



February 19, 2020

North Carolina Department of Health and Human Services
Division of Health Benefits
Dave Richard, Deputy Secretary for NC Medicaid
1950 Mail Service Center
Raleigh, NC 27699-1950
Via email to Medicaid.Transformation@dhhs.nc.gov

Re: North Carolina's Value-Based Payment Strategy for Standard Plans and Providers in Medicaid Managed Care, North Carolina Department of Health and Human Services, January 8, 2020

On behalf of the Centering Healthcare Institute (CHI), thank you for the opportunity to submit feedback on the Department's value-based payment (VBP) strategy regarding Medicaid Managed Care and how to advance the transition from fee to value. The policy document published by the Department on January 8, 2020 provides valuable insight into the Department's strategy, including the Department's desire to receive comments on ways to further align VBP arrangements to important Medicaid populations and services such as pediatrics, maternity care, pharmacy, and Healthy Opportunities. On behalf of CHI, we offer our thoughts on CenteringPregnancy (CP) as a valuable tactic to promote Advance Payment Models (APM) such as bundled payments and the value it can bring to the VBP goals of the Department, Prepaid Health Plans (PHPs), payers, and most importantly, North Carolina's Medicaid enrollees.

About CHI

Centering started in the 1990s as one healthcare provider's idea to provide more effective prenatal care to her patients. Instead of repeating the same information over and over to women one at a time, our founder, Sharon Rising, brought pregnant women together for their prenatal visits. Colleagues who learned about her groups started doing it too, and through word of mouth the demand grew for Centering facilitation trainings across the country.

CHI is a non-profit organization that works closely with health care providers from all sectors to change healthcare, especially regarding improving outcomes related to mothers, babies, and families. With over two decades of experience as the go-to resource for group care, we've developed and sustained the Centering model in more than 600 practice sites and in some of the largest health systems in the world. In North Carolina, our programs operate in 35 locations across the state that include the state's largest health system, academic medical centers, Mountain Area Health Education Center (MAHEC), Army and Navy medical facilities, independent OB/GYN physician practices, Local Health Departments, county Departments of Social Services, and community health centers. Our CenteringParenting program builds on the value that CP brings to mothers and babies through individual well-child health assessments, immunizations, and developmental screenings, as well as group education and opportunities for strengthening families beyond the fourth trimester. CP and CenteringParenting align with several of the ten goals of the Department's North Carolina Early Childhood Action Plan, including promoting healthy

babies, offering preventive health services, encouraging safe and nurturing relationships, and developing social-emotional health and resilience.¹

CHI works with payers and providers to support transformation through:

- Implementation support for system change
- Training and certification in group facilitation and group care
- Site accreditation for model fidelity and quality assurance
- Practice management and support tools including CenteringCounts™ data collection and reporting
- Curriculum materials and supplies that support providers and patients

CHI provides a mature framework to help caregivers provide better maternal health at a lower cost, which benefits providers and payers and lends itself to key strategic objectives of the Department's policy agenda.

About CenteringPregnancy

CP is a promising group prenatal care model that a growing body of evidence suggests can improve birth outcomes, as well as increase women's satisfaction with their prenatal care. In CP, facilitators lead a cohort of eight to ten women of similar gestational age through a curriculum of ten 90- to 120-minute interactive group discussion sessions that cover medical and non-medical aspects of pregnancy, including nutrition, common discomforts, stress management, labor and delivery, breastfeeding, and infant care. CP visits are reimbursable healthcare visits, yet traditional FFS payment models do not typically reward the added value that CP can achieve. Aligning emerging VBP models that reward providers for better outcomes with group prenatal care is an opportunity to make group prenatal care financially sustainable. With Medicaid, the largest payer for maternity care, states have an opportunity to offer this model to more women as part of their emerging payment and delivery system reforms.²

