discharge when the newborn component is included.

Measure Categorization

Each measure has been designated by the State as Category 1, 2, or 3 according to the following criteria:

- **CATEGORY 1** – Approved quality measures that are deemed to be clinically relevant, reliable, valid, and feasible;
- **CATEGORY 2** – Measures that are clinically relevant, valid and reliable but where the feasibility could be problematic; and,
- **CATEGORY 3** – Measures that are insufficiently relevant, valid, reliable and/or feasible.

Note that measure classification is a State recommendation. Although Category 1 Measures are required to be reported, plans and VBP Contractors can choose the measures they want to link to payment and how they want to pay on them (P4P or P4R) in their specific contracts. At least one Category 1 P4P, race and ethnicity stratified measure must be included in any maternity-specific VBP contract.[3]

Category 1

Category 1 quality measures, as identified by the CAGs and accepted by the State, are to be reported by VBP Contractors. A subset of these measures is also intended to be used to determine the amount of shared savings for which VBP contractors would be eligible.

The State has classified each Category 1 measure as either P4P or P4R:

- **P4P** measures are intended to be used in the determination of shared savings amounts for which VBP Contractors are eligible. In other words, these are the measures on which payments in VBP contracts may be based. Measures can be included in the determination of both the performance adjustment in the target budget and in the calculation of shared savings for VBP Contractors;

- **P4R** measures are intended to be used by Medicaid MCOs to incentivize VBP Contractors for reporting data to monitor quality of care delivered to patients under the VBP contract. Incentives for reporting should be based on timeliness, accuracy and completeness of data. Measures can be reclassified from P4R to P4P through annual CAG and State review or as determined by the Medicaid MCO and VBP Contractor.

[3] The quality measure set can be found under the VBP Quality Measures section for the respective measurement year and arrangement. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm

Please see the Value Based Payment Reporting Requirements Technical Specifications Manual[4] for details as to which measures must be reported for the measurement year. This manual will be updated annually each Fall, in line with the release of the final VBP measure set for the subsequent measurement year.

Categories 2 and 3

Category 2 measures have been accepted by the State based on agreement of measure importance, validity, and reliability but flagged as presenting concerns regarding implementation feasibility.

Measures designated as Category 3 are deemed unfeasible. Reasons include concerns about valid use in small sample sizes of attributed members at a VBP contractor level and limited potential for performance improvement in areas where statewide performance is already near maximum, expected levels.

Annual Measure Review

Measure sets and classifications are considered dynamic and will be reviewed annually. Updates will include additions, deletions, re-categorizations, and re-classification from P4R to P4P, or P4P to P4R, based on experience with measure implementation in the prior year.

[4] VBP Reporting Requirements Technical Specifications Manual can be found under the VBP Quality Measures section for the respective measurement year. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm