

## Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP

### Introduction

Timely and evidence-based postpartum care can have long-term impacts on the health of women and infants. Postpartum visits provide opportunities to assess women's physical recovery from pregnancy and childbirth, and to address chronic health conditions (such as diabetes or hypertension), mental health status (for example, postpartum depression), and family planning (for example, contraceptive counseling). The postpartum visit is also a time for providers to counsel women on nutrition, breastfeeding, tobacco cessation, and other preventive health issues.

The Centers for Medicare & Medicaid Services (CMS) worked in close partnership with state Medicaid Agencies on a range of activities as part of its Maternal and Infant Health Initiative (MIHI) to explore program and policy opportunities that improve outcomes and reduce the cost of care for women and infants in Medicaid and the Children's Health Insurance Program (CHIP). Through the Postpartum Care Action Learning Series (*PPC Action Learning Series*), the Center for Medicaid and CHIP Services (CMCS) provided states an opportunity to develop and implement quality improvement projects to improve postpartum care in Medicaid and CHIP. The PPC Action Learning Series was a structured, team-based collaborative learning experience, in which states and their partners exchanged ideas and best practices, and received technical assistance.

Most states pay for maternity care in Medicaid and CHIP using a bundled payment for professional services provided during the perinatal period, including prenatal care, labor and delivery, and postpartum care.<sup>1</sup> Because payment of this bundle is often triggered by delivery and not tied to performance on quality metrics, this payment structure can inadvertently function as a disincentive to the provision of postpartum care because providers receive the same payment regardless of whether the woman attends the postpartum visit.<sup>2</sup> Bundled payments can also create data quality and measurement issues because providers bill for the entire bundle rather than the component services included in the bundle, making it hard to track postpartum visits without undertaking costly medical chart review.

Through the PPC Action Learning Series, several states explored whether changing Medicaid payment or billing policies might support efforts to improve the rate of postpartum care visits and/or to improve the quality of care during the visit. This issue brief summarizes the changes three states made related to paying for maternity care and the lessons they learned.

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<sup>1</sup> Health Care Payment Learning & Action Network. "Clinical Episode Payment Models: Maternity Care." August 2016. Available at <http://hcp-lan.org/workproducts/maternity-whitepaper-final.pdf>. Note that facility fees for the birth are usually paid separately.

<sup>2</sup> The Centers for Medicare & Medicaid Services convened the Expert Panel on Improving Maternal and Infant Outcomes in Medicaid and CHIP in June 2012 to explore program, policy, and payment reforms that improve outcomes and reduce the cost of care for women and infants in Medicaid and CHIP. For more information see: Applegate, M., R.E. Gee, and J.N. Martin. "Improving Maternal and Infant Health Outcomes in Medicaid and Children's Health Insurance Program." *Obstetrics & Gynecology*, vol. 124, 2014, pp. 143–149.

## Payment strategies to improve the rate and content of postpartum visits

States may consider several alternative payment strategies to incentivize high quality postpartum care (Exhibit 1).<sup>3</sup> As long as payments are tied to quality metrics, any of these payment approaches can help states improve the rate and content of postpartum care visits by rewarding providers when the postpartum care visit happens and incentivizing key components of a high quality postpartum care visit (such as long-term weight management, pregnancy complications, and reproductive life-planning).<sup>4</sup>

- **Fee-for-Service (FFS) payments linked to quality.** This payment approach represents the first step away from traditional FFS payments toward value-based payment. Initially, practices may receive payments linked to infrastructure enhancements like transitioning to electronic medical records (EMRs), paying for care coordination nurses, or pay-for-reporting where positive or negative incentives are tied to reporting quality measures. Further along the continuum within this category, providers may receive bonus payments or penalties based on their performance on quality measures (pay-for-performance). Both managed care organizations (MCOs) and Medicaid FFS programs may use this model.
- **Alternative payment models on a fee-for-service structure.** This model accounts for performance based on both quality and cost. Providers may receive shared savings if they meet quality and cost metrics, or they may be required to reimburse the payer an established amount if they do not meet cost targets. These positive and negative payment adjustments represent upside gain-sharing and downside risks, respectively. Most accountable care organizations (ACOs) use this model. Other examples include bundled payments, episode-based payments for procedure-based care, and primary care (PCMHs) with shared savings and losses.
- **Population-based payments.** This model provides a single payment for a comprehensive set of services for specific conditions or populations and expects providers to meet quality metrics. This model offers the strongest incentive for coordinating care across providers and delivering person-centered care, as long as receipt of payment is tied to performance on quality measures. Some MCOs, ACOs, and PCMHs use this model.