CP is a model of mutual support that is aligned with the Department's goal of whole person care that creates an environment where social and economic factors that affect health can be identified and addressed, with the potential to improve outcomes and women's satisfaction with their maternity care. It involves a significant shift in the model and schedule of prenatal care because it replaces traditional individual appointments, rather than being overlaid on them like care management visits or some other prenatal care enhancements, thereby presenting opportunities for alignment with alternative payment models. For example, the North Carolina Institute of Medicine's Healthy North Carolina 2030 report includes analysis describing the high rates of infant mortality in the state and the various levers that can be used to help reduce infant mortality, including improving access and use of CP and similar programs.³

CP can be sustainably financed along the continuum of value-based payment, from enhanced payments per visit to bonuses for improvement in outcomes and use of a bundled maternity payment with CP as one of the care delivery options. Ideally, providers and payers can assess their readiness to implement

¹ NC Department of Health and Human Services. North Carolina Early Childhood Action Plan, February 2019.

² Rodin, D. & Kirkegaard, M. "Aligning Value-Based Payment with the CenteringPregnancy Group Prenatal Care Model: Strategies to Sustain a Successful Model of Prenatal Care," March 2019.

³ North Carolina Institute of Medicine. Healthy North Carolina 2030: A Path Toward Health, January 2020.

value-based payment for maternity care models like CP together. Because of the growing evidence that CP reduces costs and leads to high satisfaction with care, policy-makers, payers, and providers should work to integrate CP and VBP within maternity care.⁴

CP Alignment with VBP

North Carolina Medicaid covered 43.1% of all births in 2018, slightly more than the national average of Medicaid-funded births, according to a recent report from Medicaid and the CHIP Payment and Access Commission (MACPAC), citing analysis of U.S. Centers for Disease Control and Prevention WONDER online database.⁵ According to a recent report regarding VBP and CP⁶, having Medicaid as the primary payer of births makes “the role of value-based payment for this eligibility group a key consideration for states. Medicaid covers many women who are likely to experience health complications as well as socioeconomic risks and needs. Evidence suggests that women who get their prenatal care in Medicaid have higher odds of experiencing multiple stressors during pregnancy, of showing symptoms of postpartum depression, of experiencing physical abuse, and of smoking.⁷ In many states, particularly those that have not yet adopted the Affordable Care Act Medicaid expansion, low-income women often cannot qualify for Medicaid until they become pregnant, and as a result many enter prenatal care with unmet health needs.”⁸

In recent years, at least four payment models have been considered regarding maternity care and the move toward VBP. According to the Health Care Payment Learning and Action Network (HCP-LAN): “Often prenatal care, labor and birth, and postpartum care are viewed and delivered as three distinct periods. However, by viewing them as three phases within one episode, there is a potential for incentivizing the types of interactions and care delivery that support positive outcomes.”⁹

Options for VBP in maternity care include:¹⁰

- **Enhanced payments** for care management/social worker/group visits or improved outcomes (e.g., lower rates of elective C-sections or preterm births)
- **Bundled payments** for prenatal care and separately bundled payments for hospital and physician delivery services and/or infant care
- A **blended payment** rate for cesarean and vaginal births that assumes a lower rate of elective C-sections eliminates the financial incentive for C-sections for hospitals and physicians but runs the risk of disincentivizing medically indicated C-sections too much if payments are not correctly calibrated

⁴ Rodin, D. & Kirkegaard, M.

⁵ FactSheet: Medicaid’s Role in Financing Maternity Care. Medicaid and CHIP Payment and Access Commission (MACPAC), January 2020.

⁶ Rodin, D. & Kirkegaard, M.

⁷ D'Angelo, D. V., Williams, L., Harrison, L., & Ahluwalia, I. B. (2012). Health status and health insurance coverage of women with live-born infants: an opportunity for preventive services after pregnancy. *Maternal and child health journal*, 16 Suppl 2(0 2), 222-30.

⁸ Access in Brief: Pregnant Women and Medicaid. Medicaid and CHIP Payment and Access Commission (MACPAC), November 2018.

⁹ Accelerating and Aligning Clinical Episode Payment Models. Health Care Payment Learning & Action Network, 2018.