### Exhibit 1. Postpartum care payment models

Fee-for-service, linked to quality metrics	Alternative payment models on a fee-for-service structure, linked to quality metrics	Population-based payment, linked to quality metrics
<ul style="list-style-type: none"><li>• Foundational payments for infrastructure and operations</li><li>• Pay for reporting</li><li>• Rewards for performance</li><li>• Rewards and penalties for performance (payment for meeting quality improvement goal; penalty such as withholding payments if goal not reached)</li></ul>	<ul style="list-style-type: none"><li>• APMs with upside gain-sharing</li><li>• APMs with upside gain-sharing and downside risks</li></ul>	<ul style="list-style-type: none"><li>• Condition-specific payment</li><li>• Comprehensive population-based payment</li></ul>

Source: Adapted from the Health Care Payment Learning & Action Network.

APM = alternative payment model.

<sup>3</sup> Health Care Payment Learning & Action Network. "Alternative Payment Model (APM) Framework." January 2016. Available at <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>.

<sup>4</sup> <https://www.acog.org/-/media/Departments/Toolkits-for-Health-Care-Providers/Postpartum-Toolkit/2018-Postpartum-Toolkit.pdf?dmc=1>.

States have considerable flexibility within Medicaid statutes and regulations to develop alternative payment strategies that support implementation of quality improvement projects to improve postpartum care. CMS has approved innovative payment methodologies such as bundled payments, payments for episodes of care, patient-centered medical home (PCMH) model payments, and performance-based incentive and shared savings payments under Medicaid state plan authority. CMS encourages states that are interested in alternative payment strategies to engage CMS for technical support in developing these methodologies and to identify the appropriate Medicaid authorities required to implement the strategies.

## Examples of state payment strategies to improve postpartum care

The PPC Action Learning Series sought to support state efforts in redesigning the way they pay for maternal and infant health care to improve the rates and content of postpartum care visits. Exhibit 2 highlights three states—Louisiana, North Carolina, and Ohio—that have implemented payment changes to improve postpartum care in Medicaid.

### Exhibit 2. Examples of state payment strategies to improve postpartum care in Medicaid and CHIP

State and payment model	Summary of approach
<p><b>Louisiana</b></p> <p>Fee-for-service with payment linked to quality metrics (postpartum visit and LARC insertion)</p>	<ul style="list-style-type: none"> <li> <p><b>Background and motivation for payment reform:</b> Louisiana previously reimbursed providers for perinatal care using an obstetric care (OB) bundle. This bundle did not incentivize providers to promote postpartum visits as providers would be paid the same rate regardless of whether the visit occurred. Further, Louisiana Medicaid found that some providers were billing both the global payment and a postpartum visit code.</p> </li> <li> <p><b>Payment redesign:</b> Louisiana unbundled antepartum, delivery, and postpartum care so that providers would be motivated to encourage mothers to return for their postpartum visits.</p> <ul style="list-style-type: none"> <li>Delivery is billed using the most appropriate 'delivery-only' CPT code (59409-TH [GB, AT or GZ]; 59514-TH [GB, AT, or GZ]; 59514-80-TH [GB, AT, or GZ]; 59612-TH (GB, AT, or GZ); 59525-TH; Medicaid does not reimburse delivery CPT codes that include prenatal and/or postpartum care.</li> <li>Postpartum care is billed using the postpartum care CPT code (Z39.0-Z39.2) without any billing modifiers.</li> <li>To address barriers to providing the most effective contraceptives, Louisiana added a payment for insertion of long-acting reversible contraceptives (LARCs) in the hospital following delivery and increased reimbursement of LARCs.</li> </ul> </li> <li> <p><b>Link to quality:</b> Louisiana added new clinical practice components for the postpartum visit, including family planning counseling, breastfeeding support which included referral to the WIC Program, follow up plan for women with gestational diabetes, and screening for postpartum depression and intimate partner violence.</p> </li> <li> <p><b>Lessons learned:</b> Louisiana found that access to LARCs during the postpartum period increased after the LARC payment reforms were implemented in 2014. Using the U.S. Office of Population Affairs Contraceptive Care-Postpartum measure, the rate of access to a LARC during the postpartum period increased from 11.6 percent of women to 19.4 percent of women within two years. Additionally, the Healthcare Effectiveness Data and Information Set (HEDIS®) administrative claims data postpartum visit rate for Louisiana Medicaid increased from 29 percent for HEDIS 2015 (2014 measurement year) to 50 percent for HEDIS 2017 (2016 measurement year). The statewide hybrid rate (which is based on a combination of administrative claims data and medical chart reviews) remained relatively stable (61 percent for HEDIS 2015 versus 60 percent for HEDIS 2017). These results show that the unbundling of the postpartum visit narrowed the gap between the administrative rate and the hybrid rate from more than 30 percentage points for HEDIS 2015 to 10 percentage points for HEDIS 2017. As a result of the payment reform, the accuracy of the claims-based postpartum rate improved, which Louisiana Medicaid considers an important performance indicator.</p> </li> </ul>

State and payment model	Summary of approach
<p><b>North Carolina</b></p> <p>Fee-for-service linked to quality metrics (incentive payment for postpartum visit content)</p>	<ul style="list-style-type: none"> <li> <p><b>Background and motivation for payment reform:</b> North Carolina Division of Medical Assistance (Medicaid) and the Medicaid primary care case management program, known as North Carolina Community Care Networks (NCCCN), established a pregnancy medical home (PMH) model in April 2011 to improve the quality of maternity care, improve birth outcomes, and achieve cost savings. About 90 percent of North Carolina providers who care for pregnant Medicaid members participated in the PMH program and signed a contract with NCCCN, agreeing to meet expectations, such as completing a postpartum visit within 60 days of delivery.</p> <p>North Carolina uses the administrative method (claims data only) to measure the postpartum visit rate. North Carolina’s previous billing structure did not incentivize providers to promote postpartum care visits and limited data analysis because more than 50 percent of maternity care was billed with the global fee and did not require documentation that a postpartum visit occurred. Thus, North Carolina Medicaid decided to activate an unused Healthcare Common Procedure Coding System (HCPCS) code for a postpartum incentive payment to increase the postpartum visit rate and improve data quality.</p> </li> <li> <p><b>Payment redesign and link to quality:</b> PMH providers received a \$150 incentive payment for the postpartum visit if it was completed within 60 days of delivery and included depression screening using a validated tool, reproductive life planning, and referral for ongoing primary care. The postpartum incentive was billed using a separate HCPCS code (S0281) so that the date of the postpartum visit could be tracked. To be reimbursed, the provider had to be recognized by the claims processing system as a PMH program participant. There also had to be a paid claim in history for an obstetric (OB) package code that is inclusive of postpartum care (59400, 59410, 59510, 59515, or 59430). The OB package code and the postpartum incentive code could be on the same claim as long as the OB package code is listed first.</p> </li> <li> <p><b>Lessons learned:</b> North Carolina indicated that the postpartum incentive appeared to be prompting the scheduling of earlier postpartum visits to allow more time for outreach if the patient did not attend the first appointment, as well as more proactive efforts on the part of the practice to ensure the patient returned for the postpartum visit. The use of standardized screening tools for depression screening also increased due to the PMH incentive requirement. The rate of unintended pregnancy in the North Carolina Medicaid population also declined steadily since the launch of the PMH program, partly driven by more women returning for postpartum care and receiving their desired contraceptive method during the postpartum period.</p> <p>Building on the successes in the 7 Postpartum Care Action Learning Series pilot sites, North Carolina launched a quality improvement project in 2016 at 45 additional sites. The goal was to improve data quality and increase the proportion of women who attended their postpartum visit.</p> </li> </ul>