¹⁰ Rodin, D. & Kirkegaard, M.

- Full **episode of care** payment that treats the entire pregnancy and delivery as a single episode

As a key Medicaid service, we believe maternity care aligns with the VBP model from HCP-LAN between PHPs and providers, including Category 3B. The following table illustrates our thoughts on how CP is aligned with Categories 2-4 of the HCP-LAN model.

Category 2 FEE-FOR-SERVICE LINK TO QUALITY AND VALUE	Category 3 APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE	Category 4 POPULATION-BASED PAYMENT
A	A	A
<p>Foundational Payments for Infrastructure and Operations</p> <p>Provide financial support to offset costs associated with starting Centering, such as room upgrades, supplies, coordinator salary, and training and implementation costs</p>	<p>APMs with Shared Savings</p> <p>CenteringPregnancy reduces costs and improves outcomes related to the maternity / labor & delivery / postpartum episode. Cost reduction results from reduced preterm birth rates, NICU admission rates, and length of stay. Evidence indicates reductions of at least 33% are achievable.</p>	<p>Condition-Specific Population-Based Payment</p> <p>CenteringPregnancy reduces costs and improves outcomes related to the maternity / labor & delivery / postpartum episode. Cost reduction results from lowered preterm birth rates, NICU admission rates, and length of stay. Improvements in desired health outcomes and behaviors including prenatal care visit attendance, preparation for labor, postpartum visit attendance, and breastfeeding initiation and continuation.</p> <p>The Centering care delivery methodology is adaptable to most populations and health conditions and represents a scalable investment.</p>
B	B	B
<p>Pay for Reporting</p> <p>In states such as South Carolina, a per-member, per-Centering visit payment is incorporated into the claims process using 99078TH to identify Centering patients. Centering Healthcare Institute validates site eligibility for the payment.</p>	<p>APMs with Shared Savings and Downside Risk</p> <p>CenteringPregnancy reduces costs and improves outcomes related to the maternity / labor & delivery / postpartum episode. Cost reduction results from lowered preterm birth rates, NICU admission rates, and length of stay. Improvements in desired health outcomes and behaviors including prenatal care visit attendance, preparation for labor, postpartum visit attendance, and breastfeeding initiation and continuation.</p>	<p>Comprehensive Population-Based Payment</p> <p>The Centering care delivery methodology is adaptable to most populations and health conditions and represents a scalable investment.</p>

C		C
<p style="text-align: center;">Pay for Performance</p> <p>CenteringPregnancy reduces costs and improves outcomes related to the maternity / labor & delivery / postpartum episode. Cost reduction results from lowered preterm birth rates, NICU admission rates, and length of stay. Improvements in desired health outcomes and behaviors including prenatal care visit attendance, preparation for labor, postpartum visit attendance, and breastfeeding initiation and continuation.</p>		<p style="text-align: center;">Integrated Finance & Delivery Systems</p> <p>CenteringPregnancy is used in integrated health systems including Kaiser Permanente and U.S. Army MEDCOM</p>

Evidence from maternity bundled payment programs in three states where data is available demonstrates the value of bundled payments and the significant return on investment for state Medicaid programs. For example, in Arkansas perinatal spending decreased by 3.8% in the first year of the program and also resulted in an increased rate for chlamydia screenings. In Ohio, completed postpartum visits increased from 57% in 2007 to 80% in 2014 and the cost savings for prevented low birth weight was \$3.36 for the 1st year of life and \$5.59 long-term for every \$1 spent. And in Tennessee, the cost of perinatal episodes of care decreased 3.4% for a total of \$4,719,519 between 2014 to 2015 and also resulted in an increase in screenings for streptococcus and HIV, as well as a decrease in C-sections.¹¹

A growing body of evidence supports the potential of CP to improve birth outcomes and satisfaction with prenatal care, though some of the evidence is mixed and the evidence base continues to evolve. Numerous studies have examined the impact on outcomes, including preterm birth, birthweight, breastfeeding, and perinatal care costs, with many identifying positive effects. Cohort studies have repeatedly suggested that CP improves birth outcomes, including reducing preterm birth rates, low birthweight rates, and racial disparities in adverse outcomes, as well as increasing breastfeeding rates. It has also been found to reduce Medicaid costs in South Carolina while improving outcomes. However, non-randomized studies have involved self-selecting participants into CP, which introduces risk that these women may differ in undetected ways from those who do not choose the model. Some literature reviews—one by Cochrane in 2015 that examined group prenatal care more broadly and another by Carter, et al in 2017 that covered both observational and randomized studies—did not find consistent evidence that CP improves birth outcomes, though they suggested that further research is needed. Additional randomized trial data will continue to shed light on the impact of CP on birth outcomes, including for people at the highest risk of preterm birth.¹²

¹¹ Rodin, D. & Kirkegaard, M.

¹² Rodin, D. & Kirkegaard, M.

CP Alignment with Birth Equity

The United States faces a crisis of high maternal and infant mortality rates, with Black women at three to four times the risk as White women of death from pregnancy-related causes – risk that persists regardless of socio-economic differences.¹³ CP has a potential role as one of the models supporting birth equity as a free-standing or complementary group prenatal care model that is relationship-centered, holistic in its attention to non-medical aspects of health and wellbeing, and that provides time and opportunity for empowering group discussion while creating a supportive environment that fosters trust. Major components of the model align with needed priorities in pursuing birth equity, including:¹⁴

- **Relationship-centered care**, where small groups of expectant or new mothers can come together and experience reciprocal influence and form strong social connections in the context of their communities.
- **Time to identify and address needs in a holistic way**, with up to 15 hours of group time to explore non-medical aspects of pregnancy and postpartum topics with peers and trained facilitators.
- **Enhanced community competency**, where facilitators learn more about the communities in which participants live and raise their children, promoting greater understanding of cultural norms and the needs of different communities
- **Empowerment and respect for participants' experience** by creating a participatory atmosphere in the group
- **Enabling collaborative, team-based care** through integration of a nurse practitioner, certified nurse-midwife, physician, or community health worker facilitators, involving behavioral health techniques or providers, and making connections to community-based resources and providers

CP is an encouraging strategy to promote birth equity and is complementary to other strategies that can be employed as part of broader efforts to reduce health disparities and hold the health system accountable for addressing racism and other systemic inequities.¹⁵

Conclusion

We applaud the Department's strategy to move from FFS to VBP and hope to see additional guidance and strategies to address important Medicaid populations and services such as maternity care. CP provides numerous benefits to enrollees, providers, and payers that are aligned with VBP goals and provided through a neutral, non-profit organization with an established track record. For detailed information regarding CHI and CP, please see the following resources:

Centering Healthcare Institute

<https://www.centeringhealthcare.org>

¹³ HMA Issue Brief: How CenteringPregnancy Can Support Birth Equity, October 2019.

¹⁴ HMA Issue Brief: How CenteringPregnancy Can Support Birth Equity, October 2019.

¹⁵ HMA Issue Brief: How CenteringPregnancy Can Support Birth Equity, October 2019.

Aligning Value-Based Payment with the CenteringPregnancy Group Prenatal Care Model: Strategies to Sustain a Successful Model of Prenatal Care

<https://www.centeringhealthcare.org/uploads/downloads/Aligning-Value-Based-Payment-with-CenteringPregnancy.pdf>

HMA Issue Brief: How CenteringPregnancy Can Support Birth Equity

https://www.centeringhealthcare.org/uploads/downloads/BirthEquity_IssueBrief_Oct9th2019.pdf

CHI has significant experience in North Carolina and in multiple other states and would be pleased to help the Department, providers, and payers learn more about CP and how it can serve as a tactical approach to empowering APMs such as bundled payments to benefit North Carolina, as well as help address birth disparities in our state.

Sincerely,



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