State and payment model	Summary of approach
<p><b>Ohio</b></p> <p>Alternative payment model on a fee-for-service structure linked to quality metrics</p>	<ul style="list-style-type: none"> <li>• <b>Background and motivation for payment reform:</b> Ohio was motivated to design episode-based payments because it ranked 18th among states in highest health care costs per person, but ranked 36th in population health.</li> <li>• <b>Payment redesign:</b> Ohio designed episode-based payments for acute medical events, including perinatal care, under a State Innovation Model (SIM) grant (although a similar model could be implemented in other states without SIM funding). This new payment model was designed to decrease utilization of elective interventions, ensure appropriate length of stay, promote effective prenatal and postpartum care, and reduce unnecessary readmissions.</li> <li>• <b>Multi-Payer alignment:</b> Medicaid fee-for-service (FFS), Medicaid managed care plans, and commercial plans participated in Ohio's episode-based payment initiative. Collectively covering about 90 percent of Ohio's population, this multi-payer initiative helped to ensure that quality improvement incentives were aligned for all of Ohio's health care providers.</li> <li>• <b>Participant buy-in:</b> Providers, payers, and other stakeholders developed the episode definitions. The perinatal episode covered services provided 280 days before delivery through 60 days after delivery, with delivery being the 'trigger' event.</li> <li>• <b>Negative and positive payment incentives for the Principal Accountable Provider:</b> The physician or physician group responsible for billing the delivery procedure was designated as the principal accountable provider (PAP) for the perinatal episode of care and was expected to coordinate with other providers to ensure high quality, efficient care during the perinatal episode. Payers reimbursed providers over the course of the performance year via their traditional payment arrangements. At the end of the performance year, the PAP's average cost per episode was calculated and compared against cost thresholds that were set at a level to ensure that the episode incentive payments were budget neutral. Individual episode costs were adjusted for a number of risk factors; additionally, certain episodes were excluded based on established criteria (e.g., high-cost outliers, age restrictions). Thus, providers were not penalized for treating high-risk patients. PAPs with at least five valid episodes were eligible for incentive payments, depending on average risk-adjusted spend and performance on quality metrics. <ul style="list-style-type: none"> <li>• <b>Negative incentives:</b> If the PAP's average risk-adjusted spend was over the acceptable cost threshold, the PAP reimbursed the payer an amount that takes into account the difference between the average risk-adjusted spend and the acceptable cost threshold.</li> <li>• <b>Neutral:</b> If the PAP's average risk-adjusted spend was between the acceptable and commendable thresholds, the PAP was not eligible for incentive payments.</li> <li>• <b>Positive incentives:</b> If the PAP's average risk-adjusted spend was under the commendable threshold and the PAP met all quality metrics linked to the positive incentive payment, the PAP received an incentive payment from the payer. The payment accounted for the difference between the risk-adjusted spend and the commendable threshold.</li> </ul> </li> <li>• <b>Link to quality:</b> For the perinatal episode of care, incentive payments were tied to four quality metrics, including the HIV screening rate, Group B streptococcus screening rate, C-section rate, and postpartum visit rate. In the first performance year, Ohio set the quality thresholds at a level where 75 percent of providers would meet all metrics so that most providers would be eligible for incentive payments. To promote performance improvement, Ohio increased the postpartum visit threshold from 50 percent to 55 percent in subsequent years.</li> <li>• <b>Lessons learned:</b> Multi-payer alignment and provider participation in the design of this payment model were key to its success. Identifying a PAP also created a locus for accountability and facilitated care coordination. Finally, sharing frequent performance reports with participating providers facilitated continuous quality improvement. Each payer issued its own PAP-specific quarterly report, so that PAPs could monitor their performance in relation to other PAPs and the cost and quality thresholds. The final report displayed the incentive payment, if applicable. For Medicaid FFS, system administrators from the respective PAPs could access reports on the Medicaid portal and share results with OB providers at the facility. The reports were accompanied by an Excel spreadsheet, which provided detailed information on each episode, so that PAPs could conduct their own analyses and identify areas for improvement. Starting in September 2017, the PAP quarterly reports were aggregated into one file showing an all-Medicaid view and a breakdown by each payer and made available to providers in the Medicaid provider portal.</li> </ul>

Sources: Professional Services Provider Manual. Louisiana Department of Health. Available at <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PS/PS.pdf>.



Berrien, Kate, Arthur Ollendorff, and M. Kathryn Menard. "Pregnancy Medical Home Care Pathways Improve Quality of Perinatal Care and Birth Outcomes." *North Carolina Medical Journal*, vol. 76, 2015, pp. 263–266. Available at <http://www.ncmedicaljournal.com/content/76/4/263.full.pdf+html>.

Appendix C. Medicaid Reimbursement in the Postpartum Period. Community Care of North Carolina. Available at <https://www.communitycarenc.org/media/files/postpartum-care-and-transition-well-woman-care-appendix-c.pdf>.

North Carolina Medicaid Special Bulletin: Pregnancy Medical Home. Available at <https://www.communitycarenc.org/media/related-downloads/medicaid-bulletin.pdf>.

Postpartum Care in the Pregnancy Medical Home Setting: A Quality Improvement focus to improve women's health and future pregnancy outcomes. <https://www.communitycarenc.org/media/files/postpartum-care-pregnancy-medical-home-setting-webinar.pdf>.

Payment Innovation: Episodes. Ohio Department of Medicaid. Available at <http://medicaid.ohio.gov/PROVIDERS/PaymentInnovation/Episodes.aspx>.

Centers for Medicare & Medicaid Services. Maternal & Infant Health Initiative. Perinatal Payment Strategies. March 2015. Available at <https://www.medicare.gov/medicaid/quality-of-care/improvement-initiatives/maternal-and-infant-health/resources/index.html>.

## Lessons learned about value-based payment strategies to improve postpartum care

States are exploring a range of value-based payment strategies to improve access to and content of postpartum care, with a focus on changing the maternity bundle to incentivize postpartum visits and/or tying payment to quality metrics (such as provision of recommended postpartum care). Lessons learned among the three states highlighted in this fact sheet include the following:

- **Improving quality measurement and use of recommended services through incentive payments.** A wide variety of payment approaches can be effective in improving the rate and content of postpartum care, provided that they are designed with a clear link to specific quality metrics. Two states found that their rates of postpartum LARC insertion (Louisiana) and postpartum visit adherence (North Carolina) improved as a result of these payment reforms. Moreover, the accuracy and completeness of administrative claims data in both states improved, facilitating quality measurement using administrative data rather than chart reviews. Improved data quality also enabled more timely quality improvement efforts around visit scheduling and patient outreach.
- **Engaging stakeholders.** Broad stakeholder engagement before policy and payment change was important to obtain buy-in from key constituents and to gather clinical and business insights to improve the model. Such engagement efforts included health plans, providers, beneficiary representatives, advocates, and legislators. For example, North Carolina stakeholders recommended reducing the number of postpartum visit components required to receive the incentive payment to prevent the incentive requirements from being overwhelming and a deterrent to participation. Ohio engaged multiple stakeholders in the development of the perinatal episode of care—from creating the episode definition to identifying risk factors and exclusions. Stakeholders also discussed the episode's conceptual framework, identifying how the model might promote higher-quality, more efficient care at various stages. Clinicians helped to ensure the episode of care was tied to evidence-based practice by advocating for many quality metrics. Four quality metrics were selected to be tied to payment and an additional four were chosen for reporting only.
- **Building infrastructure.** Infrastructure, including the ability to report and collect data and to revise billing systems, must support payment changes. For example, North Carolina reported that the transition to a new Medicaid management information system caused incentive claims to be denied, which discouraged early adopters and required subsequent rounds of outreach after the issue was resolved to reassure providers that the billing code would work again. Building the appropriate infrastructure has also been important for Ohio. Ohio's payment model is based on the premise that accountable providers have access to reports to monitor their own performance and identify areas for self-improvement throughout the year. User guides are available to help providers understand the reports.
- **Communicating changes.** Releases of Medicaid bulletins and updates to policy documents are important first steps to communicating policy changes. However, clinicians, practice managers, and billing personnel need education, hands-on technical assistance, and ongoing support to navigate these policy and payment changes. For example, in North Carolina, nurse coordinators helped to communicate policy changes between the state Medicaid agency and frontline clinicians. Nurse coordinators found that clinicians in some cases had not read the bulletin or were confused by its message or skeptical, so practice-based support was essential for building trust and motivating behavior change. Nurse care coordinators also learned that it was important to conduct outreach with the health systems that owned OB offices.

- **Designating accountable providers.** Many APM strategies for maternity care require designating an accountable provider. However, the accountable provider for the delivery may not be responsible for providing postpartum care. In Ohio, for example, the delivery provider is designated as the accountable provider, but may not provide the postpartum visit. Regardless, the delivery provider is expected to coordinate with the postpartum care provider to ensure efficient, high-quality care. States implementing APM strategies should recognize how different delivery systems are organized (including factors that may affect coordination between delivery and postpartum care) and how the designation of the accountable provider may affect access to and content of postpartum care.
- **Adjusting for patient risk.** Payment methods should incentivize best practices without penalizing providers who care for complex cases. A risk-adjustment strategy should account for sicker patients with more complex medical needs and exclude cases that are outliers. For example, Ohio’s risk adjustment strategy excluded certain episodes based on established criteria (such as high-cost outliers and age) to avoid penalizing providers for treating high-risk patients.

### **For further information**

Further information about the Maternal and Infant Health Initiative please contact [CMCS\\_MIH\\_Initiative@cms.hhs.gov](mailto:CMCS_MIH_Initiative@cms.hhs.gov).